

Discontinuation of cost sharing in Uganda

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Objective To assess the effects of ending cost sharing on use of outpatient services and how this was perceived by health workers and members of a health unit management committee.

Methods From 10 districts across Uganda, 78 health facilities were selected. Attendance at these facilities was assessed for eight months before and 12 months after cost sharing ended. The data represented 1 966 522 outpatient visits. Perceptions about the impact of ending cost sharing were obtained from the 73 health workers and 78 members of the health unit management committee who were available.

Findings With the end of cost sharing, the mean monthly number of new visits increased by 17 928 (53.3%), but among children aged <5 years the increase was 3611 (27.3%). Mean monthly reattendances increased by 2838 (81.3%) among children aged <5 years and 1889 (24.3%) among all people. Attendances for immunizations, antenatal clinics, and family planning all increased, despite these services having always been free. Health workers reported a decline in morale, and many health unit management committees no longer met regularly.

Conclusion Use of all services increased — even those that had never before been subject to fees. The loss of some autonomy by the health facility and diminished community governance of health facilities may have long term negative effects.

Keywords Ambulatory care/economics; Cost sharing; Health services/utilization; Health services accessibility; Pharmaceutical preparations/supply and distribution; Uganda (source: MeSH, NLM).

Mots clés Soins ambulatoires/économie; Partage coût; Services santé/utilisation; Accessibilité service santé; Préparations pharmaceutiques/ressources et distribution; Ouganda (source: MeSH, INSERM).

Palabras clave Cuidados ambulatorios/economía; Seguro de costos compartidos; Servicios de salud/utilización; Accesibilidad a los servicios de salud; Preparaciones farmacéuticas/provisión y distribución; Uganda (fuente: DeCS, BIREME).

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Voir page 194 le résumé en français. En la página 194 figura un resumen en español.

يمكن الاطلاع على الملخص بالعربية في صفحة 195.

Introduction

Cost sharing, or user fees, have been an approach used by public sector health services in developing countries to recover some of the costs of services. Cost recovery was promoted by the World Bank and others to help bring expenditures into line with revenues (1, 2). No acceptable scheme, however, can recover other than a small portion of actual costs. The Bamako Initiative (1987) was one approach that promoted community financing of health services through a revolving drug fund (3). Success depended heavily on local management capacity and continuing central support for salaries and equipment (4). More commonly, set fees were introduced for services, sometimes called the “standard model” (5).

In Kenya, charges for treatment rather than for registration were more acceptable to the community, as long as preparation was adequate (6). User fees work best as a part of a larger process that includes quality improvement and some element of community risk-sharing — not just revenue generation (5). Equity, and specifically access for the poor, has been a major

concern with cost sharing. Common exemption methods include geographic targeting of poverty affected areas, community issued certificates, means testing through wage records, and exemption decisions at the point of service (7). For most African countries, implementation of effective exemption criteria for the poor, while limiting the leakage of benefits to the non-poor, is difficult.

Cost sharing and utilization

In Kenya, introduction of fees resulted in a decrease of outpatient attendance by 27% at provincial hospitals, 46% at district hospitals, and 33% at health centres (7). In Zambia, outpatient attendances dropped by 35% after fees were introduced, however, admissions to inpatient facilities remained fairly constant (8). In Ghana, a 40% decrease in outpatient attendance was noted after fees were introduced (9).

Few reports consider how removal of user fees affects use of services. In Kenya, outpatient attendances at three regional and four provincial hospitals rose to levels similar to those

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pre-implementation after registration fees were suspended (7). In South Africa, fees for children aged <6 years and pregnant women were eliminated in 1994, and all charges for primary health care services were eliminated in 1997. Attendance for curative services in the Hlabisa health district nearly doubled after fees were discontinued, but attendance for antenatal and children's services continued to decline (10).

Health services in Uganda

At the end of the 1980s, Uganda emerged from two decades of political and social upheaval with an under-equipped and understaffed health service (11). Cost sharing was introduced in public facilities shortly after decentralization in 1993. The intention was to lessen the impact of irregular payment of low health worker salaries, alleviate drug shortages, and strengthen community management of facilities. In some areas, guidelines and training for cost sharing management were developed (12). Some communities set their own fees and managed revenues. Fees were usually US\$ 0.25–0.45 per new visit. In Kabarole district, cost sharing reduced outpatient attendance by 21.3%, but at remote facilities, utilization increased (13). Both health workers and community members viewed the cost-sharing strategy as successful (14). Usually, the health unit management committee (HUMC), elected from the community, decided allocation of cost-sharing revenues. Up to half of funds supplemented health worker salaries, and the balance was used to clean and maintain the facilities and purchase additional drugs and supplies. The cost-sharing supplement could equal 50–150% of a worker's regular salary.

