HEALTH POLICY AND PLANNING; **17**(Suppl 1): 64–71 

# Exemptions and waivers from cost sharing: ineffective safety nets in decentralized districts in Uganda

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The introduction of user-payment for health services is frequently followed by concern about the impact on equity of access for poor people. Decentralizing governments often try to remedy the created inequities by putting in place safety nets in the form of exemptions and waivers in the user-fee systems. However, where user payments merely operate as local government strategies for health financing, without national policy they are likely to be self-defeating, as local governments are frequently more interested in raising revenue to meet recurrent costs of devolved services than in promoting equity. Thus guidelines put in place by the central government to operationalize safety nets are seen by local governments as being contradictory to this goal, and are thus ignored or altered to suit the district revenue aims. This study was carried out to investigate the context and the constraints in implementing exemption schemes. Data were collected in two selected administrative districts of Uganda (Mbarara and Mukono). Qualitative approaches to data collection were adopted, namely focus group discussions and key informant interviews with policy-makers, health administrators, service providers and community members. These methods were combined with document review.

We found little evidence of safety-net guidelines initiated by decentralized/local governments, since district local governments had little motivation to extend exemptions, waivers or credits. The conclusion is that safety nets such as waivers and exemptions will only be effective if they are backed by a national health financing policy, they reconcile the often competing demands of local government revenue needs, and are strictly enforced and supervised by both the local and central governments. The implications of the findings for remedying the tension between the needs for cost recovery and for attainment of equity goals through exemption policies for the poor and indigent are discussed.

**Key words**: equity, exemptions, safety nets, user-payment, cost sharing, decentralization, indigents, Uganda

## Introduction

Cost recovery, one of the cornerstones of the Bamako Initiative (BI), has been advocated to supplement the budgetary allocations of governments in developing countries for financing health services. It is assumed that the revenue collected will improve health services by, among other things, improving drug availability and the overall quality of health care (Creese 1991; Litvack and Bodart 1993). Recently, however, cost sharing has been shown to negatively affect health service utilization, particularly among the poor, and to increase inequality between indigent and non-indigent population groups (Mbugua et al. 1995; Russell and Gilson 1997; Asenso-Okyere et al. 1998; Nyonator and Kutzin 1999; Gilson et al. 2000; Blas and Limbambala 2001; Obore 2001). Exempting indigents from cost sharing is considered to be crucial for alleviating the negative impact of user fees on equity (Mills 1991; Willis and Leighton 1995).

The introduction of cost sharing at public health units in Uganda was recommended by a commission set up by the country's Ministry of Health in 1987. The commission was appointed to review the health services, which were near collapse, and to make recommendations on how to revive them. The commission recommended the introduction of cost sharing as a means of increasing funding for the health sector. In 1989, a National Task Force for Health Financing (NTFHF) was appointed to work out modalities for the implementation of user-fees. The task force recommended user fee structures, procedures for fee management and guidelines for paid services. Thus, there was a 'formal national policy' on cost sharing, and guidelines from the Ministry of Health, and later decentralized districts, to assist district level implementation.

To ensure equitable access to health care for individuals with limited financial resources, the NTFHF guidelines provided safety nets (granting of exemptions, waivers and credits). A patient exempted was not supposed to make any payment for services received at public health facilities and a patient granted a waiver was supposed to pay part of the treatment cost. Treatment on credit was to be given to patients who were willing to pay at a later time. Waivers were to be given to patients who could pay some charges, while exemptions were for those who could not pay at all and were to be granted upon request only. Consequently, the health worker was supposed to evaluate whether the person truly merited a waiver or an exemption. According to the guidelines, categories of patients to be exempted included children under 5 years of age, promotive and preventive services such

as immunization, antenatal and postnatal care, and family planning services. Other exemptions would be granted to patients suffering from chronic diseases such as AIDS, tuberculosis, cancer and poor individuals exempted by the local councils. Accident cases brought in by good Samaritans were supposed to be exempted.

In 1990, a Bill to formalize cost sharing was drafted by the Ministry of Health and presented to Parliament for consideration. Parliament, however, did not approve the Bill. According to the Hansard of 1990 (12th, 13th and 14th issues), opponents of the Bill argued that the population was already paying for their health through taxes and therefore there was no need for extra payment for the health services. They also argued that the majority of individuals were too poor to afford to pay for health care at the point of use. Legislators also argued that the quality of services in public health units was too poor to be paid for. Other opponents of the Bill thought that because of the reported widespread corruption in the country, health workers would embezzle the money from cost sharing. That aside, there was mounting political pressure from the population for the central government not to introduce cost sharing in public health facilities.

