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User charges in public health facilities in Tanzania: effect on revenues, quality of services and people's health-seeking behaviour for malaria illnesses in Korogwe district

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User charges in public health facilities are aimed at improving efficiency and quality of health services. In Africa, evidence about their effect on patient attendance and community health-seeking behaviour are mixed. This paper reports a study of the effect of user charges on revenue collection, quality of services and people's health-seeking behaviour in relation to malaria in Korogwe district, Tanzania. Data were collected through focus-group discussions with community members, interviewing community leaders and health workers, field observations and review of patient registers. Generally, there was no distinct difference in the trends of patient attendances before and after user fee introduction. Public awareness about cost-sharing policy was high, but had low appreciation in the administration of exemptions and waivers. Shortage of drugs, laboratory facilities, and inhospitality of nurses lowered their confidence in the user-fee system. Autonomy to collect and prioritize expenditure of user-fee revenue at the health-facility level was appreciated by community leaders and health workers who, however, had reservations with funds being held at the district level and delays by the DMO's office in approving budgets submitted in request for expenditure of such revenues. Thus, despite the potential of user charges for revenue mobilization, problems with their administration lowers public confidence in the user-fee system improving quality and accessibility of services to the poor.

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Introduction

The cost-sharing policy in the Tanzanian public health service system was introduced in July 1993 as part of economic recovery and structural adjustment programmes aiming to improve efficiency and foster sustainability in the provision of health services through community participation.[1] To enforce the referral system and to enable the citizens to get familiar with the cost-sharing system, the Ministry of Health (MoH) planned to introduce user charges in two phases, beginning with referral hospitals and then after a few years with health centres and dispensaries.[2–7] In line with the principle of universal access to health services, all public health facilities have been providing health services free of charge since independence in 1961.[8] In Korogwe district, user fees were introduced at health centre and dispensary levels from January 2002.

According to the government national cost-sharing policy guidelines, children under the age of five years and pregnant women are eligible for exemptions from user charges for basic services. Other groups of eligible people include those presenting illnesses associated with diabetes, cancer, meningitis, TB and leprosy, HIV/AIDS, and people attending for family-planning-related services.[2,9,10] Through the national parliament and government gazettes in 1999, the government officially announced that even people aged 60 years and above deserve exemptions from user charges, the information that had also been published in most of the local private newspapers.

This paper reports a study that was undertaken in 2003 in Korogwe district, North-eastern Tanzania, to establish the influence of user charges at government health centre and dispensary levels on revenue collection, quality of service, patient attendances for malaria and other illness conditions and people's health-seeking behaviour in general. In addition, interest was on views of community, health staff and community leaders regarding government policy on waivers and exemption and the autonomy they have (i.e. decentralization) in collecting and utilizing user-fee revenues.

International evidence about user charges

The last decade has witnessed numerous proposals for and actual studies on user fees among other cost-sharing mechanisms in developing countries' health sectors. Essentially, cost-sharing systems are intended to augment the inadequate government budgets allocated for health services by involving the general or selected members of the public to pay partially for their medical service needs. In the 1980s, most sub-Saharan African governments had experienced fiscal difficulties, leading to government failure to continue financing health services alone.[11] As one of the agendas for economic reforms, the World Bank recommended increased cost-recovery systems to finance publicly-provided health services.[12,13] This was envisioned to relieve the public health sector from chronic shortage of recurrent inputs such as drugs and other medical supplies. Increased cost-recovery revenues were also suggested as a means for improving the quality, effectiveness and coverage of health services and to contribute to people's ownership and sustainability in health-service provision.[11]

Mixed evidence about the effect of user charges on people's attendance at health facilities has continued to be documented, the majority of literature pointing out negative effects on the poor and marginalized population groups.[14,15] There is an assertion that user charges have a reduction effect on the demand for health services especially among the poorest population groups, although the extent to which this is the case depends on the level of the charge.[16] A study in Kenya found a drop in patient attendances in the first nine months after user fee introduction and a reverse in the trend of attendance after the government waived such fees.[17] Similar observations on user fees discouraging patient attendances were made by Yoder in Swaziland.[14,18] Moreover, the World Health Organization through the Special Programme for Research and Training in Tropical Diseases (TDR) made an evaluation on the impact of user fees on disease control in several tropical countries and found that a fee introduction or increase leads to a drop in the overall demand for care for diseases, including malaria.[19] Gilson[15] identifies that payment of user fees out of the pocket of a patient at the service counter enforces the poor delay in contacting health facilities. Meanwhile, the introduction of any cost-sharing system without having in place mechanisms to protect those who cannot afford to pay could be more risky on health than free service provision, although it is not easy to identify the inability to pay.[15,18,20–23] Nevertheless, a positive impact of user fees on quality of service and increased

patient attendance has been observed in West African countries such as Cameroon and Niger.[18,24] This evidence supports an argument that under-utilization of modern medical services might be contributed to by consumer disappointments with quality of service rather than the user fee introduction.[15,21] Of course, there is the question of which period of cost-sharing policies should be evaluated to judge their impacts.[21]

Methodology

This was a cross-sectional descriptive study conducted in 2003 in Korogwe district in North-Eastern Tanzania.

