

Cost-sharing in Kabarole District, Western Uganda: Communities' and Health Professionals' Perceptions about Health Financing

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This study investigated the perceptions towards cost-sharing in Kabarole, Uganda. The opinion of the public and professional groups about user fees was determined. The findings indicate that the Kabarole cost-sharing project was viewed as successful. Reasons for the success given were options for local decision making, community ownership and local management of funds.

Key words: Uganda; user fees; perceptions of public; quality of care

Introduction

Since the Bamako Initiative in 1987, cost-sharing has received increasing attention in developing countries. This interest is not surprising, given the low priority to health care by the governments and the limited financial support for health care financing in those countries. In many third world countries, health care services account for less than 5 percent of public spending and less than 2 percent of the Gross Domestic Product (GDP). This translates into annual per capita expenditures for health of US\$ 5 or less, which is well below the US\$ 10-12 per head per year that is considered by WHO as the lowest limit below which adequate basic health services for the population in developing nations cannot be ensured. Worsening economic

conditions have negatively affected health care funding in past years. Throughout this period, national health expenditures in the sub-Saharan least developed countries (LDCs) have decreased, not only in terms of absolute allocations, but also in relation to total budgets.¹ In addition, an average population growth of 3 percent or more in many African countries has further diminished per capita health expenditures. Between 1980 and 1985 the average per capita spending on health declined from US\$ 5.17 to US\$ 4.70, ranging from US\$ 0.53 in Zaire to US\$ 46.70 in Botswana.²

Reluctance to introduce user fees in the public health care system stems "from the fear that the poor will be inhibited from seeking health care".¹ However, traditionally, mission hospitals and dispensaries have been successfully financed in part by user fees, and they have provided access to health services to the poor by applying scales for reduced fees or by granting special exemptions. People in sub-Saharan Africa are also accustomed to paying traditional healers and traditional birth attendants for their services. However, the form and conditions of payment are flexible and accommodate the patient's ability to pay, which requires intimate knowledge of the patient and his family in question.

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In most of the countries studied, the introduction of user fees was based on a top-down approach where the government introduced fees for health services without considering the impact, i.e. utilization of services, access of the poor to services and capability and willingness of the health care clients to pay.³⁻⁵ There are few examples published from developing countries, where cost-sharing schemes were introduced in close collaboration with other stakeholder groups, e.g. community groups, non-governmental organizations and patient support groups. However, if health financing schemes are to succeed in resource-poor settings, it is important to elicit the opinions of the local people and to ascertain their level of cooperation.

There is extensive literature on patient's or client's perspective on health care in developed nations,⁶⁻⁷ but there are not many studies examining the same questions in developing countries.⁸⁻¹⁰ Even fewer are published reports where public opinion and the attitudes of health care clients and health professionals towards cost-sharing were determined in order to tailor financing schemes to suit the needs and the capabilities for payment by the population.¹¹ Design and evaluation of cost-sharing schemes in developing countries should contain such a component to appraise the opinions of health care clients, health professionals and the public at large towards financial participation. However, this rarely happens and most investigations focus on technical and purely financial aspects.

Cost-sharing in Kabarole District

Kabarole district covers a total of 8,500 sq km, with approximately 860,000 inhabitants, giving a population density of 101 per sq km. During the rainy season, many areas are largely inaccessible. Literacy is estimated at 60 percent for males and about 40 percent for females. The infrastructure of governmental health services in the district comprises a district hospital and 38 peripheral health facilities. All the governmental health activities are coordinated by the District Medical Officer (DMO) and the District Health Management Team (DHMT) of the Ministry of Health. Considering that there are two non-governmental hospitals and more than 12 peripheral health facilities run by churches serving the same population, and that the peripheral health units are geographically well distributed, the district has a potentially workable health facilities network.

Following the recommendations of the 1989 National Task Force on Health Financing, Kabarole District has been able to establish cost-sharing among government health units based on the communities' decisions to voluntarily join the financial schemes and pay for health services. Interested communities were offered assistance by the DHMT in setting up local management committees for their health unit and in training of staff in financial management. The tasks of the Health Unit Management Committees (HUMC) were to oversee the day to day operations, make policy decisions on operational and policy aspects of running the health unit, supervise the staff, and control the budget. The local political leadership – (Local Councils or LCs) – and the communities are represented in the HUMCs. The Chairman of a HUMC is nominated by the Chairman of the Local Council, who is elected by the people. The HUMC Chairman is not paid out of the cost-sharing funds and has no personal financial interest in the cost-sharing schemes. The Medical Assistants in charge of the facilities are paid monthly incentives out of the collected funds, as all the other health workers.

