

**ANALYSING UNOFFICIAL USER FEES IN GOVERNMENT  
AND NON-GOVERNMENT HOSPITALS IN UGANDA**

**Masters Mini-Dissertation Submitted to the School of Public Health and  
Primary Health Care, University of Cape Town in Partial fulfilment for the  
award of the Masters' of Public Health (Health Economics)**

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## ACRONYMS

AIDS:	Acquired Immuno-deficiency Syndrome
ARTI:	Acute Respiratory Tract Infections
DSE:	German Foundation for International Development
EPRC:	Economic Policy Research Center
GDP:	Gross Domestic Product
HIV:	Human Immuno-deficiency Syndrome
IMR:	Infant Mortality Rate
MOH:	Ministry of Health
NGO:	Non Government Organization
NUDIST:	Non-numerical Unstructured Data Index Searching and Theorizing
OPD:	Out Patients Department
UNICEF:	United Nations Children's Fund
WHO:	World Health Organization

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## **ABSTRACT**

Unofficial fees are a common feature in Ugandan health facilities and exist in different forms. This study explores the forms of unofficial fees existing in Ugandan hospitals and compares findings from government and non-government hospitals in both rural and urban areas. It also investigates the reasons for or causes of such fees as well as the relationship between unofficial fees and other factors such as quality of care within the hospitals. The overall aim of the study is to analyze the magnitude and impact of unofficial fees on patients' expenditure and thereby make recommendations for improvement in efficiency and equity with regards to out-of-pocket funding.

Both qualitative and quantitative interview methods are used to obtain data from service providers and patients in each hospital and a comparison of findings obtained using the two methods is made.

The main findings from the study are that unofficial fees are rampant in government hospitals and can be classified into four categories; fees for commodities such as drugs; fees for access to services; fees for services such as laboratory, radiology and surgery and gratuity payments. The latter category is the commonest form reported in non-government hospitals while all the others are rare. Estimates of unofficial fees amount to a significant percentage of patients' expenditure, especially in the cases where surgery and radiology are required especially for rural-based patients. It's also found that most of the patients attending government hospitals pay at least one form of unofficial fees. Unofficial fees were found to be closely associated with poor quality of care in that the latter enhanced an informal economy, which resulted in the fees being charged/paid. The study shows that efficiency and equity (access to quality care and ability to pay) are negatively affected by the practice of collecting unofficial fees.

Recommendations for policy makers to address the problem are made as well as suggestions for the best-suited methodology for analyzing unofficial fees in the Ugandan context.

# 1. INTRODUCTION

## 1.1 Overview

Uganda like many of the other developing countries is faced with a situation of 'triple burden' of disease; a public health situation characterised by high prevalence of communicable and non-communicable diseases as well as HIV/AIDS. This is coupled with a severe shortage of resources to address these problems effectively. Among the biggest health problems faced by Ugandan's are high incidences of infectious diseases, which include Malaria, ARTI and infections that cause diarrhoea. These diseases alone lead to a total of 33% of Life years lost (LYL), while the total LYL due to preventable illnesses is 75% (MOH 2000). The burden caused by these diseases is further worsened by the high prevalence of HIV/ AIDS which has to date claimed the lives of at least 500,000 Ugandans with a total of about 1.4million living with HIV/AIDS since 1986 (MOH 1999).

In order to address the above health problems the health financing system has to be effective and sustainable, and finances have to be used effectively and efficiently. Furthermore, equity in access to health care becomes very important in order to ensure that the less advantaged members of the society are not denied access.

However, the Ugandan experience as well as that from several other developing countries is that new health financing reforms such as user fees have not been successful in ensuring efficiency, sustainability and equity as well as in achieving adequate revenue generation. At the same time, the quality of care provided at health facilities continues to be very poor, with poorly motivated, demoralised staff and a lack of medical equipment, supplies and drugs.

Further, corruption particularly in the form of unofficial user fees, is known to exist in these very health facilities and this is likely to further worsen the inequity in access to care as well as the inefficiency and ineffectiveness in utilisation of patients' out-of-pocket expenditure.

Given that private health financing (mainly through out-of-pocket expenditure), contributes a very large proportion of the total per capita expenditure; US\$ 9 out of a total per capita expenditure of US\$ 14(WHO 2000), it's imperative that ways of

improving efficiency and effectiveness in utilisation of these funds are sought. Unofficial fees are generally not well documented and are not taken into account in these statistics. To date, very little has been done to investigate unofficial fees although they are likely to be a significant route of resource wastage. This dissertation explores these issues and makes recommendations on how the problems identified can be addressed.

## **1.2 Problem Statement**

The health system in Uganda continues to be grossly under-funded and the user fee policy, implemented since the mid-nineties, has not brought about significant improvement in the quality of care in government facilities (Okuonzi 2001).

It has been widely reported that unofficial fees are rampant in Ugandan health facilities, particularly at the primary care level (Jitta, J. and Van der Heijden 1993; Magyezi et al 1994; McPake et al 1999). These studies as well as others done elsewhere (Thompson and Witter 2000; Di Tella and Savedoff 2001) also highlight the strong relationship between quality of care provided and existence of informal fees. The demand for better quality of care by health care users is likely to play a role in creating situations where some service providers try to earn extra income from patients by providing better quality than they would under normal circumstances. By doing this, the service provider ends up spending more time and resources on those patients who can pay him/her unofficially, while in fact denying those who cannot access to the same quality of care. This results in inequity in access to quality of care and further worsens the situation.