Socioeconomic characteristics of the study area

The majority of the inhabitants belong to the Sambaa and Zigua tribes. Small-scale farming of crops such as maize, beans and bananas is the dominant economic activity. These crops are mainly grown for food, although they are partly sold to enable households to raise some cash to support their health care and other family needs. Swahili is the official and most common local language, although other ethnic languages are spoken. Islam and Christianity are the dominant religions.

Sampling techniques, data collection methods and research questions

A purposive sampling technique was adopted for the selection of focus group discussion (FGD) participants and key informants (administrators, nurses and clinicians) from five public dispensaries (Magamba-Kwalukonge, Kwamndolwa, Mnyuzi, Makuyuni, Ngombezi) and three health centres (Bungu, Magoma, Mombo), and local government leaders who were members of local health facility management committees. Each FGD had 8–12 participants, including women aged 15 years or above, and men aged 18 years or above (heads or representative heads of households). Health facilities were selected from different parts (wards and divisions) of the district.

Notes from FGDs written by hand were validated by transcripts from tape recordings. Also, notes from key informant interviews were taken by hand and transcribed immediately after the interview. Reviews of patient registers and user fee collection logbooks, as well as researchers' direct observations of the infrastructure conditions and general environment around health facilities were included.

Although people's decisions to contact health-care providers might be influenced by various causes, malaria was selected to be a tracer condition when reviewing the trend of patient attendance at formal health facilities because of two main reasons: (i) it is the leading communicable disease in the district and (ii) the fact that the government recently changed the malaria treatment policy. This might have in one way or another influenced people's attendance at health facilities rather than, or in addition to, the user-fees system *per se*. Nevertheless, in order to justify the basis for our conclusion regarding the influence of user fees on patients' attendance, records were also made on all other causes of attendances before and after user fee introduction. An attempt was made to examine, among other things, how people perceived modern antimalarial drugs in comparison with traditional medicines. In relation to this, it was presumed that sometimes people's failure or reluctance to seek care in relation to malaria at health facilities might be due to their negative attitude towards the types of drugs prescribed there, e.g. fansidar (sulphadoxine-pyrimethamine), rather than user charges. Community members and health workers were asked to express their opinions as to whether or not the user-fee system has been associated with improvement in the quality of service, and whether the waivers and exemption policy worked. In addition, observations were made of the trends in revenue collection in relation to patient attendances, and if user fee revenues were lowered due to waivers and exemptions granted.

Data management and analysis

Transcription of FGDs and key informant interviews were each done with assistance from a social scientist. FGD and interview notes were triangulated with quantitative data from document review and researchers' observations.

Results

Implications of user charges on quality of service and people's health-seeking behaviour

On the one hand, health personnel and community leaders were all of the common opinion

that since the user-fee system was still new at lower health facility levels in their district, it was too early for them or the rest of the community to judge its failure or success in terms of quality of service. On their side, however, they appreciated that the revenue collected (although generally lower than anticipated) has so far been utilized on activities related to quality of service improvement. In particular, they mentioned things like the minor repair of old facility buildings, toilets and purchase of supplementary drugs to top up the drug kits, which sometimes run out of stock of some essential drugs. The kits are normally supplied on a monthly basis from the MoH through the Medical Stores Department. Other expenditures identified include the payment of electricity bills at some health facilities, the occasional purchase of kerosene for use at dispensaries without electricity, payment of wages to the watchmen and partial use of the money to pay bus fares for someone sent from health facilities to liaize with the DMO's office in request of approval of expenditure budgets on the revenue collected at health facilities.

Regarding the availability of drugs, it was appreciated by all these respondents that the previous frequent shortages of chloroquine (CQ) that posed alot of challenges to health workers dealing with patients is no longer experienced since the government officially launched sulfadoxine-pyrimethamine (SP) as the national first-line antimalarial drug. Nevertheless, the rate of consumption/patient demands for antipyretics (especially paracetamol) was reported (by health service personnel) to have increased tremendously after SP introduction compared to the period beforehand. Quinine was reported to have run out of stock a few days after the kits received from the MoH were opened. This shortage was linked with most under fives and other severe malaria patients being prescribed this drug as per the government treatment guidelines.