Following the rejection of the Bill by parliament, central government suspended the introduction of cost sharing as a national policy. It instead mandated district authorities to start charging for health services and to encourage population-based decisions through the village councils. Subsequently, districts adopted, with varying degrees of modification, the recommendations made by the coordination unit and started charging users in the community for health services. From this time on, the Ugandan Ministry of Health, pushed by its donors, pushed many districts, sometimes against their will, to adopt user-fees and exemptions.

In encouraging decentralized districts to introduce cost sharing in their area of jurisdiction following the rejection of the Bill by the Uganda legislature, the Ugandan Ministry of Health used a loophole in the 1993 Local Government statute. Sections 12 and 6 of the 1993 Local Government statute effected decentralization of services and had empowered district authorities to raise revenue for the devolved services. Thus there was no legal enactment of cost sharing as a national policy but there was a local government strategy for health financing within the framework of service delivery in decentralized districts. This loophole was later to give local governments and lower level health units considerable discretion on what aspects of the policy to implement and which ones to modify or omit altogether.

In March 2000, the Minister of Health wrote a cabinet memo arguing that cost sharing in health units should be formalized since more than 43 out of Uganda's then 45 districts were already implementing the policy. Cabinet went ahead and approved the proposal thus paving the way for legislative enactment to formalize cost sharing in public health services. The cabinet approval was widely misreported in the press as parliament approval of cost sharing. However, during the March 2001 presidential elections and bowing to political pressure, cabinet shelved cost sharing, claiming that the people could no longer afford to pay for health services at the point of use. As of April 2002, the Ugandan government has been under pressure from donors and health workers to re-introduce cost sharing in health units. Hence, in the last 12 years, cost sharing in public health units has been instituted, abolished, re-instituted and abolished again, depending on the pressure received from donors and the local population.

Few studies have assessed the operation of safety nets in Uganda's health services during the implementation of cost sharing. Community perception of the exemption reforms and other safety nets is also largely unknown. The few published and unpublished studies that have attempted to explore aspects of exemptions, however, indicated discouraging results. Okuonzi and Birungi (2000), for example, reported that individuals who could not pay for their health care charges were more numerous than had been envisaged. The same authors also indicated that there were no mechanisms for clearly identifying or protecting the indigent. The reforms of focus in our study included decentralization, the administrative and financing components, as much as cost sharing as part of the financing reforms. The study was carried out to provide information on whether exemptions from cost sharing for the poor worked to reduce long-standing inequities in access to health care or merely exacerbated them.

## Methodology

The study was exploratory and data were collected in two selected administrative districts: Mbarara, located approximately 300 km west of Kampala, and Mukono, close to Kampala city. Our interest was in the processes of policy implementation more than in quantifying the various measures such as health facility exemption rates or cost recovery rates. The selection of the two study districts was based on the assumption that Mbarara district would be a representative case of implementation problems within the countrywide decentralization of the health sector, and Mukono district was said to have a well-developed health care delivery system under decentralization and would therefore have fewer challenges in implementing reforms in the health sector. The two districts, however, provide prototypical examples of the Ugandan health care system.

From an economic perspective, the majority of the population in both districts could be described as peasants: they produce food crops (plantains, sweet potatoes, cassava and vegetables) for home consumption and regional marketing. Cash crops, such as coffee, are cultivated on a small scale in Mukono district, while cattle are raised in Mbarara district. Income generated from agriculture is seasonal and at times affected by natural disasters such as droughts. Several large sugar and tea plantations in Mukono employ some residents as casual labourers. Both districts have a few salaried workers, such as teachers, civil servants, retail traders and transporters.