With the 2001 election campaign, President Museveni abolished cost sharing in the public sector, and fees were stopped in March 2001. This was influenced by a report that cost sharing was leading to unnecessary suffering and even death (13). To compensate for the loss of cost-sharing revenue and potential consequence on drug availability, the Ministry of Health introduced a supplemental buffer fund of 7 billion Uganda shillings (US\$ 5.5 million) from the World Bank-supported district health services project (DHSP). This represented an increase of 22% to the ministry's drug budget for 2001.

Abolition of cost sharing was intended to improve access to health services for the poor, as 46% of Uganda's population earn less than US\$ 1 per day and 60% of households have a monthly income under US\$ 50 (15).

We have been monitoring the Integrated Management of Childhood Illness (IMCI) approach in 10 districts (population 5.7 million) since 1999 (Fig. 1). We undertook a study in 2002 to assess how the end of cost sharing would affect use of IMCI services. The IMCI impact study, of which this study forms a part, received ethical approval from the Uganda National Council for Science and Technology and the Johns Hopkins School of Public Health Committee on Human Research.

Methods

We selected 80 clinics from the primary health care units in the 10 districts. Eight health centres in each district were selected randomly from a stratified listing of health facilities according to size. Three were selected from among HC2 units (outpatient services), three from HC3 units (outpatient plus maternity), and two from HC4 units (outpatient, maternity, inpatient, and a medical officer). Of the 80 clinics, 72 were public sector facilities and eight were nongovernmental units.

In Uganda, nongovernmental facilities received government support but had their own source of drugs. Most health facilities studied were rural; a few were in periurban sites. Data were available from 78 clinics, as two were closed. Data came from the facility records. Questions were developed by the research team at the Institute of Public Health of Makerere University, with input from the Ministry of Health and district health managers. Questionnaires for key informants were pilot tested and modifications made.

For each facility, the most senior health worker present and the most senior member of the HUMC available provided perceptions about clinic operations after abolition of cost sharing. Interviews lasted about 45 minutes. At 73 facilities, health workers were present who knowledgeably answered most if not all questions about the function of the unit. One or more members of the HUMC were present at 78 sites. Interviews and reviews of records were conducted by the research team. Key informant interviews used questions for health workers and for members of the HUMC that were similar but not identical. Responses were recorded in writing by the research team. Data for attendance were available for the eight months before and 12 months after cost sharing ceased. No unique identifiers were recorded, and names of the health facilities were deleted after data entry. The research team did not know members of the HUMC, but they did know some of the health workers.

Results

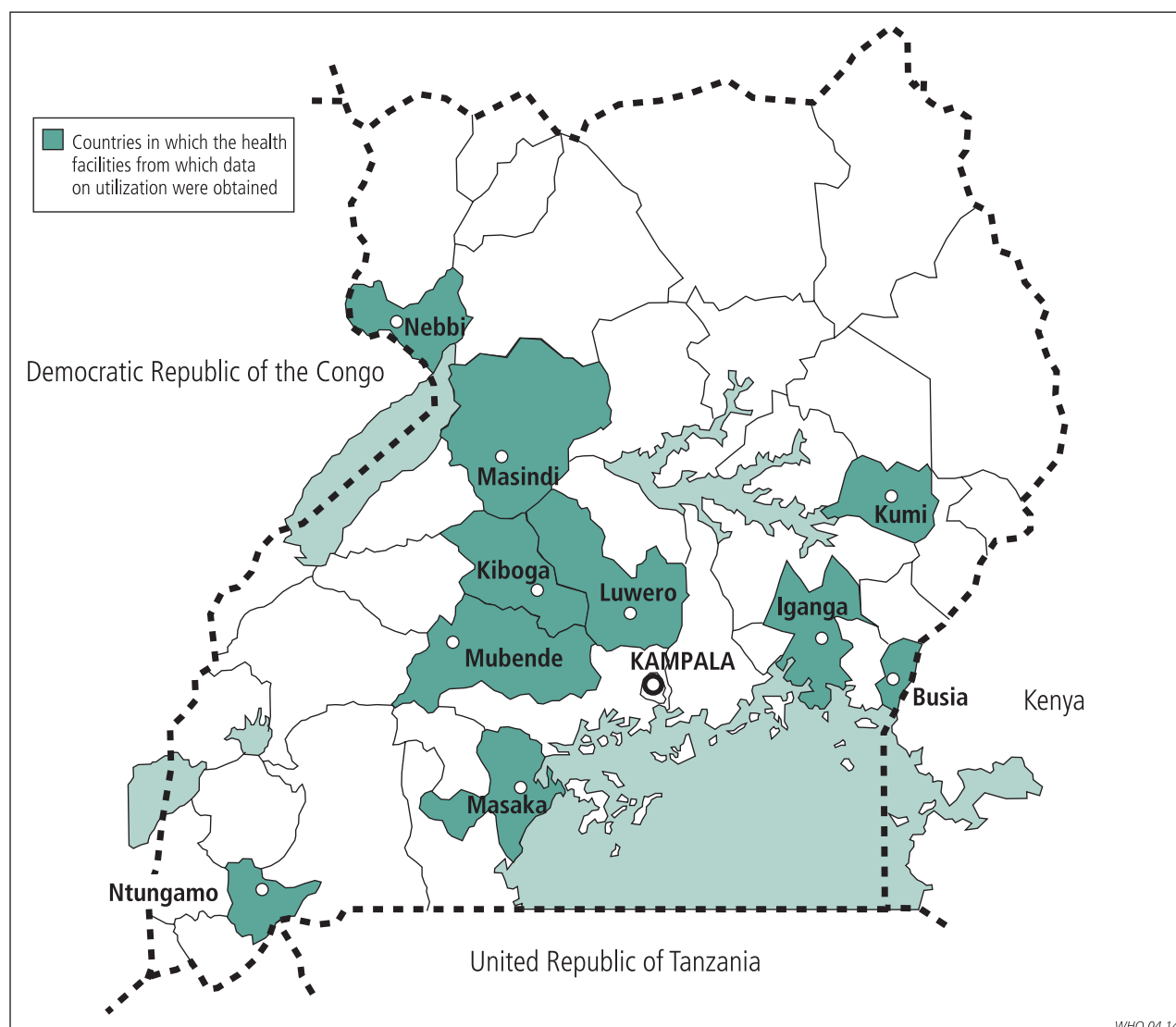
During the 21 months of this study, 1 966 522 visits were made to the 78 facilities in the 10 districts. Of 934 119 new visits, 322 447 (34.5%) were for children aged <5 years. Among the 187 559 patients who reattended, 106 853 (56.9%) were children aged <5 years. New visits are shown by month in Fig. 2.