Within two years, all communities in the catchment areas of the 38 health facilities in the district had joined the scheme and had introduced fixed user fees. The process of introducing cost-sharing was decided and facilitated by the local representatives of the villages and was implemented through the HUMCs. The fee was determined by the committee in consultation with the local civic leadership (LC). At the beginning of cost-sharing, the fees were fixed at levels usually between 50-100 Uganda Shillings (USH) or US\$ 0.05-0.10 for one consultation and subsequent re-attendances, including drugs. The money collected was managed and utilized locally under the responsibility of the HUMCs, and audited by the LCs. Therefore, budgets for these funds were under local jurisdiction. The HUMCs and LCs were trained by district staff in accounting and management of funds. Exemption schemes for the poor were established through the LC system. The local village representative confirmed in writing if someone was unable to pay. If somebody did not pay, but was not eligible for exemption, he/she was charged later and the money was collected by the local community representative.

In Kabarole, utilization rates for outpatient health services have been affected only marginally by the introduction of

the user fees which is in contrast to experiences from other countries where attendance rates dropped substantially after user fees were charged.³⁵ In some areas in Kabarole, attendance rates for outpatients even increased after cost-sharing was introduced.¹² In this paper, we now report the results of an opinion poll of health care professionals and the general public in Kabarole district regarding the cost-sharing practices in the district. The research behind this paper was motivated by the need to find out more systematically how the public, health professionals and community leaders perceived cost-sharing and what suggestions they had to make in order to improve the system. This information was considered important for formative program evaluation and subsequent program modification of the Kabarole cost-sharing project.

Methodology

From a list of the 38 government health units and 12 health units run by churches in the district, 30 health units were chosen for the study (22 government health units and 8 church run health units). Church operated health facilities, which have traditionally practiced cost-sharing for many years, were included in order to compare factors such as use of funds, satisfaction with staff by clients, perceived quality of care by users, etc. Comparisons of responses in regard to the situation of the health care services before and after the introduction of cost-sharing were done only in government health facilities.

The selected health units in the district were all headed by qualified Medical Assistants. They were well distributed and represented all the six counties in the district. Interviewing took place in the catchment areas of these 30 health facilities. From each selected health facility, the Medical Assistant in charge and the HUMC Chairman were selected. Thus, 30 Medical Assistants and as many HUMC Chairmen were asked to participate in the study. A structured questionnaire was used for assessing their knowledge and attitudes towards cost-sharing. The questionnaire included questions regarding the staff's attitude towards charging fees, how the funds were spent, and how they benefited from the cost-recovery schemes. The questionnaire was pre-tested in Fort Portal on ten health workers and ten residents. The corresponding answers from the HUMC chairman and the Medical Assistant in a specific facility was the basis used to validate the answers. In order to enhance the capacity building effort of

the study, community members from different areas were trained in interview techniques and they participated in the data collection.

Success of cost-sharing was defined by the following four indicators: staff motivation, patient acceptance of user fees, improved quality of services, and a one year uninterrupted implementation of cost-sharing. Success of cost-sharing was measured through responses to a set of four questions addressing the four indicators: Did staff incentives increase health staff motivation? Were the user fees accepted by the patients? Did user fees increase the quality of service delivery? Was the cost-sharing scheme implemented for one year without interruption? The four questions were developed through a small pilot survey asking the residents and health workers in Fort Portal how they perceived "successful" cost-sharing. A cost-sharing scheme was rated as successful when the interview respondents answered positively to at least three out of the four questions and when the results from the corresponding focus group indicated that the community was generally happy with cost-sharing.