The most indigent segment of population in both districts includes widows, the elderly and individuals such as the formally unemployed youth and unmarried young women

**Table 1.** Summary of type of funding received by different referral units in the Ugandan decentralized health system

| Type of unit | Type of funding | |
|---|---|---|
| | Poverty Action Fund | Non-Poverty Action Fund |
| Health centres (including Level IV, Health Sub-Districts) | PHC conditional grant, development course; PHC conditional grant, recurrent non-wage | Wages for staff from the centralized payroll |
| Public district level hospitals | PHC conditional grant, recurrent wage<br>PHC conditional grant, recurrent non-wage | Hospital grants for recurrent non-wage expenditure<br>Wage component for district hospitals |
| Private not-for-profit health centres Level IV(Health Sub-Districts) | PHC conditional grant, recurrent wage<br>PHC conditional grant, recurrent non-wage | User fees and other sources including donors |
| Private not-for-profit hospitals | PHC conditional grant for private not-for-profit hospitals | User fees and other sources including donors |
| Regional referral units | | Regional hospital grants for recurrent wage and non-wage expenditure |
| National referral units | | Hospital grants (wage, non-wage and development) |

with children. These are generally excluded from economic support networks and are usually unable to obtain either formal or informal monetary credit. In addition, they usually do not own property goods such radios, bicycles or poultry, which they could sell in times of illness.

We conducted the study in three government hospitals and 16 government health centres and sub-dispensaries. A team consisting of two principal researchers and eight research assistants carried out the study with the support of public health researchers from Makerere University.

Document review included a systematic collection and analysis of published and unpublished material on exemptions. At the national level, documents were reviewed from the Ugandan Ministry of Health, the Local Government, the Makerere University library and international development agencies. In the districts, documents were reviewed at the administrative headquarters, hospitals and health centres. The documents included policies, guidelines, memos, study reports, information on notice boards and minutes of meetings. Hospital and health unit records were found to be poorly kept and therefore could not provide information on health service use by indigents.

Semi-structured interviews were conducted with health workers (doctors, clinical officers, nurses, nursing aids, other paramedic staff), health managers, community leaders and the population of selected communities. A total of 29 semi-structured interviews were conducted: 22 in Mbarara district and seven in Mukono district. Mbarara was purposely over-sampled because it is larger than Mukono in both size and population. Over 90% of the individuals contacted consented to be interviewed.

Thirteen focus group discussions (10 in Mbarara and three in Mukono districts) were held with individuals in communities of both districts. The focus group discussions aimed at exploring community knowledge, opinions and attitudes on exemptions and waivers, determining the utilization of health facilities.

Data collection was preceded by a preparatory phase that involved training research assistants, translating, testing and refining the data collection instruments. Notes and tapes from the key informant interviews and transcripts of focus group discussions were analyzed through several processes involving identification of emerging themes. Permission to carry out the study was obtained from Uganda's National Council for Science and Technology, district authorities and study respondents.

## Results

### Financing arrangements under decentralization

*Funding grants in decentralized districts*

The health sector in decentralized districts is funded by two main grants from the central government: Poverty Action Fund (PAF) grants and Non-Poverty Action Fund (Non-PAF) grants. PAFs cater for programmes that directly relate to poverty such as primary health care (PHC) activities. Non-PAFs are any other funds from any source (including government) to the health sector. Programmes that benefit from the PAF are guaranteed funding from the central government and the funds are disbursed to the districts every quarter. Each financial year, the central government defines the amounts for each component of the grants. Funding arrangements for the health sector are constantly changing as a result of the dynamic nature of the PHC funds. Table 1 summarizes the type of funding received by different referral units in Uganda.

There are four PAF conditional grants to the health sector:

(1) PHC conditional grant, recurrent wage component.
(2) PHC conditional grant, recurrent non-wage component.
(3) PHC conditional grant, the development course, which has two expenditure categories: construction/upgrading of Health Centres Level IV and Health Centres Level II, and in-service training.
(4) PHC conditional grant for private not-for-profit or non-government organization (NGO) hospitals and lower level units.

Public lower level health units receive only one PAF grant: the PHC conditional non-wage grant (grant 2 above); wages for staff at the public health units are paid through the centralized payroll. The lower level private not-for-profit units receive only the PHC conditional NGO grant (grant 4 above). Lower level units receive their funds through the hospitals/Health Centres Level IV that head their Health Sub-District.

For the Health Sub-Districts, the public upgraded Health Centres Level IV receive three types of PAF grant: the PHC conditional wage and non-wage grants (grants 1 and 2) and the development course grant (grant 3). Private not-for-profit Health Centres Level IV receive the PHC conditional wage and non-wage grants (grants 1 and 2 above). They also receive Non-PAF funds from user fees and other sources including donors.