All people approached agreed to participate. Among the 73 health workers, 32 (44%) were men. Of those interviewed, 20 were nurses, 17 clinical officers, 14 midwives, 10 nursing assistants, two medical officers, and 10 from other categories. Most health workers had spent at least two years in their present location, and 21 (29%) had been there for more than five years.

Attendance

Table 1 shows the mean monthly attendance figures for the 78 health facilities during the eight months before and 12 months after the abolition of cost sharing in March 2001. After cost sharing was abolished, the mean number of monthly new visits at the 78 facilities for all people increased by 17 928 (53.3%): from 33 653 visits a month during cost sharing to 51 581 per month after cost sharing ceased (March 2001 is excluded from calculations). The increase for children aged <5 years was 3611 (27.3%): from 13 204 to 16 815. After cost sharing, the workload for health workers increased by 46.9%: from an average of 446 new cases per month to 655. Among children aged <5 years, however, the number of new visits increased by 19.5% from an average of 190 per month during cost sharing to 227 after abolition. Although IMCI-trained health workers saw more children during cost sharing, the increase in the numbers after cost sharing ended was not significantly greater than the increase among non-IMCI trained health workers. After the end of cost sharing, immunizations each month for children aged <5 years increased by 17.2% — although these were free before cost sharing ceased. Over the same time, antenatal visits increased by 25.3% from 7133 to 8938 per month. For another free service — family planning — the increase was 472 per

Fig. 1. Map of districts in Uganda included in study of effects of abolition of cost sharing



WHO 04.14

month (32.3%). Reattendances also increased. For all persons this was 1889 visits a month or 24.3%, but for children under 5 it was 2838 (81.3%).

Perceptions of health workers

At the 78 facilities, we interviewed 73 health workers who had worked in the units for at least six months before the end of cost sharing (Table 2). Not all health workers felt they could knowledgeably answer every question. With the end of cost sharing, 54 (73.9%) health workers felt that people had better access to health services, especially the poor. Improved drug supply was noted by 17 (23.6%) health workers. The major negative effects noted were the lack of supplementary funds to buy essential drugs (29, 39.7%) or to supplement support staff, particularly those not on the central payroll (39, 53.4%). Most health workers felt that after cost sharing had ended neither the mix of illnesses among patients (57, 78.1%) nor the age of patients who paid visits (51, 69.9%) changed. Health workers felt that they had a more negative attitude toward their work after cost sharing ended (40, 66.7%).