Focus groups were conducted to assess the knowledge and attitude of the general population and health care users in regard to health financing. Eligible households were identified, using a two stage probability sampling. Focus groups were held in three remote areas in order to assess any deviation among households residing more than 10 km away from a health unit. The focus groups were held in the vernacular language and were tape recorded. All transcripts were translated into English for analysis. A total of 15 focus group discussions were conducted with 95 participants. Each group consisted of 4-7 participants. Some groups consisted of male and female participants. In the others, the genders were separated in order to assess any gender related effects. All the identified persons were permanent residents of the areas, and therefore were being served by the adjacent health facility. A prepared topic guide was used to focus the discussions on the selected objectives. The discussions centered around topics such as communities' perception about cost-sharing, accessibility of services, affordability of fees, exemption for the poor, etc. Controversial issues were discussed at length in order to arrive at a group consensus. However, dissenting views were not disregarded in the analysis.

The study was approved by the Ministry of Health and the local health department in Kabarole district. Verbal consent for the study was sought from chiefs in the selected areas and from study participants. The study was conducted in 1993.

Results

Health Professional Interviews

In all 60 respondents, - 30 Medical Assistants and as many Chairmen of HUMCs, - were interviewed. Four HUMC Chairmen refused the interview and were replaced by the Vice Chairmen. Forty-four interviewees were from government health facilities and 16 from the NGO health units. Out of the 22 government health facilities, 19 (86 percent) were rated as having a successful cost-sharing scheme. The interviews with the health professionals revealed that the level of fees was determined by the HUMCs in all government health facilities. Only four out of the 8 NGO health facilities had HUMCs; however, the level of the fees was set by the central administration and this procedure was the same for all the NGO units. When asked how the collected funds were spent, the following answers were given as shown in Table 1.

The top three priorities were payment of staff allowances (considering the meager and irregularly paid staff salaries), purchase of essential items including drugs, and maintenance of the health facility buildings. When the responses from the medical staff and the chairman of the management committees were analyzed separately, a similar trend was found and the answers did not differ significantly ($p>0.05$). When asked whether the collected funds were enough or the fees needed to be raised, the following answers were given: 73 percent of the respondents from government health facilities said that the fees were too low and 14 percent said

that they were too high. Again, the responses from the health staff and the chairman of the management committees were similar. Of 56 respondents, 29 (52 percent) recommended that user fees should be increased. This answer was given more often by NGO affiliated respondents (75 percent) compared to the government staff (43 percent). The amount to be paid, as suggested by government affiliated respondents, ranged between 100 and 500 USH (mean 310 USH) and between 200 and 3,000 USH (mean 1,480 USH) by the NGO staff.

Most of the respondents felt that cost-sharing was a success in their respective areas and said that they support it (39 or 88 percent from government health units and 14 or 87 percent from NGO health facilities). Five government health workers and two staff from NGO units stated that they did not support cost-sharing in their health facilities. When the answers from those who responded positively towards cost-sharing and those who said cost-sharing was not useful were compared, the following results were obtained: 42 percent of those supporting cost-sharing said that user fees were affordable, compared to the 28 percent of those not supporting cost-sharing. Out of the cost-sharing supporters, 51 percent replied that cost-sharing had improved staff morale, as compared to 14 percent of those who objected to cost-sharing. In regard to the improvement of service delivery, 75 percent of the supporters said that the quality of service delivery had improved while only 14 percent of the non-supporters said that the services had improved. When asked whether waiting times for patients had decreased, 88 percent of the supporters responded positively while all the non-supporters responded negatively. Another question asked was, "Has cost-sharing increased health staff availability during hours of duty?" As many as 88 percent of the supporters said 'yes' while all the non-supporters said

Table 1 Responses of Medical Assistants and HUMC Chairmen on How Funds from the Cost-sharing Scheme were Used (n=60, Multiple Responses Possible, Percentage in Brackets)

Activity/item	NGO	Government	All	Significance
Repair of building	12 (75.0)	29 (65.9)	41 (68.3)	$p=0.774$
Construction of new building	7 (43.8)	11 (25.0)	18 (30.0)	$p=0.318$
Maintenance of equipment	10 (62.5)	21 (47.7)	31 (51.7)	$p=0.575$
Buying essential commodities	16 (100.0)	40 (90.9)	56 (93.3)	$p=0.818$
Staff allowances	16 (100.0)	43 (97.7)	59 (98.3)	$p=0.955$
Transport (district capital, etc.)	9 (56.3)	25 (62.5)	34 (56.7)	$p=0.983$
Others	5 (31.3)	15 (34.1)	18 (30.0)	$p=0.883$

'no'. Out of the supporters, 97 percent said that the collected funds should be spent and controlled locally. Over 90 percent of the supporters stated that community participation in cost-sharing is essential. The non-supporters replied negatively to both questions.