The magnitude of unofficial fees in Ugandan hospital has however not been established and therefore the impact of such fees on access and quality of care is unknown.

Unofficial fees render the patients or health system beneficiaries incapable of controlling their expenditure on health care. This is compounded by the fact that the service users are not well informed about what quality and quantities of services to expect at the different health facilities. This is likely to make them vulnerable as a target for collection of unofficial fees.

Unofficial fees may also affect the efficiency of health care spending as well as equity in access to health care. The lack of accountability and proper documentation of collected official fees also results in misuse of funds and further hinders progress towards efficient use of the scarce resources available.

### **1.3 Background**

The Ugandan health system is financed mainly through taxation and out-of-pocket expenditure, 35.1% and 48.2% of total health expenditure respectively (WHO 2000). Private health financing thus contributes a very large proportion and given that the tax base of the country is very small (6% of the GDP Macrae et al 1996), out-of-pocket expenditure remains one of the largest sources of financing for health care in Uganda. According to the user fee policy, users of services were expected to pay a fee to contribute to the cost of each service provided at each visit. The revenue raised was to be retained at the health units and used for improving health services through provision of drugs and by improving staff motivation (MOH 1997). Exemption mechanisms were also put in place to ensure access for the poor and free care for those with specific conditions that were considered to be of high public health importance.

Successful implementation of user fees as a health financing reform is dependent on several factors, one of the most important being that the quality of services provided at the health facilities must be improved (McPake 1993; Gertler and Van der Gaag 1990; Hotchkiss 1998). Failure to do this is likely to deter utilisation of services because of price increases. Even with an improvement, the poorest may have reduced access. In most health units in Uganda particularly in the government facilities, there was hardly any improvement in quality unlike the case in non-government facilities where user fee schemes have existed for a longer time (MOH 1997). The Government acknowledges this and continues to seek ways to address the problem.

Unofficial fees may have substantial influence on increasing inefficiency and poor utilisation of funds generated from out-of-pocket payments. Lack of information on the magnitude and impact of unofficial fees on the out-of-pocket expenditure hinders

progress in effectively assessing efficiency and equity in health care expenditure. This information is also essential in opening up options for revenue generation, which would be specifically directed towards improvement in the quality of services. Furthermore, this information would be essential in designing new policies that could check further existence of such fees and improvement of implementation of user fee schemes.

#### **1.4 Aim and Objectives**

##### **Aim**

To increase understanding of the causes and effects of unofficial fees and thereby contribute to improving the use of out-of-pocket expenditure by health system managers and patients at both government and non-government facilities in Uganda.

##### **Objectives**

1. Determine the different types and amounts of unofficial fees existing in the different hospitals.
2. Determine the factors that lead to different types of unofficial fees.
3. Assess the impact of unofficial fees on health care in general.
4. Develop a methodology for measuring unofficial fees in health care
5. Develop preliminary recommendation for improving efficiency in health expenditure.

#### **1.5 Research Questions and Hypothesis**

##### **Questions**

1. Are unofficial fees important in the overall cost of health care born by patients?
2. Are unofficial fees critical in increasing the quality of care in hospitals?
3. What are the best mechanisms to incorporate unofficial fees in the normal resource control?

##### **Research Hypothesis**

Unofficial fees are not associated with poor quality of services.

## **1.6 Structure of Dissertation**

In Section 2, an overview of the country context is presented. This includes the historical and current political and social context, the national health profile, national health systems as well as the health care financing systems. The section ends with a review of other contextual issues relevant to the subject at hand.

Section 3 consists of a detailed review of literature on user fees and unofficial fees in health care. It starts off with a brief user fee policy analysis followed by a brief assessment of the performance and impact of user fees in Uganda. Experiences from other developing countries with user fees are also discussed. A definition of unofficial fees, types and magnitude is presented, followed by a discussion of why unofficial fees exist in general and in Uganda. The impact of unofficial fees on equity, efficiency and quality is then discussed. The section ends with a review of the gaps in knowledge about unofficial fees.

Section 4 addresses the research methodology used in the study. It details the study design, sampling, data instruments and data collection procedures, data management and analysis processes. It ends with a discussion of the biases and limitations of the study.

In Section 5, the key findings of the study are presented both descriptively and analytically. A detailed discussion of research findings follows.

Section 6 includes the conclusions drawn from the study and the recommendations to be made to policy makers and health care providers.

## **2. COUNTRY CONTEXT**

### **2.1 Introduction**

Uganda is a small East African country sharing borders with Kenya (east), Sudan (North), Tanzania and Rwanda (South) and Democratic Republic Of Congo (West). The total population is approximately 21.9 Million people (MOH 2001)

The population is multiethnic with over 30 tribes and languages.

Uganda is a former British colony, which obtained its independence in 1962 following which it experienced several years of political instability until more recently when it returned to democratic rule under the current president, Yoweri Museveni.

Below is a brief description of the political and social-economic situation in the country, the country health profile, the health system structure, health financing systems as well as other relevant contextual issues

### **2.2 Historical and current political and Social-economic context**

After independence in 1962, Uganda's political situation underwent several years of instability, characterised by coups, civil wars in several areas in the country and violent suppression of the opposition by the government of the day. The 'divide and rule' colonial policies had left a legacy of inequity patterns of development, encouraging ethnic and religious divisions, which continued even after independence (Macrae et al 1996).

As a result of the prolonged political instability, the government social structures under went severe decline with collapse of many of the government institutions. After several years of Guerrilla warfare, the government led by Yoweri Museveni took power in 1986. A democratic government that is elected every 5 years now governs the country.