Drug supply was felt in general to be not worse after than during cost sharing, except for nalidixic acid, gentamicin, and

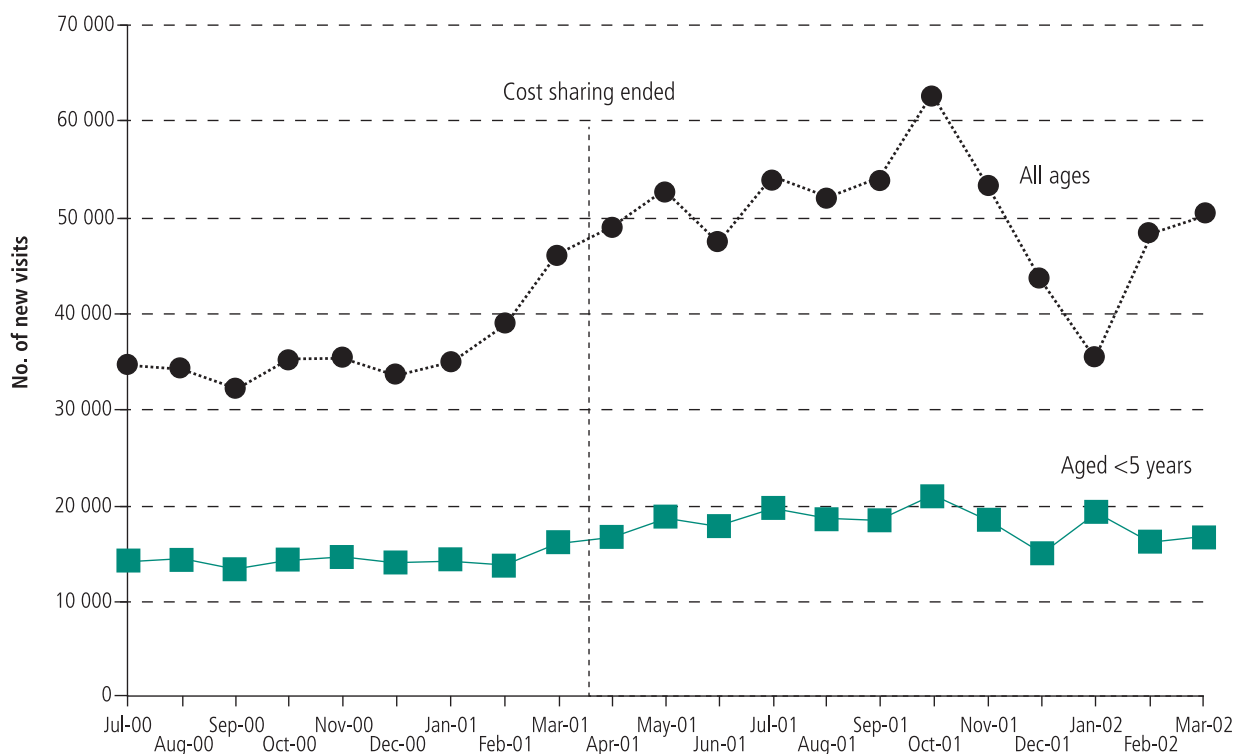
amoxicillin, which were judged less available. Among equipment and supply items, health workers said the supplies of mothers' cards (22, 32%) and syringes and needles (37, 51.4%) were less available (data not shown). Cleanliness and maintenance of the facilities were thought worse than during cost sharing by a third or more of health workers. Outreach services were felt to be the same or better by 69 (96%) (data not shown). Health workers noted that the HUMC was meeting infrequently or not at all after cost sharing ceased and felt that central government was taking a larger role in the management of health units.

Perceptions among members of the health unit management committee

Most of the 78 members of the HUMC interviewed had served on the committee for at least four years or more, and 71 (90.9%) had lived in the adjacent community for more than five years. A third of those interviewed were committee chairpeople and three-quarters were men. Most (60, 77.8%) had been trained for their HUMC duties.

Committee members generally were able to answer all questions, although some did not know specific answers for certain aspects of clinic functions. The main positive benefit of

Fig. 2. New attendances in people of all ages and children < 5 years between July 2000 and March 2002



WHO 04.15

the abolition of cost sharing mentioned was a greater access to services, especially for poor people (52, 71.2%). Easier availability of drugs was volunteered by only 11 (15.1%) committee members. Drugs were noted to more easily available at facilities that reported decreased attendance, and these were often non-governmental units. Members of HUMC felt that the absence of cost-sharing funds reduced availability of essential drugs (44, 60%) and support for ancillary clinic staff (45, 62%). Decreased morale among health workers after cost sharing ceased was cited by 22 (30%) HUMC members. Members agreed that no changes in the age composition of the patients or the mix of diseases had occurred. Most felt that the health worker in charge of the clinic now spent the same amount of time or more time at the clinic than before. They thought attitudes among the workers in charge and other clinic workers had not deteriorated appreciably. Only the cleaning services and maintenance of the clinic were seen to have worsened substantially. Members of the HUMC reported that they rarely if ever met after cost sharing ceased.

Discussion

At the time many developing countries were turning to cost sharing as a method to bridge deficits in health budgets, many reports documented the effects of fees on service utilization, particularly among poor people. Few reports have documented how discontinuation of cost sharing affects service utilization.