Private not-for-profit hospitals receive one grant, grant 4 above. These hospitals also receive Non-PAF funds from user fees and other sources including donors. Public district level hospitals receive two types of PAF grants: the PHC conditional wage and non-wage grants (grants 1 and 2). These hospitals also receive the Non-PAF Hospital grant for recurrent non-wage expenditure and wage component for district hospitals. Regional referral units receive the Non-PAF Regional Hospital grants for recurrent wage and non-wage expenditure. The national referral units receive the Non-PAF Hospital grants (wage, non-wage and development). Hospitals heading Health Sub-Districts receive, in addition, PHC recurrent non-wage budget for management of Health Sub-Districts and lower level unit service delivery.

*Degree of financial decentralization*

Under the decentralized system, local governments are responsible for raising revenue for service delivery. However, decentralized districts in Uganda have a low revenue base and can barely fund their activities. Hence the central government provides more than 95% of the decentralized districts' financial resources.

At the beginning of each financial year the central government defines the amounts for each component of the grants to decentralized districts. All the funds sent to decentralized districts remain effectively controlled by the central government, which decides how they should be used. Each time funds are released from the central government they are accompanied by a 'white paper' that specifies the money sent and a breakdown of how it is to be used. Authorities in decentralized districts do not have powers to use the money outside activities outlined by the central government in the 'white paper'. Doing so constitutes an offence with dire consequences such as reprimand, dismissal or imprisonment.

*Funding constraints in decentralized districts*

The funds from the central government were insufficient to meet all the needs of the health units. They were often released late, difficult to access because of bureaucracy and had several strings attached to them. Besides, there was always a shortfall in the approved monthly releases from the central government, which in turn depend on the revenue collected by the Ministry of Finance. Districts adopted cost sharing reforms in order to supplement the inadequate central government funding to the health sector. However, money accruing from cost sharing was insufficient in smaller health units to bridge the funding gap. District health managers admitted that exemptions were instituted without any clear source of funds to compensate the medical expenses for exempted patients.

**Positions of key stakeholders on exemptions**

The implementation of exemptions depends on the interests, positions and actions of various stakeholders that have kept changing over time depending on the pressure from the population. In the heat of political campaigns for the presidential elections in March 2001, the central government opted to scrap cost sharing in order to ease political pressure. The Ministry of Health was supposed to implement central government plans, therefore its interests changed with the political position of the executive of the central government. On the other hand, decentralized districts welcomed cost sharing, viewing it as a remedy to ameliorate the services that had seriously deteriorated and also to cope with the increased responsibilities of the decentralization policy. Although in theory the districts were the owners and implementers of user fee reforms and the imbedded exemptions, in practice they were not consulted when these were being designed. It was the central government that dictated how to implement them and only passed them on to the districts after it had failed in implementing the process.

Respondents told us that while decentralized districts were striving to raise revenue for the devolved services, the Ministry of Health advocated for exemptions and waivers without funding the schemes. Hence decentralized districts did not view safety nets as being in their interest. Soon the districts lost interest in the process because the revenue base was low and central government had set the fees at a low level in order not to discourage utilization of services. One hospital administrator in a government hospital observed: "I hope you are aware that cost sharing is illegal. There is no law in Uganda governing cost sharing. Leaving the districts to implement cost sharing was a trick used by the government to put it at an advantage of not being politically responsible for its outcome. For those of us at the district level, we also pushed the problem down to lower health units so that they make their decisions on cost-sharing."

The district health staff had an interest in cost sharing and not in administering exemptions and waivers because the former

strengthened their welfare through top-up of their meagre government salaries, which also were often delayed. They therefore had a very strong incentive to collect as much in fees as possible. Many admitted during interviews that they deliberately did not inform the public about the possibility of exemptions and waivers as a way of ensuring that maximum revenue was realized from cost sharing. Health staff held the view that there should be fewer exemptions, so as to raise more revenue for running the health facilities. Besides, their families and friends could get free treatment. It should be noted that health workers, being civil servants and not elected by the local population, were not fearful of the reaction from the population. Many individuals in villages reported that their communities did not have a representative on hospital and health unit management committees as stipulated in the guidelines from the Ministry of Health. To them, these committees did not intervene for the poor but instead brought in their families, relatives and friends to receive exemptions even when they could afford to pay for their treatment.