The economic situation in the country declined significantly over the years from the late 1960s till the end of the liberation war in 1986. This is demonstrated for example by a decline in economic growth between 1971 and 1986; the Gross Domestic

Product (GDP) dropped by 20% in real terms and production had fallen by 74% by 1989 (MFEP 1992 in Kivumbi et al 2000).

There was a rapid drop in income per capita of 6.2% per annum between 1973 and 1980, this was 10 times more than the average drop in other African countries (Lateef 1990 in Macrae et al 1996). This contributed to the greatly reduced tax base that the country has (6% of GDP) compared to an average of 20% in Sub-Saharan Africa (Macrae et al 1996).

The new government of 1986 was therefore faced with the heavy task of rebuilding the country's economy and this was the main focus of President Museveni's 10-Point program of 1986. Uganda is now rated one of the fastest growing economies of the world, with a GDP growth of 7% per annum (Okuonzi et al 2000) and an increase in per capita income from US\$ 150 in the 1980s to 320 US\$ in 1998 (World Bank 1998; Okuonzi et al 2000). However, 80% of Ugandans depend on subsistence agriculture, which provides both low and unstable incomes (Tigwalana 2001).

Following the take over of power in 1986, the government embarked on a restructuring program that involved all sectors of government. The health sector was one of those that underwent significant reforms aimed at rebuilding the health system and improving access to services by all Ugandans.

These reforms occurred, at a time when several other Less Developed Countries (LDC) were undergoing similar restructuring processes characterised by macro-financing reforms. At the heart of these reforms was a drive by the World Bank and the International Monetary fund (IMF) encouraging LDC to develop and implement macroeconomic policies and structural adjustment programs that would control public expenditure and bring about changes in the public and private sector institutional structures (Mills and Gilson 1995).

More specifically, user fees and other cost recovery mechanisms were often and continue to be an integral part of World Bank loan conditionality (McIntyre 1997).

### **2.3 National Health Profile**

As the health system of the country broke down during the years of political turmoil, so did the health status of the people. It has been reported by Macrae et al (1996) that the WHO league tables placed Uganda at the top of African countries in terms of health status in the 1960s whereas by 1986, it ranked fortieth. This can also be

demonstrated by an increase in the Infant Mortality Rate (IMR) from 91.9/ 1000 (1973-77) to 116 (1980-86) (UNICEF 1989 in Macrae et al 1996; Okuonzi et al 2000).

With continued attempts to rebuild the health system since the take over of power in 1986, the government has registered some successes in improving the health status of Uganda. However, the reliability of current statistics is still very poor and progress towards health gains has been hampered by HIV/AIDS, since the late 1980s and affects a very large proportion of the Ugandan Population.

The latest statistics show an improvement in the IMR; 97/1000 in 2000 however, there has been a worsening of Maternal Mortality Rate from 506 / 100000 in the early 1980s to 550/100000 in 2000 (MOH 2000). Such statistics show that Uganda still has a very big battle to fight if the health profile of its people is to improve significantly.

Key non health-care determinants of health are also still far below what the World Bank states as critical levels of such determinants. For example, the coverage of the population with safe water was only 41% and female literacy rate only 26% compared to critical levels of 80% for each of these indicators (World Bank 1998/99; Okuonzi et al 2000). Improvement in these and other non-health determinants of health will take more than just the efforts of the health sector, but a cross sectoral approach involving different ministries and the communities themselves.