On the other hand, there was a mixture of opinions among FGD participants (discussants) at community level concerning the issue of quality of service following the introduction of user charges. Some were of the opinion that user charges have increased health workers' attention to patients and have improved the quality of some services, while the remaining majority of the discussants felt that the quality of services was still poor. The most stressed shortage is a lack of blood transfusion facilities at most health centres and dispensaries, a lack of essential drugs and poor health staff (especially nurses') courtesy when dealing with patients and pregnant women. The concern among most of the participants was that although the rate of charge per outpatient per visit was shillings 500, many people in the villages still found it difficult to pay along with other household expenditure commitments.

Concerns were also shown by some community FGD participants that there has been a tendency to prescribe the same type of drug based on clinical diagnosis since laboratory facilities were absent at most peripheral public health facilities. Contributing further to the issue of laboratory, one village government chairlady argued, 'Many young children become anaemic, needing blood transfusion, but none is available at the village dispensary. So people would wish to be rushed to the district government hospital (Magunga) or Kwamndolwa Mission health centre. Again, this depends on whether or not one is able to pay either for the service or for transport or both'. Some participants expressed their dissatisfaction with patients sometimes paying user charges but ending up being directed to buy drugs from other sources because of drug shortages at the health facility in question. One participant in Magamba Kwalukonge village argued, 'It makes no sense to pay Shillings 500 without being given some drugs. Otherwise it is an over-charge because once the money is taken it is never returned to the payer'.

While it was also appreciated that SP is regularly available at primary health-care facilities, views from all the community FGD participants indicated that the introduction of SP as the first-line drug for malaria treatment was not appropriate since such a drug causes allergy and other side effects (e.g. Steven-Johnson syndrome locally called 'the burning of the skin'). This situation was described to have discouraged many residents from using SP (especially in children), even if it was prescribed at health facilities, while others saw no relevance in even contacting health facilities for mild malaria conditions particularly when they were certain that they would be prescribed with SP. There were those who felt that the previous CQ drug was still effective despite the government decision to phase it out on the grounds that it was no longer effective. Some discussion participants reported that either their relatives or they

themselves used CQ and were cured, but now they have realized no potential advantages with the use of SP. Others noted that even amodiaquine has side effects although it was effective. The majority of the discussants were of the opinion that, apart from its side effects, SP is also less efficacious in curing malaria. In one village, most of the discussants seemed to be sceptical of the competence of some clinical assistants and clinical officers to manage some drugs on the grounds that such personnel had never attended or had incomplete appropriate training courses.

Delay in contacting health facilities or self-medication with local herbs from retail sources and consulting traditional health practitioners were reported to be a common option for those who find it difficult to pay user charges. In every village visited, some discussants argued that with only shillings 300 one could access a dose of antimalarial drug directly from a kiosk or shop rather than paying shillings 500 at a dispensary or health centre. Attempts to self-medicate or consult traditional healers were reported to have contributed to most children and some adult persons residing far from health facilities developing severe malaria and coming to contact formal health facilities only with serious anaemia, *degedege* (convulsion) or coma. Figure 1 summarizes FGD participants' opinions as to why malaria has persisted in their areas despite high community awareness.

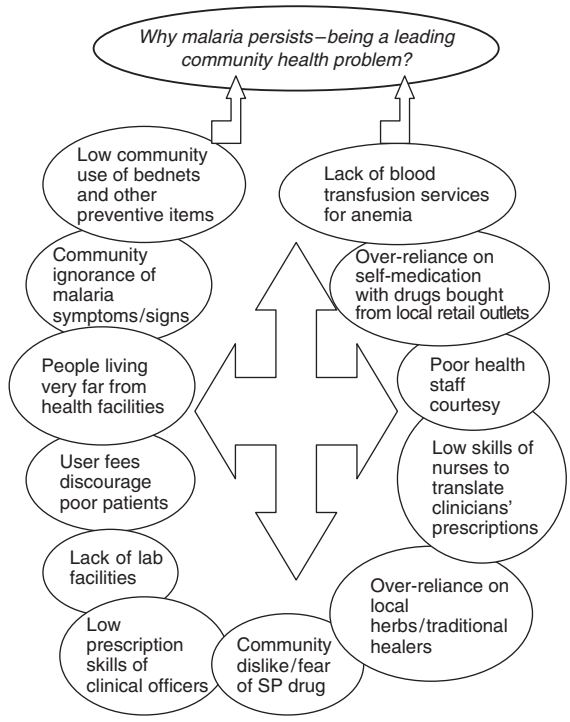

Figure 1 *Discussants' views as to why malaria persists in being a major community health problem*