### Guidelines on safety nets ignored, selectively applied or non-existent

Given the clash on interests, many district authorities and health workers embraced cost sharing in the health units but were reluctant to implement guidelines concerning safety nets. We found a tendency by health workers in lower level units to view safety nets as an imposition by the central government. This was coupled by a lack of binding legal enactment to formalize cost sharing, which made local government authorities and health workers reluctant to implement Ministry of Health guidelines on safety nets. Thus, these guidelines were ignored, abused or selectively applied to suit the revenue aims of local governments and health units.

Key informant interviews, document review and observation at health facilities in the districts revealed that there were at least three types of guidelines to be used in giving exemptions/waivers. The first set of guidelines was from the Ugandan Ministry of Health, designed as the Health Unit Level Health Management Information Systems (HMIS) Manual, and was in two volumes: volume 1 for December 1996 and volume 2 for July 1997. These guidelines are the point of reference for this study. The second set was designed by a few decentralized districts as a way of encouraging access to health care for all. The third was by a few local health facilities and departments in hospitals who were supposed to have their own guidelines on exemptions. Key informant interviews with health facility administrators and hospital records indicated that neither Ministry of Health nor local guidelines were used at health facilities when giving exemptions and waivers. Although theoretically still in force, we found that the guidelines from the Ministry of Health were not followed by health workers and were either poorly distributed or not distributed at all to the lower health facilities.

Several reasons were given for the non-use of guidelines. Central to these was lack of political support at all levels of local government. Many of the interviewed service providers considered the guidelines not suitable for the local situation. As one hospital administrator typically observed: "the guidelines on exemptions are not a government policy on exemptions from cost sharing, but are someone else's ideas. We may choose to follow them or ignore them. For our cases here, we do not follow them but have instead guidelines set by our own management committee."

At district headquarters, authorities claimed they had locally designed guidelines, which they had sent to all health units for review. We found some documentary evidence at one health unit and district headquarters, in the form of memos, to prove their existence. Likewise, we found very few health facilities where the health workers followed locally designed guidelines. In Mbarara district, we found only one health centre with a letter from the chairman of the district health committee suggesting ways of extending exemptions to those in need. Even then, the health staff in-charge reported that they had not followed the advice in the letter while giving exemptions. Other health facilities in the two study districts had neither the letter nor any knowledge of the existence of guidelines from the district director of health services concerning administering safety nets. We did not find any healthcare managers at the district level with up-to-date information on what took place at health facilities as far as exemptions and waivers were concerned. Instead they thought that health workers exempted patients based on their best subjective judgement.

### Logistics and infrastructure constraints

The guidelines on exemptions stipulated the use of exemptions and waiver books for every patient treated without paying. By observation, however, we found that the exemption and debtors' books were not used in many health units. Besides, the books left out vital information about the patient such as age, sex, profession/occupation and nature of the illness, which could be useful in assessing patients for exemption. The books were usually not available in most health facilities, especially in the rural areas. Most health facilities did not have specific staff in charge of cost recovery as stipulated by the guidelines. In many health facilities, service providers and members of management committees had not received any training on handling exemptions.

The guidelines also stipulated that the health unit management committee (HUMC) was supposed to review outstanding debts to decide if they could be waived for the poor. The target was to recover 90% of the debts. In cases where 90% of the debts were not recovered, the guidelines stipulate disciplinary action to be taken against the defaulters. Many HUMCs had operational problems and lacked the logistics and capacity to trace the defaulters in the communities. In most cases no action was taken against defaulters. Likewise, the HUMC did not seek the opinion of the community members when deciding whom to exempt, as stipulated by the guidelines.

### Local population's views on safety nets

Focus group data suggest that many individuals in villages were not aware that exemptions and waivers existed at health

facilities, and hence had no access to services. The few who knew about exemptions thought that they were given only to people related to local leaders and health workers. Such people reported that one could be exempted if he or she approached his local leader and pleaded his or her case. Participants in focus group discussions claimed that many ill individuals with little or no economic resources, and who could not count on alliances or personal acquaintances at the health service level, hesitated to approach health workers to plea for free treatment. Others were reported to resort to self-medication using drugs bought from local shops, or using herbs or other traditional therapies.

During focus group discussions, it became evident that often those who use self-medication were mothers with sick children who did not get support from their husbands or families; some may even be single adolescent mothers. They pointed out that the situation was difficult because peak malaria transmission usually occurs during or soon after the rainy season, which is also the planting season, when most households do not have any money to hand. According to them, this is also the beginning of the school term when most families have to pay school dues for their children, leading to competition for resource allocation in the household.