We found that perceived quality of services did not seem to suffer and that drugs and medical supplies were perceived generally to be available after cost sharing ceased. The Ministry of Health was able to quickly create a US\$ 5.5 million buffer fund to supply additional drugs to facilities. Improved access

by the poor was the major positive effect of the end of cost sharing that was cited by both health workers and community leadership. Perceptions of drug availability at times seemed inconsistent, perhaps because although some drugs were readily available, others were in short supply. Most health workers and HUMC members felt drug supplies were the same or reduced. Health workers at government facilities tended to perceive drug availability as worse than health workers at nongovernmental organizations' facilities. Some health workers and HUMC members, mainly at nongovernmental organizations' units, felt drug availability had increased. This is not surprising, as nongovernmental organizations' units generally continued fees as public sector facilities became free, which reduced utilization of nongovernmental organizations' facilities. The shortage of essential drugs was seen as less of a problem by health workers than by HUMC members. This may be explained by variations in perceptions among the health facilities and across districts. Several health facilities reported that, although drugs were readily available, the supplies lasted for a shorter period of time because of increased utilization; shortages of antibiotics were perceived by health workers to be more common. Vitamin A, oral rehydration salts, and antimalarials were thought to be more available after cost sharing ended. Overall, for most drugs, health workers presented a mixed picture of availability: the same or less.

The success of the transition from a cost-sharing system speaks well for the Ugandan health workers who seemed to continue fulfilling professional responsibilities in spite of a loss of income from cost-sharing revenue. Health workers may, in the long term, shift more of their time to their private clinics to compensate, thus shortening the opening hours of government clinics. This is likely to be the case if salary payments become

Table 1. Use of health services in 78 health facilities in 10 districts for eight months before and 12 months after cost sharing ended

Month	New visits		Mean patients seen per health worker			Reattendance at clinics				
	Total people seen	Total children aged <5 years seen	All ages	Aged <5 years		All ages	Children aged <5 years	Total immunizations	Total attendances at antenatal clinics	Total family planning visits
				Non-IMCI ^a health worker	IMCI health worker					
2000										
July	34 688	13 491	444	181	211	8825	3634	30 517	7599	1475
August	34 369	13 655	440	184	222	7281	3645	30 781	7651	1633
September	22 157	12 575	412	169	199	6880	3202	28 728	6624	1430
October	35 183	13 462	451	182	209	7281	3410	29 212	7397	1593
November	35 396	13 811	453	187	219	8534	3843	26 639	7152	1519
December	33 596	13 133	430	117	210	7438	3304	24 391	6033	1281
2001										
January	34 922	13 402	447	180	210	8106	3671	25 249	7962	1417
February	38 909	12 095	490	171	190	7826	3204	26 648	6646	1341
March^b	45 923	15 038	588	203	224	9465	3001	27 353	7108	1365
April	48 962	15 628	627	209	218	7152	2552	28 310	7538	1501
May	52 394	17 386	671	235	250	8606	3376	31 050	8536	1697
June	47 177	16 595	604	224	239	8703	3829	31 593	7577	1657
July	53 697	18 565	688	247	269	10 572	7807	32 458	10 069	1941
August	51 763	17 232	655	229	234	11 748	8609	34 073	9534	1998
September	53 435	17 246	676	227	232	12 954	9202	32 223	8941	1923
October	61 855	19 766	782	260	255	13 010	9383	38 226	9308	2141
November	52 621	17 197	666	226	231	9833	7350	34 710	9012	1905
December	43 227	13 861	547	183	187	7721	6485	27 452	7989	2136
2002										
January	56 260	17 980	712	237	238	9311	6373	32 085	10 263	2250
February	47 741	14 859	604	196	203	7303	5191	34 287	9388	2031
March	49 844	15 470	630	203	211	9010	5782	34 171	9107	2020
Mean cost-sharing visits per month^b										
July 2000– February 2001	33 653	13 204	446	171	209	7771	3490	27 771	7133	1461
April 2001– March 2002	51 581	16 815	655	223	231	9660	6328	32 553	8939	1933

^a IMCI = Integrated Management of Childhood Illnesses.

^b Values for March 2001, the month during which cost sharing was eliminated, are not included in calculations of mean attendances or changes in utilization.

irregular again. Although health services are decentralized to districts, the central government has recentralized payment of all health workers because of irregular salary payments by local government.

The service utilization data show an interesting pattern after the end of cost sharing. Although new visits for all ages increased by 53.3%, the increase among those aged <5 years was 27.3%. This could suggest that children were being taken to clinics for serious illnesses before the end of cost sharing, so removal of cost sharing made little difference. It might also mean that barriers other than user fees, such as transportation or lack of trust, impeded access. The intra-household decision-making process for care seeking may be different for older children and adults than for children aged <5 years.

We did not set out to measure utilization at other types of facilities in these districts. Some health workers, however,

felt that the increased utilization of public sector facilities represented a shift from nongovernmental organization and private practices.