Community confusion about the structure of user charges

The term 'structure' of user charges used here is taken to mean the rates of user charges implemented at the study health facilities and the type of services charged for. Apparently, there was confusion among the majority of participants concerning specific health services for which the current user-fee payment was made. Some of the questions the moderator was frequently asked by the participants indicated their lack of knowledge of what specific types of health services the current user-fee rate of shillings 500 was meant for. Most of them seemed not to know that such a rate of payment was valued per person per one outpatient visit regardless of the type and number of diagnoses and prescriptions, as reported by the local health personnel. In addition, community members were reported to have been disappointed by patients occasionally being asked to buy injection syringes or by women being required to pay for the services relating to delivery contrary to the government exemption policy. It was argued, to avoid this inconvenience that, some women decide to deliver at home with assistance from traditional birth attendants (TBAs). Some community members (including some village leaders) were heard complaining that 'how can shillings 300 be charged just for buying an exercise book for keeping their records at health facilities each time they visit there while the price of one exercise book is only shillings 100 in the retail shops/kiosks'. Reacting to this claim, health personnel revealed that the shillings 500 charged was meant for covering both the cost of the exercise book and whatever type of service the patient concerned was going to be given based on the diagnoses and prescriptions made.

Nevertheless, some participants revealed that those considered poor people were contacting private health facilities, where they used to pay even more than they would have done at government health facilities under the

current user-fee system. But one participant had the following opinion against private health-care prescriptions, 'Private health facilities are profit oriented rather than providing the real services. They can prescribe for malaria instead of typhoid, and usually tell their clients to return/go back'. Lack of beds for admitting patients or pregnant women in serious conditions at least temporarily at public dispensaries, shortage of beds at the district government hospital and lack or shortage of dental services at health centre and dispensary levels were also mentioned, in addition to other shortages as described in Figure 1.

Influence of user charges on patient attendances and revenue collection

As shown in Figures 2 and 3, patient attendances at all the health facilities visited cannot directly justify that the introduction of user charges has significantly influenced patient attendances. The trend of the recorded malaria patient attendance was established by calculating the total number of malaria cases recorded as a percentage of all patient cases diagnosed and recorded for various types of illnesses per year between 1998 and 2001 (before user fees) in comparison with the year 2002 (during

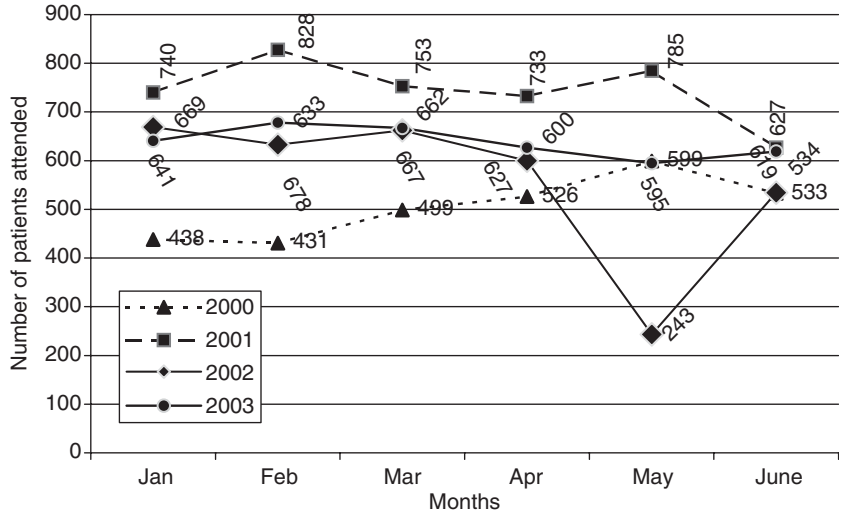

Figure 2 *Monthly OPD attendances for the 5+ years age group at three Govt peripheral health facilities in Korogwe district, Tanzania*