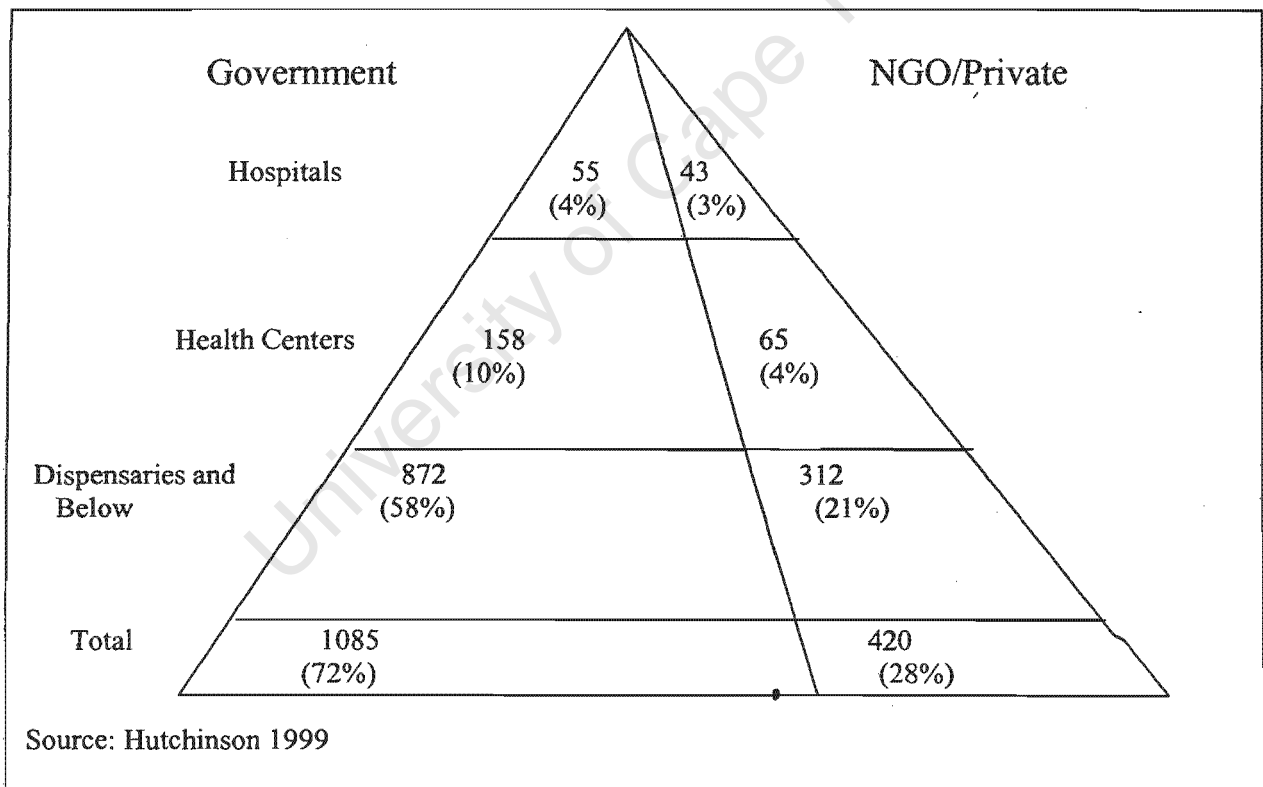
#### **2.4 The National Health System**

Uganda like many other African countries inherited a health system, which favoured urban-based curative care (Macrae et al 1996). The distribution of health facilities was far from equitable, with some regions having far more access to modern health facilities. After Independence, the government embarked on a program to expand health services to the different regions of the country, however, still more emphasis was placed on building hospitals rather than developing lower level facilities. By 1993, an inventory of health units showed that 49% of the population lived within 5km of a health facility, which had been integrated to provide both curative and preventive services (MOH 1993; Hutchinson 1999). Management of the health system had for many years been centralised and based in the MOH. Decentralisation to the district level was introduced in the late 1990s.

### 2.4.1 Health Facilities

There are a total of 1637 health units in Uganda, of which 1156 (71%) are government units and 481 (29%) are non-government (MOH 2001). The system comprises of health posts, dispensaries, health centres, district hospitals, regional hospitals and 2 National referral hospitals. Most of the current facilities have been in existence since the 1960s with only a few newly built facilities mainly in under-served areas. However, rehabilitation of existing infrastructure has been taking place since the late 1980s and several lower level facilities were recently upgraded into higher level health centres, which are now used as headquarters of the health sub-districts around the country.

**Figure 1: Distribution of health facilities in Uganda, 1995-96**



Considering that the population has been growing at a rate of 2.5-3% since independence; and the increasing burden of diseases particularly HIV/AIDS, it's expected that the health system is extremely constrained in that available resources are far lower than needed to meet the demand. Many of the health facilities are

understaffed and yet the population of patients using the services far exceeds the levels that would be considered adequate for the existing facilities and services.

The Population / medical personnel ratios remain quite poor. 1996 statistics show that overall population per staff was 8311, with a population per doctor ratio of 20,228 almost three times the ratio in 1970 (MOH 1996). The Ugandan statistics are also quite poor compared to many of the other countries in Central and Southern Africa (WHO 2000; World Bank 1998).

#### **2.4.2 Decentralisation**

Shortly after the National Resistance Movement came into power in 1986, it introduced a system of local governance, which became formalised in 1988 by the Resistance councils and committees statutes. Governance was based on a tiered system of local councils, ranging from the village to the district level, which helped to raise political awareness among Ugandans (Hutchinson 1999).

The local government statute of 1993 limited the role of central government to policy formulation, planning, inspection and management of national programs. With this statute in place, health services became decentralised to local government.

Health services then became a responsibility of the local governments, in particular primary health care, while the ministry of local government became responsible for directing policy between central and local authorities; ensuring good governance that is conducive for provision of cost effective and sustainable health services (Okunzi and Lubanga 1997; EPRC 1996). The MOH remained with the responsibility of issuing regulations, policies and advice; set standards; provide technical supervision; and inspection of services to ensure that set standards and administrative efficiency are achieved at the district level (World Bank 1996; Langseth 1996 in Hutchinson 1999).

The Ugandan decentralisation takes the form of devolution. In this form, responsibility for overall implementation of projects and or maintenance of operations on a sustainable basis is assigned to local governments (Mills and Gilson 1995; Silverman 1992 in Hutchinson 1999). The intent of government in decentralisation is to increase local capacity for planning, financing and managing the delivery of services and to promote greater community involvement in health care decision

making (Hutchinson 1999). Achieving these objectives of decentralisation is critical for successful implementation of health financing reforms such as user fees and for elimination of practices that hinder this.

## **2.5 Health care financing**

Due to the decline in the national economy, the health sector like others, suffered a severe reduction in financing over the years of political instability. Macrae et al (1996) point out that in the fiscal year 1986/7 the value of the budget of the MOH was only 6.4% of the 1970 level. While the government has made significant increases in health expenditure, the bulk of financing is private and there is a high dependence on donors as well. Current health expenditure is estimated at US\$ 12 per capita, of which US\$ 4 is contributed by the government and donors and US\$ 8 is private contribution by the service users (WHO 2000).

Donor contributions have been reducing gradually over the years with government contributions increasing. In the early 1990s the government contributed 20% while Donors contributed 80% of the Public expenditure on health, but in 1999/2000 financial year, the government versus donor contributions was 46%: 54% respectively (Okuonzi 2001).