Table 2 shows that rather than the very poor, most of the patients who received exemptions at Ruhoko health centre in Mbarara district were actually prisoners, health unit staff and catechists, who were deemed by the communities to be less poor. As it was later established, there was a government prison close to the health unit and prisoners were exempted from health care charges.

Participants of focus group discussions complained that it was difficult to access exemptions because the mechanism for obtaining exemption, where it existed, was time-consuming and complicated by bureaucracy. It involved several people at several levels ranging from the local leaders to health unit heads and HUMCs. A focus group in a remote village of Mbarara district described their situation as follows: "Usually determination of who is exempt is based on the mercy of the medical person, but this system is not fair because if somebody knows you, whether you have money or not, you will be treated, and if you do no not know anybody, you will not be treated." Another focus group in a rural village of Mukono district also expressed dissatisfaction with registration fees: "There is nothing for free here. Before you can even request a credit or an exemption, you have to pay at least 500 Shillings (US$0.5) for registration. If you do not have it, you cannot even see the health worker to plead your case. Even when you are discharged but have no money to clear your bill, they will not allow you to leave the hospital until you have paid in full."

**Table 2.** Distribution of exemptions/waivers given to patients at Ruhoko Government Health Centre in Mbarara District for the period 1998 to 1999

| Reasons for exemptions | No. of patients exempted (n = 210) | |
|---|---|---|
| Prisoners | 71 | (33.8%) |
| Tuberculosis | 43 | (20.4%) |
| Health unit staff | 8 | (3.8%) |
| Catechists | 10 | (4.7%) |
| Armed forces | 24 | (11.4%) |
| Health unit management committee | 1 | (0.5%) |
| Referred | 1 | (0.5%) |
| Maternity | 2 | (1.0%) |
| Failed to pay | 42 | (20.0%) |
| Orphan | 2 | (1.0%) |
| Mental case | 6 | (2.8%) |

*Source*: Records at Ruhoko Health Centre, July 1999.

### Suggestions about how to handle cost recovery and exemptions

*Suggestions by users*

The dominant view during focus group discussions was that the current system of exemptions should be scrapped because the staff at health units had misused it. Respondents suggested that health care services should be provided free as had been the case since colonial times. They claimed that they paid taxes to government every year and these taxes should cater for free health services. To support their argument they pointed out cases where patients treated on credit were given incomplete dosage and told to get the remainder when they had paid in full. Such patients rarely went back to get the remaining dosage since in most cases they did not have the money. Individuals also reasoned that patients exempted at lower health units and referred to higher levels of service expected free treatment at the place of referral, which was not the case.

*Suggestions by district officials and health workers*

Health workers and managers were of the view that exemptions needed to be kept at a minimum in order to raise more revenue to run the health facilities. Some advocated for the total scrapping of exemptions because they were costly and difficult to implement. The main problems they identified were financial constraints, identifying the poor among the poor to be exempted and recovering debts from patients who defaulted or migrated. Health workers revealed that some patients were able to pay but did not want to pay, claiming that they had paid taxes to government. To prove this they cited cases where patients denied exemptions at public health units paid for their treatment costs at non-government units. They suggested remedial efforts such as educating communities on the importance of user fees and reaching the indigent through outreach programmes.

## Discussion

As in many developing countries, reforms in the health sector in Uganda have introduced changes that have in many cases worked against equity goals. Our study found that exemptions from cost sharing face serious implementation constraints in decentralized districts. Individuals in communities

expressed dissatisfaction with exemption schemes. Data from focus groups, key informants and exit interviews suggest that exemptions are often granted to individuals on grounds other than the socioeconomic criteria of indigence.

Districts embraced cost sharing in order to raise additional revenue to meet the increased costs under service devolution. However, districts are not comfortable implementing aspects of a cost sharing policy that tend to compromise the basic local government's goal of maximizing revenue. The central government's pursuit of equity in service utilization, through the introduction of exemptions and waivers, is seen as contradictory and compromising this goal.