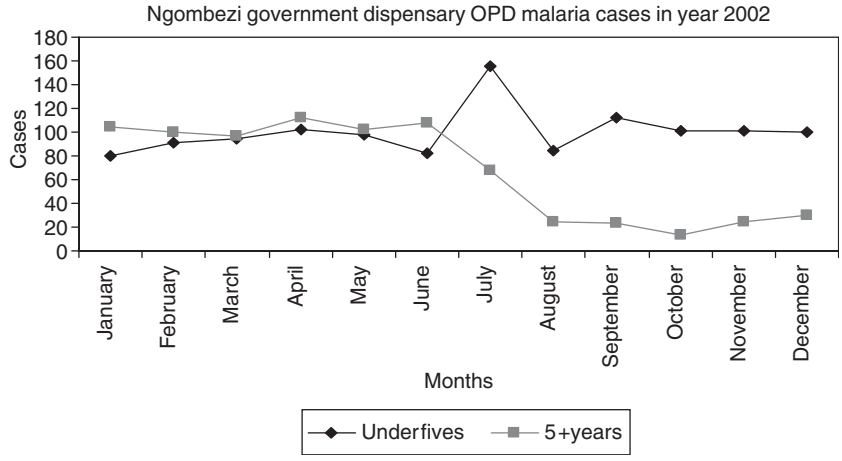

Figure 3 *Ngombezi Government dispensary malaria cases attended during 2002*

user-fee implementation) at government health centres and dispensaries. At some individual health facilities, records showed that the attendance rates were higher for some months than for other months within the same year. Only at one dispensary (Ngombezi) attendance dropped sharply in 2002 (Figure 3) and in the first quarter of 2003 compared with previous years and in the rest of the months of the year (data not shown). According to those in charge of the dispensary, the noted slight decline in attendances in 2001 for the under fives in comparison to those aged five years and above was contributed to among other things, the government introduction of SP to replace chloroquine as the first-line antimalarial drug. It was clarified that many people hesitated to use SP for fear of allergic reactions and other side effects, according to their perception. Conversely, despite the introduction of user charges at the dispensary since January 2002, the attendance for the under fives was higher than that of the previous year and that of the 5+ years age group. In discussion with those in charge at the health facility, it was inferred that user charges have possibly had no direct significant effect on attendance for the under fives who are eligible for exemptions according to government policy guidelines. In the first half of years 2000 and 2003 (January – June), monthly OPD attendances of patients aged five years and above (5+years) showed some remarkable fluctuations at the three health facilities that were found with well-documented patient registers. For example, it can be observed in Figure 2 that while in 2000 attendances were generally increasing between January and June, there were fluctuations without a particular trend during the same period in 2001. In 2002 and 2003 there was a slight decrease in the attendance trend between February and May. Furthermore, it can be observed that although attendances for 2001 (before user-fee introduction) were higher than those for the year 2002 and 2003 (during user-fee introduction), attendances for the latter period were still higher than those for the year 2000 (also before user-fee introduction).

The annual total attendances (Figure 4) indicated that the attendance rate among the 5+ years group was increasing between January 1998 and December 2000, dropped dramatically by 11% between 2000 and 2001 and slightly increased by 1% between 2001 and 2002. However, this figure does not reflect a comparative attendance trend between only one year (2002) of implementing user charges and four years (1998–2001), the period before user-fee implementation. Only monthly patient attendance records for the first quarter of 2003 (refer to Figure 2) indicated a continued drop in attendance for the 5+ years age group (who according to policy are supposed to pay user charges). Also, records from individual health facilities indicated that the monthly number of attendances fluctuated even in years before user-fee introduction, as has been the case in different months of 2002 and the first quarter of 2003 after user-fee introduction. It was only at the Magoma government health centre that a decrease in outpatient attendance occurred

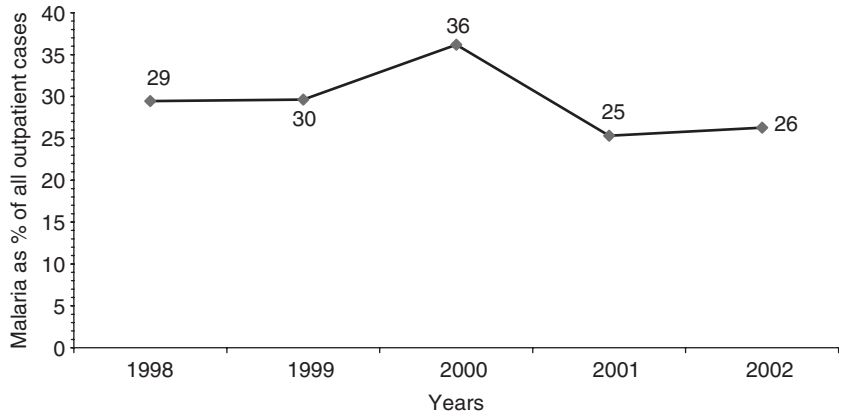

Figure 4 *Trend of malaria cases as percentages of all age group outpatients attended at peripheral Govt health facilities before user-fee introduction (1998–2001) and 2002 when user-fees were being implemented in Korogwe district*

during the initial 3 months (first quarter) of 2002, but it increased thereafter.

Patient records also indicated an increasing trend of severe malaria inpatient admissions in all age groups between 1998 and 2002 at Magoma health centre. Conversely, there was a decreasing trend of non-severe malaria inpatient cases of all age groups at that facility. It was testified by key informants that community over-reliance on traditional medicines and the poverty conditions facing most of the households contributed to people's delay in contacting health facilities even for malaria illnesses, as one community leader testified, 'Leave alone the issue of fees, some households find it difficult to raise even 1000 shillings in a month and end up opting for paracetamol from kiosks or just use mitishamba' (local herbs) (Table 1).