The main challenge facing the government in financing health care is that the tax base from which funds are raised is still very small, a legacy of the two decades of political instability. As a result of a poor economy and low tax base, combined with increasing demand for health services and donor pressure, the government adopted the user fee policy, initially starting at the district level then later becoming a national policy. The goal of this policy was to increase funding for health through users contributing a nominal fee at the point of delivery of services. Although there was a lot of resistance against introduction of these fees especially by the politicians, sustained donor pressure and enthusiasm by the MOH and district health staff resulted in fees being introduced at most peripheral and district health units by the end of the 1990s. A national policy was later passed in 2000 by the MOH (MOH 2000).

User fees have not been very successful as a source of revenue for the public health sector in Uganda although this also varies greatly between different facilities. Okuonzi 2001, reports that according to the national health accounts of 2000-2001,

user fee revenue was a mere 3.6% of the public health expenditure<sup>1</sup>. However, it's important to note that as is evident from the national health accounts document 2000-2001, these statistics don't take into account expenditure in the private and informal sectors where a considerable proportion of Ugandans seek health care. In these sectors, out-of-pocket expenditure is the main means of health care financing.

Government hospitals are generally mainly financed by funds generated from tax revenue and receive their funding from the ministry of finance through the ministry of health. However, with user fees, the hospitals have been receiving a percentage of their recurrent expenditure from fees paid by patients. The percentage contribution of these fees varies greatly in the different hospitals but has been reported to be as much as 26% of non-salary recurrent expenditure in some hospitals<sup>2</sup>. These funds are used to replenish stock of emergency drugs and to provide financial incentives for staff in form of bonus payments.

On the other hand, non-government hospitals are mainly funded by money obtained from donors (usually religious groups attached to the different hospitals) and patients' user fees. Most of the funds for purchasing drugs and other medical supplies are obtained from user fees. Government also provides funding to NGO hospitals through paying salaries for key staff such as doctors and pharmacists as well as providing subsidies for drugs and other medical supplies.

Government hospitals are vulnerable to inconsistent funding as they have one main source of funding: government, which experiences shortages quite frequently and this sometimes results in delays in replenishing stock of drugs and payment of staff salaries. These problems ultimately compromise the quality of care in government hospitals and could result in charging unofficial fees.

## **2.6 Other Key contextual issues**

Politics in Uganda is a major influence on health policy. At the time of this study: April-May 2001, Uganda had just gone through its second presidential elections since return to democratic rule in the 1990s.

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<sup>1</sup> Information was obtained from the national health accounts review of 2000-2001

<sup>2</sup> Information from informal interviews with accountants from two government hospitals.

During those election campaigns, User fees in government health units were the single most important campaign issue for the health sector (Okuonzi 2001). All six presidential candidates agreed unanimously that user fees should be abolished. And as a result, the government abolished user fees from all government health units with effect from March 1<sup>st</sup> 2001, just 10 days before elections day. This move has been interpreted differently by different people, however, one cannot ignore the fact that the election campaigns played a major role in this decision.

The new policy on the other hand is one that should raise a lot of concern by proponents of equity in health care provision. The minister of health is quoted, in a statement printed in one of Uganda's daily newspapers; The New Vision 17<sup>th</sup> Feb. 2001, as having said that " The new policy is that there will be two lines of service; a line for the rich who can pay and get served quickly, and one for those who can't pay, these will have to wait longer to get served". He went on to say that, " The market will determine which wing you go to, nobody tell you whether you go to Sheraton or college inn, it's your pocket."

This has big implications for equity, particularly in terms of access to quality care (drug availability, health workers' attitude and so on) in the different lines of care; paying or non-paying.

Similar methods of collecting fees have been used in other countries for example, in Bangladesh this method; termed *self-selection* was used to generate extra funding from the paying patients while providing services free to those who identified themselves as not willing or unable to pay (Thomas et al 1998). Researchers however, found that the quality of medical services provided was similar for both paying and non-paying patients and the difference was in the additional hotel (non-medical) services. This seems unlike the case in Ugandan government hospitals where such methods have been used. It is a common finding that the quality of care in the non-paying wing is much poorer, often characterised by lack of drugs, very long waiting lines and poorly motivated and over-worked medical staff (Wamai 1992; Mwesigye 1995). Indeed the minister also seemed to have the same expectation when he said that patients who cannot pay would have to wait longer to be served. This method may create more polarising of health care provision in Uganda if the issue of improving quality for the non-paying patients is not addressed.

## **2.7 Summary of Key contextual issues**

1. The long history of political instability lead to collapse of most of the social services, the health system being one of those most affected. This necessitated development and implementation of several structural adjustment programs in all sectors of government in order to redress the situation.
2. The National Health profile is quite poor, as shown by the poor health indicators above. At the same time, Uganda is faced with a "triple burden" of disease i.e., high prevalence of both Communicable and Non Communicable diseases as well as HIV/AIDS.
3. Although Uganda is rated one of the fastest growing economies, 44% of the population still leave below the poverty line (DHS 1995/6) and resources for funding health care are greatly limited due to this as well as due to a very low tax base from which government generates funding.
4. The biggest burden for financing health care still lies with the individual; i.e., mostly private financing for health care (66% of per capita expenditure on health is from private contributions as fees paid out-of-pocket or through payment of government taxes).
5. Funding for government hospitals is inconsistent at times as a result in delays of funds being moved from treasury through the MOH to the hospitals. This has a negative impact on the quality of care in these hospitals and may influence existence of unofficial fees.
6. The health financing reforms, in particular user fees have not been successful in significantly improving revenue generation and quality of care in government hospitals. At the same time, more recent changes (abolition of fees effective from March 2001 and implementation of a dual system) may result in further problems particularly for equity in access to quality health care.