Focus Group Discussions

Ten focus group discussions were conducted within the catchment area of a government health facility, while five were held at NGO health units. Three focus groups were organized outside the 10 km radius of a health unit. Generally, answers did not differ significantly between males and females. People living outside the 10 km radius of the health facility seemed to be less informed and less positive about cost-sharing.

Most groups supported cost-sharing schemes and indicated that customarily people pay something for drugs and for the services provided by traditional healers and midwives. Cost-sharing was not new. They pointed out that cost-sharing should remain since it helps to support the staff and health facility upkeep. "Cost sharing has helped us. That is why people pay freely". (male, from Ruteete) "*The services we get from our unit are reasonable, though they need improvement. So we should continue with cost-sharing.*" (male, from Rwimi). Some participants opposed user fees, mainly because the required drugs for treatment were not available. "*If the medicines could be made available we would pay, but sometimes we take money outside (clinics) because the medicine is not in our health unit.*" (male, from Kibiito) However, those who were reluctant to pay mentioned that when cost-sharing was introduced, they were not educated on the issues of health financing and never understood cost-sharing schemes fully. "*Anyway, we never understood cost-sharing at the beginning.*" (male, from Kyenjojo) Those who were against cost-sharing were mostly from areas where cost-sharing had been introduced and practiced for less than one year or where cost-sharing schemes did not run well.

Quality improvement of health services was reported more often in those health units which had practiced cost-sharing for more than two years, especially those which had had user fees in place for more than two years. "*The government unit has been so bad, but now they have started to help us. I came here when I had a miscarriage and I was treated well*

and got better. I paid only 1000 USH." (female from Buttiti) Also, drug supply was said to be more regular in those units which practiced cost-sharing.

In one health unit, cost-sharing did not lead to improvement of services. In spite of incentive payments to staff, they were said to report late to duty and be absent often. Therefore, the cost-sharing scheme caused discontentment among the community and had to be stopped. "*The services at this unit are poor. The in-charge is never at the unit and failed to tell us how our money is used.*" (male, from Kyegegwa) Proper accountability of funds and availability of information to the population on how the funds were spent were seen by many community members as essential issues and were raised in almost all discussions.

In all the focus group discussions, it became obvious that some major concerns of the participants regarding the delivery of health services related to non-medical factors such as waiting time, politeness and discipline of staff, cleanliness of the unit, etc. "*The staff in government health units are arrogant. May be, because patients do not pay. The staff in the church health units are polite and disciplined.*" (female, from Kisojo) "*Nurses in government units are arrogant, but in mission units they welcome us. So, teach your staff first to be polite.*" (female, from Mitandi) Participants from areas where cost-sharing had been practiced longer were more likely to report that services had improved in their health units.

The fees paid in most health units ranged between 100 - 500 USH. A majority of respondents agreed that this was affordable. Most people said that the fee should be fixed and should be the same for all in order to ease management of funds. A few people felt that a scale of fees, according to the severity of the disease, should be used instead of a uniform fee, but most objected to it. "*If we grade the fee according to sickness or age, it will be like business.*" (female, from Buttiti).

Most people indicated that they were willing to pay more if the services would be improved. Further, 200 USH was seen as too low; instead, 500 USH was suggested. "*USH 500 is okay, as far as I see the economic status of people.*" (male from Kyakatarara). "*If they would give us all facilities like blood tests and regular drug supply, 200 USH would*

even be little. The fee should be about 2,000 USH" (female, from Ruteete). *"We can increase the fee only if we know that something better will be done. In Uganda, we know that 100 USH is not enough. I suggest 500 USH, provided that the services are there."* (male, from Kibiito).