The trend of revenue collections from user charges on outpatients followed the same pattern as patient attendances (Figure 5). Focusing on malaria attendances as a tracer condition, it can be observed that, in general, the revenue collected from user charges increased with an increase in the number of patients registered at the health facilities. Between January and May, one of the high malaria transmission seasons, revenue collections were higher than during the rest of the year. Although the period between July and October is renowned to be a cash crop harvest and selling season during which the majority of the households at least access some money, it is the period in which revenue collections are lower due to lower patient attendances due to malaria. A similar trend was observed at other health facilities. Although user fee revenue records were not based only on malaria patients but also on patients presenting with other medical conditions, malaria was considered to have contributed more as a proportionately leading cause of patient attendances (Figure 4 and Table 1).

Also, it was argued by health workers and some community leaders that during long rain seasons (March–May and October–December), malaria morbidity in under fives is usually at its peak as most of the village residents are busy preparing their rice and maize *shambas* (farms), thus sparing little time to take care of their children at home. This period was also reported to be the time at which most households have little cash because they have not harvested (in fact they are cultivating) while the little cash they have spent either on the purchase of fertilizers and other farming tools and food (e.g. maize flour) from retail shops. Furthermore, it was lamented that from October each year, most households have a tendency of reserving some cash in preparation for the December Christian and Islamic Holydays, new-year celebrations and school fees for their children at the beginning of a new year. Consequently, this leaves no cash or expenditure for health, including transport cost to health facilities for those living very far away.

Decentralization in user fee collection and expenditure

Health workers and community leaders were aware that the collection and expenditure of revenues from user charges has to follow the officially acceptable policy guidelines, although local authorities had some mandates to oversee the process in line with

Table 1 *Malaria inpatient cases registered at Magoma Health Centre between 1998–2002*

Year	Severe/complicated cases	Non-severe cases	Malaria cases as a % of all cases diagnosed
Under fives			
1998	13 (7.7%)	156 (92.3%)	169 (55.96%)
1999	62 (15.54%)	337 (84.46%)	399 (30.06%)
2001	194 (26.22%)	546 (73.78%)	740 (—)*
2002	303 (44.56%)	377 (55.44%)	680 (40.45%)
5+ Years group			
1998	19 (12.34%)	135 (87.66%)	154 (24.37%)
1999	39 (15.06%)	220 (84.94%)	159 (11.97%)
2001	129 (30.64%)	292 (69.36%)	421 (—)*
2002	112 (34.89%)	209 (65.11%)	321 (19.09%)

*% not indicated

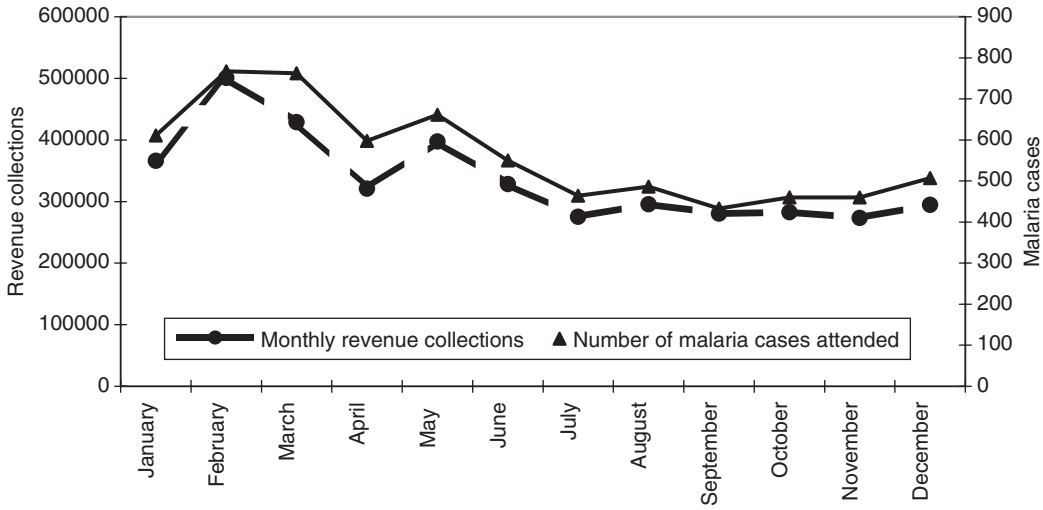

Figure 5 *Monthly user fee revenue collections in relation to malaria cases (5+ years age group) attended at OPD at three Govt health facilities in Korogwe in 2002*