### 3. LITERATURE REVIEW

#### 3.1 Introduction

There are many reports on user fees particularly in developing countries, as they are a common component of health sector financing reforms in many of these countries. User fees in form of out-of-pocket expenditure, account for more than 40 percent of total health expenditure in most African countries (Shaw and Griffin 1995). On the other hand, not much literature is available on unofficial or informal fees in the health sector although they are believed to exist in many transitional and developing economies around the world (Thompson and Witter 2000; Di Tella and Savedoff 2001). The importance of knowing the extent to which such fees exist and affect cost of access to health care is paramount, as they may be a major inhibiting factor to improving access and possibly quality of care provided.

There seems to be a link between user fees (official fees) and existence of unofficial fees, given that unofficial fees have been reported in many of the developing countries where user-fee policies are being or have been implemented. It's therefore imperative that in investigating unofficial user fees, an analysis of existing user fee policies is necessary in order to explore these links. Some writers believe that the existence of official fees could influence unofficial fees in the health system and that in fact removal of official payments may facilitate elimination of such fees (Okuonzi 2001).

In this chapter, we explore the literature available on both user fees and unofficial fees in the health sector in Uganda and other countries around the World, as well as the relationship between the two. The user fee policy in Uganda, its impact: successes and failures and system capacity issues that may have contributed to the results are discussed briefly. A discussion of unofficial fees experience in Uganda as well as other countries, why these fees exist and how they may impact on implementation of the user fee policy follows. Finally important gaps in knowledge around unofficial user fees are discussed.

### 3.2 User fees

User fees constitute payments made by the health service users at the service point, as contribution towards costs for the service they are receiving (Beattie et al 1996). User fees are one of the ways through which the population can cost-share with the government in provision of social services such as health care. In the absence of more equitable forms of cost sharing such as health or social insurance in most developing countries, user fees become a more and more common source income to finance health services in these countries (Gilson 1997).

Many low and middle-income countries have introduced fees for their social services since the 1980s (Russell and Gilson 1997; Gilson 1997). The theoretical arguments advanced in favour of user fees by international policy analysts and economists emphasise the efficiency gains achieved through a pricing strategy based on neo-classical theory (Gilson et al 1995). The basic argument is that no one should consume a good or service unless its value to them is at least equal to the value of the most useful alternative goods or services that could be produced with the resources used. Health services provided for 'free' will be used not only by those who need them, but also by those to whom the value of the services is only slightly greater than zero (Akin 1986 in Gilson et al 1995). Fees are suggested as a means to deter those who don't really need the services from using them.

Fees proponents also emphasize the potential of user fees to promote equity by charging those who can afford to pay while exempting the poor through targeting mechanisms. Indeed additional revenue can be used to improve the coverage and quality of services (Griffin 1992; Gilson et al 1995)

User fee policy without price discrimination has been shown to be regressive and raises problems for equity and efficiency (McPake 1993; Gertler and Van der Gaag 1990). However, demand for basic health care has been shown to be inelastic in studies from several developing countries (Lavy and Germain 1994; Akin et al 1995)

In Uganda, a new fee for service policy was initiated in 1997 (MOH 1997) and the most important reasons given by the government included,

1. raising revenue to improve quality and
2. reducing misuse or excess unlimited use of services.

### **3.3 Ugandan user fee policy**

A simple analytic model identifies four key factors that should be considered in developing any fee system: the context of development and implementation, the actors, the content of the policy package and the processes of policy development and implementation (Gilson 1997; Gilson and Mills 1995; Walt 1994; Walt and Gilson 1994). This conceptual framework is used as an analytical tool for presenting literature on the user fee policy and unofficial fees.

Below is a description of the context, content and processes for introduction of user fee policy in Uganda and which actors played an important role in the formulation and implementation processes.

#### **3.3.1 Context**

The country context has been reviewed in the previous chapter and many of the issues pointed out were as important at the time of design and implementation of the fee policy as they are today.

The Key contextual issues include;

1. The long history of political instability led to collapse of most of the social services, the health system being one of those most affected. This necessitated development and implementation of several structural adjustment programs in all sectors of government in order to redress the situation.
2. The National Health profile is quite poor, as shown by the poor health indicators above. At the same time, Uganda is faced with a "triple burden" of disease i.e., high prevalence of both Communicable and Non Communicable diseases as well as HIV/AIDS.
3. Although Uganda is rated one of the fastest growing economies, 44% of the population still live below the poverty line (DHS 1995/6) and resources for funding health care are greatly limited due to this as well as due to a very low tax base from which government generates funding.
4. The biggest burden for financing health care still lies with the individual; i.e., mostly private financing for health care (66% of per capita expenditure on health is from private contributions as fees paid out-of-pocket or through payment of government taxes).

5. Funding for government hospitals is inconsistent at times as a result of delays of funds being moved from treasury through the MOH to the hospitals. This has a negative impact on the quality of care in these hospitals and may influence existence of unofficial fees.
6. The health financing reforms, in particular user fees have not been successful in significantly improving revenue generation and quality of care in government hospitals. At the same time, more recent changes (abolition of fees effective from March 2001 and implementation of a dual system) may result in further problems particularly for equity in access to quality health care.