All the groups agreed that the poor who cannot afford to pay should receive free treatment. It was suggested that the LC representative should give them a letter of exemption, but the debts would have to be recorded and cross-checked by the in-charge of the health unit. The stamped LC letter would be filed by the staff at the unit for proper accountability. This practice is already in place in most health units with cost-sharing, and few public complaints have been raised about misuse. *"We could have forms and those who cannot afford the fee could go to the LCs and the management committee, and then be exempted."* (male, from Kibiito)

In spite of the fact that all participants in the focus groups knew about cost-sharing, it was pointed out that there is a need for more information about the cost-sharing schemes. Health committees and health staff should regularly meet with the people and inform them on the use of the fees they have paid. This forum, together with the participation of development committee members from the area, could be used to discuss possible fee increases and ongoing problems with the service delivery. All participants agreed that the meager salaries of the government health workers needed to be supplemented, and advocated payment of a substantial amount from the user fees as incentives to the health staff.

Participants from areas where services were provided mainly by NGO health facilities and which traditionally had had user fees for a long time, were generally happy with the services. From among them, there were surprisingly few complaints about the level of payments for health care services, taking into account the fact that some NGO units charged fees 5-10 times higher than those charged by the government health units. Interestingly, in all the NGO health units, some kind of staff allowance was paid.

Discussion

Providing equitable coverage of effective health care services among underserved populations has been difficult in most

developing countries. To meet this challenge, Kabarole district initiated cost-sharing in government health units. The decision to start cost-recovery was appropriate in the present situation in Uganda, as illustrated by the voluntary participation of the local administration, the political leadership and the communities. The concept of cost-sharing was supported by a majority of the people who participated in the study. The success of cost-sharing in Kabarole was demonstrated by the finding that out of 22 government health facilities, 19 were rated as having successful cost-sharing schemes in place. In comparison to the areas which were rated as successful, the three "unsuccessful" schemes were characterized by the following: user fees were not popularly accepted because people did not know how the funds were used; poor motivation of staff was demonstrated by absence from duty; lack of improvement of services was obvious; and, user fees were not consistently implemented. The implications of this lack of success in these three areas are very basic: staff incentives cannot be funded so that staff motivation and quality of services are less likely to improve, money available for additional drugs and maintenance of the infrastructure is limited, and these communities do not identify themselves as partners in the delivery of health services.

All the community members who took part in the focus groups knew about cost-sharing. They supported an active role for the communities in locally designed and managed cost-financing schemes, with full autonomy to local groups regarding use of the funds. The desire and willingness to participate in the cost-recovery schemes was a result of two key factors: 1) realization of the severe resource constraints that limit the capacity of the health system to satisfy all demands for health care, and 2) the inability of government to provide health services of adequate quality to all, free of charge.

Success of cost-recovery strategies depends on the resulting quality improvement of health care services which must be sufficient in the view of the clients to attract the population to health units on a fee-for-service basis. If providers do not offer better quality services, they will fail to earn the trust and confidence of the population and people will seek health care from alternative sources. This lack of confidence and trust in the services greatly inhibits the willingness of the members to pay for health services. It

was fortunate that Kabarole district was in the project area of the Basic Health Services Project, a support project from the German Agency for Technical Cooperation (GTZ). This project provided the initial input necessary to improve the Kabarole health services which had been negatively affected by the long civil war in Uganda. As these initial improvements in health care reached a threshold where communities realized that positive changes in the health care system had actually taken place (approximately two years after the start of this project), they were prepared to contribute for their health care. This boost from the Basic Health Services Project was a critical factor in the introduction of the cost-sharing schemes and facilitated their implementation. Similar efforts on cost-sharing took place in other districts of Uganda, where no special support in addition to government funding was given. In many of these places, cost-sharing efforts failed because the government resources plus the revenues from user fees were still not enough to bring the health care services to a level where the population could clearly perceive improvements in the services provided.

Funds from cost-sharing were kept at the local level where they were collected, and it was possible for the local communities to decide on their own how the funds should be spent. The Ugandan Government allowing this process of strengthening and empowering communities was absolutely essential. The power to decide locally was a new and exciting experience and a great encouragement to all involved (health staff, community leaders and the people). In spite of the communities' free choice on how to spend the cost-sharing revenues, the pattern of spending was very much similar in the different locations: in most health units, over half of the funds were used to pay incentives to the health staff and the remaining funds were divided between purchase of drugs and supplies, transport and building maintenance. That the local control over the health funds by the communities had worked is shown by one example in a health unit, where people could not see any improvement of service delivery after cost-sharing was introduced and subsequently stopped paying. The substantial monthly incentive payments to the health staff (up to one government salary and more) indicate that the local leaders and the communities obviously recognized the extreme importance of the human resource factor, which is so often overlooked in developing countries. It is

remarkable that all the HUMCs in the health facilities, classified as having a successful cost-sharing scheme, decided to pay these incentives to their staff and have continued to pay the incentives without interruption since the cost-sharing schemes were started. It is our assumption that the community felt that they got something in return for their financial contributions, since people's behaviour generally indicates what their values are.