In contrast with the rather flat trend for new cases of children aged <5 years after cost sharing (27.3% increase), the number of children aged <5 years who reattended after the initial visit increased by 81.3%. For all patients, this increase in reattendance was only 24.3%. Follow-up visits for children for continued symptoms or complications, which the IMCI approach emphasizes, may have been easier when they were free. The picture may be less clear than it would otherwise seem, as health facilities often have problems separating new and follow-up visits in their records.

The figures for new visits among children aged >5 years could suggest that the much larger surge in adult attendance represents utilization for minor conditions. Most health workers,

Table 2. Opinions of health workers and members of the health unit management committee on the effects of abolition of cost sharing on specific health facility activities.

Opinion	Health workers ^a		Members of health unit management committee ^b	
	All respondents	Respondents agreeing with opinion (%)	All respondents	Respondents agreeing with opinion
Positive effects of cost-sharing abolition ^c				
Easy access to health services even by the poor	73	54 (73.9) ^d	73	52 (71.2)
Improved drug supply	73	17 (23.6)	73	11 (15.1)
Increased central government control and financing	73	5 (6.8)	73	5 (6.8)
Coming to clinic early in disease course	73	5 (6.8)	73	2 (2.7)
Other	73	11 (15.1)	73	10 (13.7)
Negative effects of cost-sharing abolition ^c				
Inadequate availability of essential drugs	73	29 (39.7)	73	44 (60.0)
Lack of salary supplement for health staff	73	39 (53.4)	73	45 (62.0)
Low morale among health workers	73	10 (13.7)	73	22 (30.2)
Other	73	19 (8.2)	73	12 (16.4)
Reason for increased utilization				
Increased availability of drugs	55	37 (67.3)	51	3 (5.9)
Access by all persons	55	5 (9.1)	51	46 (90.2)
Other	55	13 (23.6)	51	2 (3.9)
Effects of abolition of cost-sharing on types of illnesses presenting				
Disease pattern has changed	73	12 (16.6)	77	9 (11.7)
Disease pattern has not changed	73	57 (78.1)	77	59 (76.6)
Other	73	4 (5.4)	77	0
Effects of abolition of cost-sharing on age of patients coming				
Patients now are older	73	8 (10.9)	77	3 (3.9)
Patients now are younger	73	5 (6.8)	77	14 (18.2)
Patient age is unchanged	73	51 (69.9)	77	48 (62.3)
Effect of abolition on attitude of the in-charge				
Attitude improved			74	9 (12.2)
Attitude unchanged			74	43 (58.1)
Negative attitude			74	12 (16.2)
Effects of abolition on health worker attitude				
Attitude improved	60	5 (8.3)	70	7 (10.0)
Attitude unchanged	60	15 (25)	70	36 (51.4)
Negative attitude	60	40 (66.7)	70	20 (28.6)
Amount of time in-charge worker spends in facility after abolition				
Time increased			76	24 (31.6)
Time the same			76	29 (38.2)
Time decreased			76	16 (21.1)
General availability of drugs and supplies				
Increased	71	41 (57.7)	74	27 (36.5)
Same as before	71	9 (12.7)	74	10 (13.5)
Reduced	71	21 (29.6)	74	31 (41.9)
Equipment availability				
Increased	60	26 (43.3)	66	24 (36.4)
Same as before	60	20 (33.3)	66	18 (27.3)
Reduced	60	23 (38.3)	66	20 (30.3)
Availability of services ^e				
Increased	67	27 (40.3)	70	32 (45.7)
Same as before	67	19 (28.4)	70	18 (25.7)
Reduced	67	20 (29.9)	70	20 (28.6)

(Table 2, cont.)

Opinion	Health workers ^a		Members of health unit management committee ^b	
	All respondents	Respondents agreeing with opinion (%)	All respondents	Respondents agreeing with opinion
Meetings of the HUMC				
Increased	71	5 (7.0)	77	8 (10.4)
Same as before	71	12 (16.9)	77	23 (29.9)
Reduced	71	20 (28.2)	77	22 (28.6)
Greatly reduced	71	20 (28.2)	77	11 (14.3)
Not meeting at all	71	10 (14.1)	77	9 (1.7)
Other activities of the HUMC				
Increased	62	9 (14.5)		
Same as before	62	12 (19.4)		
Decreased	62	41 (66.1)		

^a 73 health workers participated. Not all health workers interviewed were knowledgeable about a particular question. The percentage shown for each question is calculated on the number of respondents who felt able to answer that question, which varied from 51 to 73.

^b 78 members of the HUMC participated. Not all HUMC members interviewed were knowledgeable about a particular question. The percentage shown for each question is calculated on the number of respondents who felt able to answer that question, which varied from 51 to 77.

^c More than one answer possible.

^d Values in parentheses are percentages.

^e Cleaning, maintenance, outreach services, hours, transport, and staff allowances.

however, felt that after the end of cost sharing, no change was seen in the case mix of patients who attended.