### **3.3.2 Content**

The government policy was to support local financing and management initiatives, which would lead to improvements in the quality and volume of health services. This was to be achieved through proper and successful implementation of user fees at all government units.

With the new policy, it was expected that the quality of services at government facilities would improve through the retention of collected fees at the health facilities in order to supplement drugs and health providers' salaries (MOH 1997). The primary goal of introducing user fees was therefore to raise revenue for improving quality of services.

Similar objectives are found with health financing reforms in other African countries (Nolan and Turbat 1995; Russel and Gilson 1995). However studies have shown that there has been little success in meeting this objective (Russell and Gilson 1997).

The Ugandan user fee policy implementation guidelines spelled out the following key issues (MOH 1997);

- Fees were to be charged to service users at all government health units. 100% fees collected were to be retained by all health units
- The District health team was to monitor the collection and use of fees subject to decisions by Health unit management committee (HUMC) and guidance of the District Local Council (DLC).

- The amount to be charged was to be determined locally by the HUMC and the health unit staff and would be on fee-for-service basis (charged according to the service they receive).
- A higher fee would be charged at higher-level facilities in order to discourage those bypassing the referral system, but lower fees for those who are referred.
- Collection and accountability for the fees collected was the responsibility of the health unit staff, and clear lines of accountability were spelled out.
- Exemptions for patients were available based on specified criteria, i.e.,
  - ⇒ Highly communicable diseases: TB, Leprosy, Guinea worm, Trypanosomiasis and Ochocerciasis.
  - ⇒ Immunisation
  - ⇒ Treatment for which conditions set by the donor state that treatment should be provided free.
  - ⇒ Vitamin A deficiency disorders or prophylaxis.
- Credit was to be given if a patient could not pay either part or all his fees at the time of treatment. The debt was expected to be paid later. Unit staff were responsible for giving credit.
- A waiver could be granted for those judged unable to pay all or part of the fees. This would be done by the HUMC during regular review of debtors.
- Funds raised were to be spent on recurrent budgets; staff incentives, drugs and other operating expenses.
- The officer in charge on the health unit was to ensure that fees are collected but also that the best quality of care possible is provided
- Health unit staff members were to communicate regularly to the service users and local leaders on amounts collected and how they were used.

All the above guidelines were recommended by the MOH although the DLC, HUMC and staff could all agree to draw different guidelines according to the local situation (MOH 1997).

### **3.3.3 Process**

The introduction of the fee policy was faced with a lot of resistance particularly from the politicians. On recommendation by the health policy review commission in 1987, the government accepted to implement user fees in government health units (MOH

1990, Okuonzi 2001). However, when a bill on user-fees was prepared and presented in parliament in 1993, it was rejected, with politicians arguing that the social and political cost of user fees were much higher than the economic benefit (Okuonzi 2001).

Momentum to introduce the fees was however sustained by the donors, the MOH and the health care staff at the district level. And with the local government act in place, government encouraged decentralised district authorities to start charging a nominal fee for the health services they provided (Kivumbi and Kintu 2000; Okuonzi 2001). User fees were adopted by several districts with varying degrees of modifications of the recommendations made by the MOH for the fees' implementation.

The user fees implementation remained an initiative of the decentralised districts until 1999 when the MOH submitted a policy on User fees to cabinet, which was approved with conditions. The Central government made payment of user charges in government health facilities a national policy in March 2000 (Kivumbi and Kintu 2000; Okuonzi 2001).

Implementation of the fee policy in Uganda was decentralised so the district health teams and the local government were the key players in implementation. Incentives for this was that 100% of the fees collected at the health facilities were to be retained at the health facilities and used to improve quality of services there (MOH 1997). This was the same for hospitals in the districts as well as the teaching hospitals and the national referral hospital. The latter are autonomous and thus self-accounting.

Two broad categories of the User fee system have been identified through reviews of user fee experience in different countries; national user fee systems implemented at different levels of care and community financing initiatives at the primary and peripheral levels of the health system, often supported and co-ordinated at the national level (Nolan and Turbat 1995; Gilson 1997; Mills, Bennett and Russell 2000). In the case of Uganda, one can safely say that it started off as a Community financing initiative run by the local government in the decentralised districts which later evolved into a national system when the national policy was passed in 2000.

The health care providers were key stakeholders in the implementation of the fee policy as they were directly responsible for the collection of fees, provision of quality health care and accountability for the funds collected.

The major failure of the fee policy was the failure to implement effective exemption mechanisms (McPake et al 1999; Kivumbi and Kintu 2000). McPake et al (1999) report to have found that exemptions for the poor particularly were hardly implemented in most of the Ugandan health centres they surveyed.

### **3.4 Performance and impact of the User fee policy in Uganda**

#### **3.4.1 Revenue and sustainability**

Reviews of the fee policy in Uganda, like in many of the other African countries where this policy has been implemented, reveal that there has been little success in raising significant amounts of revenue. On average, national user fee systems have been shown to generate only 5 % of the government recurrent health expenditure (Creese 1990; Gilson, Russell and Buse 1995; Nolan and Turbat 1995), Uganda is no exception.

However, hospitals seem to perform better than lower level units for example, hospitals like Mulago (national referral), Jinja and Mbale (district hospitals) attained between 10 and 20% revenue from User fees in the 2000 financial year (Okuonzi 2001).