The lower level health units, which are heavily dependent on cost sharing, particularly dislike the type of equity pursued by the central government. The matter is complicated by the lack of a formal national policy on cost sharing that is clearly enforced and monitored centrally. Owing to popular resistance, the Ugandan government opted to stave off political opposition by letting cost sharing operate as a local government strategy for health financing rather than a national policy. This left local governments with a wide latitude to implement or not implement safety nets. Local governments further gave wide discretion to lower level health units to determine exemptions and waivers as they see fit. However, lower units are being asked to explore means of sustaining their operations and they necessarily rely heavily on cost sharing.

This leaves the Ugandan health worker with a dual challenge: working without adequate supplies at the facility, and exempting ill individuals in need of assistance. In most cases health workers opt for non-exemptions of indigent and other marginalized groups to keep their units operating. This scenario demonstrates that exemption schemes seem to have failed in Uganda because they lacked adequate financing mechanisms such as direct central and/or local government subsidies for exemptions and waivers. The schemes were developed without putting in place the capacity and logistics required for their implementation both at the national and service delivery level. Guidelines to regulate exemptions are non-existent or ignored, or selectively applied at the lower unit level. The lack of political will and commitment to the implementation of safety nets means that lower level units have little incentive or guidance to implement them. Thus very few indigents receive exemptions and waivers. On the other hand, many non-poor are exempted by virtue of their connections to local leaders and health workers.

The suggestions by users, district officials and health workers about how to handle cost recovery and exemptions are contradictory. While users advocate for free health services, district officials and health workers want cost recovery with minimum exemptions. This is not surprising because the users, who are mainly peasant farmers with unstable income, want to access health services even when they have no money at hand. On the other hand, district officials and health workers want user fees to run the health units. Resolving the conflict between revenue collection at health units and providing services to users who have no money is a dilemma faced by public health planners in developing countries. We agree with Whitehead et al. (2001) that the answer to this dilemma is crucial, and will need to encompass not only health-systems policy, but also broad development issues to alleviate poverty.

Our findings are consistent with the experience from many other countries, which shows that exemption mechanisms in most developing countries face challenges in providing equitable access to health care for poor and marginalized groups. Such studies include Hecht et al. (1993), Huber (1993), McPake et al. (1993), Chisadza et al. (1995), Ensor and San (1996), Ndyomugyenyi et al. (1998), Okello et al. (1998), Gilson (1997), Pannarunothai and Mills (1997), Jeppsson and Okuonzi (2000), Blas and Limbambala (2001) and Obore (2001). These studies contend that implementation often varies from policy intent. Gilson (1997) points out that the implementation of exemptions does not protect the poor in many places and rather benefits more wealthy groups such as civil servants and soldiers who are exempted from fee payment. However, the difference here is that the problem has more to do with a lack of political will to implement safety nets than a problem of identifying the needy indigents.

## Conclusion

While this and other studies have provided useful information showing that the poor and other marginalized groups lack equitable access to health care in many developing countries, not much has been done to address this dilemma. Developing countries implementing cost sharing and the imbedded safety nets (exemptions mechanisms and waivers) can draw some lessons from our study. First, safety nets that are not based on a sound national legislative base and which are not properly monitored and supervised by the central government are unlikely to go any length to protect the poor. In situations such as decentralization where local governments' major interest is to maximize revenue to meet the costs of decentralized services, rather than promoting equity in service utilization, safety nets are more likely to be abused or not implemented at all.

Secondly, in contexts where safety nets exist in theory but are inoperational in practice, even district revenue collection goals are compromised as the exemption scheme is misused to exempt the richer among the poor at the cost of service quality improvement. There is a need to formalize the user fee policy and all its embedded safety nets, and to effect their enforcement and monitoring in the decentralized districts, if safety nets are ever to protect the poor in this form of health financing mechanism.

Thirdly, both central and local governments should explore other means of sustaining the operations of lower level health units that rely heavily on cost sharing. We have seen from this study that the more a unit relies on cost sharing for its activities, the more inequitable its service delivery becomes. Central governments have an option of either patching up the weaknesses of the policy, or doing away with the policy and seeking alternative, equitable ways of delivering services to the population, most of which, in contexts like Uganda's, are too poor to afford to pay for health care at the point of use. Unless governments are strongly committed to assisting

patients in need of assistance, there is a danger that utilization of health services, especially by the poorest, may continue to be low.

## References


Asenso-Okyere WK, Anum A, Osei-Akoto I, Adukonu A. 1998. Cost recovery in Ghana: are there any changes in health care seeking behaviour? *Health Policy and Planning* **13**: 181–8.