The causes for the dramatic decrease in attendance after October 2001, seven months after cost sharing was abolished, are unclear. The perception among health workers and community members was that the additional drug stocks made available at the end of cost sharing were exhausted. As we did not assess drug stocks, we were unable to confirm this. Although this decrease was mirrored in new visits of those aged <5 years, the decrease was smaller. If anecdotal accounts that the attendance drop was due to reduced drug availability are true, the perceived presence of drugs may be less of an important factor in health seeking for children than for adults.

The number of immunizations given and attendance for antenatal and family planning services also increased, although these services were free both before and after cost sharing. Perhaps increased attendance for curative services created more referrals within the facility for these services, or a greater awareness. This underscores the importance of integrating services at the facility level. These findings are in contrast with the decline in utilization of preventive services noted in the Hlabisa district of South Africa after cost sharing ended there (10).

That health services became free to the patient with the end of cost sharing should not be assumed. Informal "under-the-table" payments to health workers are a feature of many nominally free health services and were an acknowledged practice in Uganda before cost sharing. Payments to health workers may have returned after cost sharing ended, although this study was not designed to assess this. The possible return of informal payments may be reflected by the uncertain effect of the abolition of cost sharing on the perceived morale of health workers. Those who would certainly be worse off without cost sharing would be the non-skilled staff who received some cost-sharing funds but would be less likely to access informal payments. Although health workers themselves said their attitude toward their work had deteriorated, most HUMC members did not

note any changes. The long-term morale of health workers should be monitored. A certain degree of autonomy, as well as some level of authority to go with their prescribed autonomy, is an important contributor to morale at the facility level. The end of cost sharing has curtailed this substantially, as well as the nascent health worker links with the community formed through participation in the HUMC.

A major reason for this reversion to free services has been community governance of health facilities. One of the great strengths of Uganda's cost-sharing approach was retention of funds by the community in which they were collected and creation of a community governance mechanism to oversee allocation. The HUMC could be argued to have been self serving, with personal gain from taking part. Many HUMC members may have seen their job mainly as managing cost-sharing funds, which would explain why committees have largely stopped meeting. Although this may be true, that some alternate method was not introduced to preserve this first entrance of community governance into the health system is unfortunate. Accountability of the health worker now seems to be moving away from the community back to the health system.

This study was limited to some extent by reliance on health worker and HUMC perceptions, when more objective data, had it been available, might have given a different picture. This is particularly true with respect to drug stocks and maintenance of health facilities. The limited resources available did not allow us to survey a representative sample of end users.

This study has several potential areas of bias. The health facilities chosen, despite the stratification used, may not have represented truly the districts as a whole, and the 10 districts included may not have been representative of Uganda's 56 districts. The research team, despite their experience and training, may have influenced responses. The number of "don't know" responses, particularly from the HUMC members may have resulted in an unrepresentative finding for some questions.

Both health workers and HUMC members have lost personal benefits from cost sharing; this clearly could have influenced their responses.

Conclusion

Utilization data from the first 12 months of free services are encouraging, especially with the infusion of drugs into the system. The difficulties of the public sector with respect to drug supplies make these services vulnerable when emergency buffer funds are exhausted. This is important as Uganda now moves from a predominantly “push” system of pre-packed kits for health centres to a “pull” system based on drug requisitions.

The study shows that elimination of cost sharing increases service utilization — more so for adults than for children. From the rate of visits per year, however, health services provided by the public sector and nongovernmental organizations are underused in these districts.

During the first eight months of this study, cost sharing brought in an estimated US\$ 28 042 to these 78 local health

facilities, assuming a cost of US\$ 0.25 per visit. The loss of these discretionary funds, and particularly the sense of autonomy and community governance that went with this, may be seen by policy makers as a reasonable trade-off for increased access. It would be better to have both responsibility to communities and access. ■

Conflicts of interest: none declared.

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Résumé

Abandon de la participation aux frais en Ouganda

Objectif Evaluer les incidences de l'arrêt de la participation aux frais sur la fréquentation des services de consultation externe et sur l'opinion à ce sujet des agents de santé et des membres des comités de gestion des services de santé.

Méthodes Soixante-dix-huit établissements de santé ont été choisis dans 10 districts en Ouganda. Pendant les 8 mois qui ont précédé l'interruption de la participation aux frais et les 12 mois qui ont suivi, on a mesuré le nombre des visites dans ces services. Au total, 1 966 522 consultations externes ont été enregistrées. Les 73 agents de santé et les 78 membres des comités de gestion des services de santé disponibles ont été invités à donner leur opinion sur les effets de l'abandon de la participation aux frais.

Résultats L'arrêt de la participation aux frais a été suivi d'une augmentation mensuelle moyenne de 17 928 (53,3 %) premières consultations et de 3611 (27,3 %) premières consultations chez les

enfants < 5 ans. Le nombre mensuel moyen des malades revenus pour une nouvelle consultation a augmenté de 1889 (24,3 %) et celui des nouvelles consultations chez les enfants < 5 ans de 2838 (81,3 %). Les consultations pour une vaccination, une visite prénatale ou des conseils de planification familiale ont toutes augmenté alors qu'elles ont toujours été gratuites. Les agents de santé ont déclaré que leur moral avait baissé et de nombreux comités de gestion des services de santé ont cessé de se réunir régulièrement.