The focus groups from the catchment areas of non-governmental health units (church-run) showed that patients still preferred services offered by NGO health units compared to government units, even if the fees were substantially higher. The discussions revealed that patient satisfaction was consistently higher in the NGO health units compared to government facilities. Some of the reasons were :

- 1) Waiting times were shorter;
- 2) Supplies and drugs were continuously available;
- 3) Access to services were not limited because of lack of a positive attitude among the health staff; and
- 4) Health workers were perceived as having higher professional competence than government health workers. This is attributed to an efficient organizational infrastructure, a vigorous supervision system, etc. In spite of the progress in improvement of the government health services in Kabarole, there are still lessons to be learned from the NGOs on how they run their health care programs successfully and maintain the quality of services.

In Kabarole, both the groups, - health professionals and communities, - acknowledged that qualitative improvements in the health care service delivery have taken place after cost-sharing was introduced. However, from the perspective of health care workers, quality of services was defined as utilization of services, motivation and competence of staff, availability of medical equipment and supplies, etc., while community members added other dimensions to their perception of quality of health care services, i.e. politeness of staff, decreased waiting time, cleanliness of the staff and of the facility and availability of drugs. The perception of quality of health services by the community was similar in the catchment areas of both government and NGO health facilities and it stressed the importance of courtesy, friendliness and client-focused behavior from the health staff.

From the group discussions, it was clear that the communities appreciated the flexibility of the health financing efforts in the district. This offered unique opportunities to develop a local user fee scheme adapted to local conditions. This approach also made it possible for the community members/groups to have a chance to actively participate in this developmental process. As it was left open to the communities to decide how they would design their financing schemes, one would have expected a great variety in the design and implementation. Surprisingly, most communities came up with similar ideas (for example similar levels for fees, staff incentives, etc.) showing that an active consultative process between communities engaged in the design of cost-sharing had taken place. This is an encouraging observation which shows that the self-help idea and community participation are firmly rooted in the population of Kabarole.

We took a non-critical approach to the concept of "community": There may be problems with assuming that LCs and HUMCs genuinely represent health service users and the community. The possibility that the enthusiasm for the cost-sharing scheme evident from these sources is driven by self interest may exist. Medical Assistants, as direct beneficiaries from the cost-sharing funds through the incentive payments, (as all other health workers) may have had too positive a view on the cost-sharing schemes. Their answers may have been positively biased. The participation of community members as interviewers in the study may have also compromised the internal validity of the study. Random-repeat interviews were not done in order to determine a possible interviewer bias. In our opinion, the advantages of active participation of community members in the research and evaluation process outweigh the disadvantages and strengthen the ongoing participatory process of communities in health matters. While information from a relatively small sample of health workers and community members was collected and a range of opinions from a limited number of focus groups was solicited, the external validity of our conclusions may be compromised. Therefore, our study results can not necessarily be generalized and applied to other parts of Uganda or East Africa.

In spite of the shortcomings of our study, we are confident that most of the local health financing schemes were

considered successful by health professionals and the public at large. This is also supported by the numerous discussions we had with the health staff, HUMC members, community representatives and political leaders in which overwhelming approval for cost-sharing was expressed. The introduction of cost-sharing schemes with fixed user fees was facilitated by the efforts of the District Health Management Team of Kabarole district through its persistent approach to community empowerment and through a community process which was allowed to happen and which was actively supported and recognized by the Ugandan Government. The communities also started to realize their own potential for development which is often unrecognized and untapped. The fact that the communities were trained and enabled to actively manage and control the funds from the cost-sharing project provided a boost to local community commitment and participation. One important lesson from the Kabarole experience is that funds generated from cost-sharing schemes should be kept at the level where they are collected and local jurisdiction should decide on how these funds are used.

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