Blas E, Limbambala ME. 2001. User-payment, decentralization and health service utilization in Zambia. *Health Policy and Planning* **16** (Suppl. 2): 18–27.

Chisadza E, Maponga CC, Nazerali H. 1995. User fees and drug pricing policies: a study at Harare Central Hospital, Zimbabwe. *Health Policy and Planning* **10**: 319–26.

Creese AL. 1991. Cost sharing for health care: a review of recent experience. *Health Policy and Planning* **6**: 309–19.

Ensor T, San PB. 1996. Access and payment for health care: the poor of Northern Vietnam. *International Journal of Health Planning and Management* **11**: 69–83.

Gilson L. 1997. The lessons of user fee experience in Africa. *Health Policy and Planning* **12**: 273–85.

Gilson L, Kalyalya D, Kuchler F et al. 2000. The equity impacts of community financing activities in three African countries. *International Journal of Health Planning and Management* **15**: 291–317.

Hecht R, Overholt C, Holmberg H. 1993. Improving the implementation of cost recovery for health: lessons from Zimbabwe. *Health Policy* **25**: 213–42.

Huber JH. 1993. Ensuring access to health care with the introduction of user fees: a Kenyan example. *Social Science and Medicine* **36**: 485–94.

Jeppsson A, Okuonzi SA. 2000. Vertical or holistic decentralization of the health sector? Experiences from Zambia and Uganda. *International Journal of Health Planning and Management* **15**: 273–89.

Litvack JI, Bodart C. 1993. User fees plus quality equals improved access to health care: results of a field experiment in Cameroon. *Social Science and Medicine* **37**: 369–83.

Mbugua JK, Bloom GH, Segall MM. 1995. Impact of cost sharing on vulnerable groups: the case of Kibwezi in rural Kenya. *Social Science and Medicine* **41**: 829–35.

McPake B, Hanson K, Mills A. 1993. Community financing of health care in Africa: an evaluation of the Bamako Initiative. *Social Science and Medicine* **36**: 1383–95.

Mills A. 1991. Exempting the poor: the experience of Thailand. *Social Science and Medicine* **33**: 1241–52.

Ndyomugyenyi R, Neema S, Magnussen P. 1998. The use of formal and informal services for antenatal care and malaria treatment in rural Uganda. *Health Policy and Planning* **13**: 94–102.

Nyonator F, Kutzin J. 1999. Health for some? The effects of user fees in the Volta Region of Ghana. *Health Policy and Planning* **14**: 329–41.

Obore Nathan. 2001. Marketization of health care: a critical analysis. *Uganda Health Bulletin* **7**: 3.

Okello DO, Lubanga R, Guwatudde D, Sebina-Zziwa A. 1998. The challenge to restoring basic health care in Uganda. *Social Science and Medicine* **46**: 13–21.

Okuonzi SA, Birungi H. 2000. Are lessons from the education sector applicable to health care reforms? The case of Uganda. *International Journal of Health Planning and Management* **15**: 201–19.

Pannarunothai S, Mills A. 1997. The poor pay more: health-related inequality in Thailand. *Social Science and Medicine* **44**: 1781–90.

Russell S, Gilson L. 1997. User fee policies to promote health service access for the poor: a wolf in sheep's clothing? *International Journal Health Services* **27**: 359–79.

Willis CY, Leighton C. 1995. Protecting the poor under cost recovery: the role of means testing. *Health Policy and Planning* **10**: 241–56.


## Acknowledgements


The authors thank the UNDP/World Bank/WHO Special Programme for Research and Training in Tropical Diseases' (TDR), Social, Economic and Behavioural Research for financial support (Study ID No. 980752). We also wish to express our gratitude to the facilitators of the scientific writing workshop in Manila, Philippines – Dr Johannes Sommerfeld, Mr Erik Blas, Dr Norman Hearst and Dr Bo Eriksson – for the support and guidance provided during the writing of the manuscript. Lynn Hollies, Julius Massaga, Xavier Nsambagasani, Anne Katahoire, Allen Magezi, Augustine Mutumba, Portase Muhumuza (RIP), Samuel Okuonzi and Chris Mugarura are greatly acknowledged for their contribution to the study. Representatives of the Ugandan government, district staff and community members are thanked for making the study a success. The Child Health and Development Centre, Makerere University and the Department of International Health, University of Copenhagen are acknowledged for academic support and office space.


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