the decentralization policy. The government guidelines stipulate that the revenue collected from user fees must be used to improve health services at the health facility in question, although all the planned or contingency expenditure of that money at local level must be approved by the DMO's office. Each health facility has a health facility management committee, comprised of members of primary health-care committees at village and ward level, led by the village government chairpersons of the localities in which the health facilities in question are. As per the established guidelines, the secretaries of such health-facility committees are those in charge of the respective health facilities. They are responsible not only for keeping the minutes for each committee meeting held but also for executing the committee's planned activities in liaison with the committees' chairpersons. Other members of this committee include representatives from different sectors — agriculture, education, water and at least one woman to represent the women in the community. According to the explanation given by health-facility staff and community leaders and then confirmed by the DMO, the facility committee normally meet to identify the priority service areas requiring user-fee funds, and send their budget plan and minutes to the DMO within the limits of the revenues collected in a specific period. The DMO then scrutinizes the plan and the minutes of facility committees and decides to approve the plan if it is realistic. The plan for the dispensary sometimes has to go through the Ward Development Committee first before it is sent to the DMO. One government dispensary (Kwamndolwa) was found to have not yet spent any revenues collected in the last 6 months. Neither was there a budget plan showing how the funds would be spent. It was stressed that delays in getting budget approval by the DMO in relation to user-fee revenues requested have somehow demoralized user-fee revenue collectors at the health facility and members of health-facility committees.

Viability and controversy of exemptions and waivers

Records and interviews of individual health staff in charge of eight primary health-care facilities confirmed the granting of waivers and exemptions to some people. For example, according to the available records, children under five have all been given service free of charge. However, there were some reservations with regard to the administration of waivers and exemptions. At all health facilities visited, it was found that the monthly and annual revenue collections were lower than anticipated due to waivers and exemptions. Records on patients who were granted waivers were found systematically documented, except at the Mombo health centre. As for exemptions,

it was added by those in charge of health facilities that the proportionately higher number of under fives and pregnant women, let alone other vulnerable groups who are eligible for exemptions, had tremendously lowered the amount of revenue collections. This has reduced the potential of user charges for quality of service improvement particularly within a short period since they began to be implemented at dispensary and health-centre levels. It was reported that a lack of designated accounts personnel for user-fee collection has increased the workload on the clinical officers in charge of health facilities and nurses who find themselves spending a lot of time listening to requests from poor patients who ask for waivers and keeping records of user-fee payments made by other patients instead of concentrating on medical service delivery only.

Although the administration of exemptions was seen to be easy and non-ambiguous, the identification of poor patients eligible for waivers was reported to be difficult and controversial. It was lamented that while some non-eligible patients continued to claim for waivers, there was a possibility that those eligible could end up not being waived as health staff found it difficult to confirm their inability to pay. Clinical officers at three health facilities were not happy with what they took to be the tendency of some local government leaders (e.g. ward councillors) to recommend some non-eligible patients for waivers on grounds of nepotism, friendship or other forms of relationship. 'You either accept the recommendations, otherwise you lose the job or get a transfer', they claimed. It was added that the ambiguity of identifying the poor or waiving the non-poor due to political pressure has sometimes made health workers hesitate to keep records on waivers because no staff wanted to be accountable to the health facility management or district health authorities for deciding to approve waivers without strong basis for justifying just in case they were asked to. Similarly, some community FGD participants stated that waivers were sometimes granted on the basis of 'who know who' with some politically influential persons or their relatives being waived, while the poor were ordered to pay even if at deferred interval. The basis for which waivers were granted were reported by health staff to include patient's appearance in terms of their physical health, the way they were dressed (e.g. dirty and torn clothes, barefooted). The economic status of people living around health facilities was known to health staff and local government leaders, which, it was claimed, made it easy in this regard to confirm those who deserved waivers.

It was also reported that although many people (young and old) occasionally asked for waivers, while it was difficult to waive all of them, an attempt was made to register the names of those who failed to pay directly but asked to be serviced with the promise of settling their debts later. This was reported to have been possible because the chances for most of the patients to return for services were many, thus making it easy for the local health staff to recall patients based on the available records on the respective patients register. However, this exercise was reported to be unreliable because some people did not keep their promises and continued claiming that they had not yet raised enough cash to pay and that they had had to face other family financial commitments that were difficult to avoid. This habit apparently disappointed local health staff involved in revenue collection, as the clinical officer in-charge of Magoma health centre complained, 'Some people are rude. They tempt to try health staff by pretending to be unable to pay while they actually are. Some of them are even businessmen, yet they claim against the little fee charged'. Almost all health facility officers in charge identified themselves as the officers most responsible for finally deciding who should be waived, although letters from local government leaders recommending some patients to be waived were also occasionally accepted. Even malaria patients were among those reported to have benefited from waivers.