Conclusion La fréquentation de tous les services a augmenté — y compris ceux qui n'ont jamais été payants. La perte d'autonomie des services de santé et la part réduite de la communauté dans la gestion des services de santé pourraient avoir des incidences défavorables à long terme.

Resumen

Suspensión de la compartición de costos en Uganda

Objetivo Evaluar los efectos de la suspensión de la compartición de costos en el uso de los servicios de ambulatorio, así como la percepción de esa medida por parte del personal de salud y de los miembros del comité de gestión de los puestos de salud.

Métodos Se seleccionaron 78 establecimientos de salud de 10 distritos de Uganda y se evaluó la asistencia a dichos establecimientos durante los ocho meses anteriores a la interrupción de la compartición de costos y los 12 meses posteriores a la misma. Los datos reflejan 1 966 522 consultas externas. La percepción sobre el impacto de la medida se determinó sondeando a los 73 trabajadores de salud y los 78 miembros de los comités de gestión de los puestos de salud que estaban disponibles.

Resultados Tras suspender la compartición de costos, el número medio mensual de nuevas visitas aumentó en 17 928 (53,3%),

pero entre los menores de 5 años el aumento fue de 3611 (27,3%). La media mensual de repeticiones de visitas aumentó en 2838 (81,3%) entre los menores de 5 años, y en 1889 (24,3%) entre todas las personas. El número de visitas a los servicios de inmunización, los consultorios de atención prenatal y los servicios de planificación familiar aumentó en todos los casos, pese a que esos servicios habían sido siempre gratuitos. El personal sanitario refirió un deterioro del espíritu de trabajo, y muchos comités de gestión de los puestos de salud dejaron de reunirse regularmente.

Conclusión El recurso a todos los servicios considerados aumentó, incluso en los casos en que antes no se exigía el pago de honorarios. La pérdida de parte de la autonomía de los centros de salud y la más deficiente administración comunitaria de los mismos podría tener efectos perjudiciales a largo plazo.

ملخص

إنهاء العمل بنظام المشاركة في تكاليف الخدمات الصحية في أوغندا

(أي بنسبة ٥٣,٣٪)، أما بين الأطفال الأقل من عمر ٥ سنوات فكانت الزيادة بنحو ٣٦١١ زيارة (أي بنسبة ٢٧,٣٪). كما ازداد العدد المتوسط للزيارات الشهرية المتكررة للأطفال الأقل من عمر ٥ سنوات بنحو ٢٨٣٨ زيارة، (أي بنسبة ٨١,٣٪)، ولعامّة الناس بنحو ١٨٨٩ زيارة (أي بنسبة ٢٤,٣٪). كما ازداد معدل التردد على عيادات التطعيم والرعاية قبل الولادة وتنظيم الأسرة، بالرغم من أن هذه الخدمات كانت وما تزال تقدم مجاناً. وبين تقصي آراء العاملين الصحيين انخفاضاً في روحهم المعنوية، مما أدى إلى توقفاً لاجتماعات الدورية للعديد من اللجان الإدارية للوحدات الصحية. **الخصيلة:** تبين الدراسة ازدياد الإنتفاع بجميع الخدمات بما في ذلك الخدمات التي كانت وما تزال تُقدم مجاناً. وقد يؤدي فقدان المرافق الصحية لبعض الاستقلالية إلى آثار سلبية على الأمد البعيد.

الهدف: تقييم آثار إنهاء العمل بنظام المشاركة في تكاليف الخدمات الصحية المقدمة للمرضى الخارجيين، واستطلاع رأي العاملين الصحيين وأعضاء اللجان الإدارية للوحدات الصحية حول الوضع الجديد. **الطريقة:** تم انتقاء ٧٨ مرفقاً صحياً من عشر مناطق صحية في أوغندا، وأجري حصر لعدد المترددين على هذه المرافق قبل ٨ أشهر من إنهاء نظام المشاركة في التكاليف وبعد ١٢ شهراً من إنهاء هذا النظام. وقد بلغ عدد زيارات المرضى الخارجيين ٥٢٢ ٩٦٦ ١ زيارة، وتم تقصي آراء العاملين الصحيين البالغ عددهم ٧٣، وآراء ٧٨ عضواً في اللجان الإدارية للوحدات الصحية حول آثار إنهاء العمل بنظام المشاركة في التكاليف. **الموجودات:** أدى إنهاء العمل بنظام المشاركة في التكاليف إلى زيادة العدد المتوسط للزيارات الشهرية الجديدة للمرافق الصحية بنحو ٩٢٨ ١٧ زيارة

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