Conversely, many discussants in all FGDs expressed their discontent with what they referred to as the tendency of some health personnel, especially nursing staff, to discriminate against patients who show difficulty in paying user charges at public health facilities. In comparison with the period beforehand, one observant said that, before cost-sharing policy started, there was no discrimination of poor patients as there is today, whereby those who pay are handled more carefully. In order to avoid being demoralized by the language of nurses it was lamented that some poor people opt to contact local health practitioners. Doctors and clinical officers were generally

commended for their hospitality and indiscriminate handling of patients. It was also said that some health personnel at drug delivery counters were disobeying directives given by their senior officers concerning waivers by asking for payments from patients who were already indicated to be waived. The notion that old people aged 60 years or above were practically exempted was criticized by most of the participants. Some of them, however, viewed that not all old people are unable to pay as some are wealthier/richer than young people. The point that letters of recommendations from local government leaders were accepted for those who requested waivers was strongly criticized by community FGD participants in all the villages visited.

Discussion

Implications of user fees on quality of service

Although the consumer is sovereign in economic terms, there is a danger in drawing judgement based merely on opinion surveys of service users who might be over-ambitious when it comes to quality of service assessment. Some lay people may expect a dispensary to provide the same quality type of services as the health centre and even a hospital. Another bias in opinions obtained from users and health provider surveys might arise from the way the two groups perceive and judge things based on their personal psychological feelings, preferences and understanding in health matters. While for a common community member good quality of service might mean the availability of drugs, diagnostic and bed facilities, short patient waiting time and staff courtesy, the interest of a health worker might include things like working environment, such as attractive and well-equipped offices, building, working gears, and greater autonomy to make decisions on their patients/health clients, including among other things the mandate to prescribe drugs. However, there are things that health workers should admit as a matter of fact, although it does not seem to be directly linked with user-fee implementation. For example, the issue of hospitality of the health workers is something a client can judge rather than health workers judging themselves. Consumers expect good service when they pay their money, e.g. user charges; therefore, how they are handled by their providers is an important concern to them. Some of the reported shortages such as drugs, laboratory facilities, beds for patients and skilled staff, as depicted by FGD participants, cannot be directly linked with the introduction of user charges at the dispensary and health-centre level in the last two years, as the situation has been so even prior to their introduction. Nonetheless, it is important to admit that the public has not appreciated user charges to have positive effects on the quality of service at facility levels.

Impact of user fees on patient attendances

Trends in patient attendance rates could not give a clear picture of the impact of user charges on patient attendance at health facilities. One of the limitations of this study in arriving at a sounder conclusion about this is that the period of only one year after user-fee introduction is too short to be compared with what happened several years before 2002. We have also seen that any of the observed decreases in attendance in the year 2001 through 2002 in relation to malaria was partly contributed to by government introduction of the new first-line drug, which is not the drug of choice for most of the community members, so their hesitation to contact public health facilities is partly contributed to by their attempt to avoid being prescribed SP. On the other hand it can be inferred that in some ways user fees might also have discouraged potential clients who avoided paying user charges and ended up getting SP they did not prefer or being directed to buy drugs elsewhere.

Autonomy to utilize the user fee revenue collected

For the user-fee system to mark an improvement in the quality of services would depend on, among other things, the way the revenue collected is utilized and the time at which the funds would be available for use. It makes no sense if funds are collected but not used in time or at all. It also makes little sense if those responsible for the collection of funds at the community level have unnecessary autonomy to account for and manage such funds. The dissatisfaction by revenue collectors with the bureaucracy and delays in the DMO's office in approving the requested funds is an indication that decentralization of authority for

administering user fees is yet to trickle down as envisioned by the government policy. It is economically inefficient for those in charge of the facilities to travel to the district capital to process the collection of funds, as this is an unnecessary administration cost.

Viability of Waivers

The weakness of government cost-sharing policy in not giving clear criteria or definition of persons who deserve waivers has apparently given local health workers a loophole to make their own judgements, which widens the chance for the policy to be poorly implemented. In addition to hidden agendas by those who might have been motivated by revenue collections, the possibility that the poor have ended up paying while the 'rich' have benefited from waivers becomes evident; a situation that has been similarly reported from Uganda,[25] other places in Tanzania[10,26] and in other African countries.[15,18,21]

Conclusion

In some ways, findings from this study are in line with evidence from other countries that user charges have some undesirable impact in communities where they are implemented, especially when they are not associated with a simultaneous improvement in the quality of services. The waivers and exemption policy seemed to be widely known in Korogwe district, but problems in identifying the poor limited the scale to which waivers have been granted. Meanwhile, decentralization of user-fee planning and administration is yet to be realized. The granting of many waivers without a system where health facilities are compensated for the waivers they granted to patients might have been another factor that prompted health-facility administrators and health staff dealing with patients to put more stress on revenue collection than waivers. More studies would be useful after several years of user-fee implementation in order to arrive at a sounder conclusion about the effect on quality of service and efficiency.

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