Poor revenue collection, may be explained by several factors which may include; lack of improvement in the quality of services provided, leading to poor utilisation; the inability and or lack of willingness to pay by the service users; poor accountability for the collected funds particularly at lower level facilities and so on. Unfortunately, not much research has been done to explain why the policy performed this poorly in terms of revenue collection. This however is not unique to Uganda, poor performance of fee policies in terms of revenue generation has been reported in many of the developing countries where user fee policies have been implemented (Nolan and Turbat 1995 in McIntyre 1997).

In NGO hospitals usually run by missionary groups, user fees have existed for much longer and they seem to be a lot more successful there. In fact with reduction of donor funding, many of these NGO have become even more dependent on user fees for their

recurrent budgets (Okuonzi 2001). It seems that revenue generation is more successful in NGO health units and there is a need to determine what factors may be influencing this success. Unofficial fees have not been reported to exist in NGO units and yet research conducted for primary care units in Uganda showed these fees to be rampant in government health units (McPake et al 1999; Okuonzi 2001). This possible link between poor performance of user fees and existence of unofficial fees needs to be explored and may indeed explain why NGO health units are more successful in revenue generation.

If the price of a service increases, say with introduction of user fees, some people may decide that the perceived benefit of the service is not 'worth' the higher price and be unwilling to pay for the service (McIntyre 1997). This may indeed be the case in government facilities and could explain partly, why user fees deter utilisation and revenue generation is poor. This would certainly significantly reduce the revenue raised in government facilities through the user fee scheme as compared to NGO facilities where quality of care may be perceived to be better.

Creese (1990), points out that fees have two effects, they generate revenue from those patients who judge the service to be worthwhile at the going price; and they divert patients who either cannot pay, or who judge the services less desirable than some other alternative, to other sources of care.

Research needs to be conducted to determine the magnitude of unofficial fees and how they affect revenue collected through user fees in the government units. Existence of unofficial fees could also deter patients from utilising the health services if they perceive them to be more expensive than in places where such fees don't exist. Jitta and Van der Heijden (1993) and MCPake et al (1999) argue that any health sector policy must take realistic account of how it will be mediated through such an environment if it is to achieve its objectives.

### **3.4.2 Quality of care**

Although improvement in quality of care was the main goal of introducing user fees in Uganda, research has so far shown no evidence of significant improvement in quality in government units. There have been some reports of increase in staff morale

and drug availability in some units since the fees were introduced, however, significant improvement in quality of care cannot be verified (Okuonzi 2001). McPake et al (1999) found that, many of the government health units still offered poor quality services; they lacked essential drugs and staff absentees were common. Jitta (1998) and Ocom (1997) also found that there had not been any significant improvement in quality of care with or without user fees since 1990. Unfortunately, no formal study has been made to measure quality of care in hospitals before and after user fees, although many have reported to have an increase in drug availability after fees were introduced. For patients, drug availability and friendly staff are the two most important measures for improved quality (MOH 1997). Therefore units that report improvement in drug availability could be said to have improved in the quality of care they provide. At the moment, there seems to be mixed views on whether fees have had a positive impact on quality or not.

#### **3.4.3 Health care utilisation and efficiency**

Advocates of user fees argue that demand for curative health care is price inelastic and that charges will deter the consumption of unnecessary care and at the same time, quality of care provided will improve (Litvack & Bodart 1993; De ferrati 1995).

It has also been shown that when user fees are introduced in tandem with increase in quality of care, utilisation increases (Litvack & Bodart 1993). Very few developing countries have been able to achieve this as in most cases, introduction of fees is not accompanied by improvement in the quality of care.

In Uganda, there have been reports of reduced utilisation following introduction of user fees. In a household survey conducted in 1999, it was found that 51% of the population who live within walking or easily accessible distance from health facilities, including private NGO units, do not use these facilities because of the requirement to pay fees (MOFPED 1999 in Okuonzi 2001). These findings are not unique to Uganda. In a Tanzanian study, it was found that after introduction of fees, only 27.3 % of government health facilities reported to have drugs available at all time compared with 80% of private health facilities (Hussein & Mujinja 1997). The same study reports a drastic fall in health care utilisation after the fees were introduced of up to 50%.

Perceived quality of care is an important determinant of health care utilisation. In the Tanzanian study, health care consumers' perception of quality of care was given as the number one reason for choice of health care facility (Hussein & Mujinja 1997). Price is therefore just one of the factors that affect health care utilisation and other factors include household decision making to seek care, distance to health facility, attitude of health worker, availability of prescribed drugs and overall quality of care (Abel-Smith & Rawal 1992; Mwambu 1986).

#### **3.4.4 Equity**

High levels of poverty and unemployment in Uganda like in most African countries means that many households find it difficult to pay for social services. Fees in health care in developing countries have generally raised concerns of worsening inequities in access to health care for the poor (Russell and Gilson 1997; Thomas et al 1998). Although in many of the countries with user fee policies, the poor are catered for by having exemptions or fee waivers, according to research finding, these mechanisms have not been effective in ensuring access for those who are unable to pay (Russell and Gilson 1997).

Failure of exemption mechanisms has been found to be a result of several factors. Russell and Gilson (1997) identified the following factors as key issues in failure of exemptions;

- Difficulties in assessing household incomes (lack of information on household income) especially in countries where a large section of the population are farmers with seasonal income;
- Economic incentives not to implement exemptions especially in countries where exemption decisions were made by the health workers and collected fees were retained locally. Exempting many people was seen as a loss of income to the health facility.

According to Thomas et al (1998), targeting the poor for exemption can run into three sets of difficulties i.e., technical feasibility of accuracy in targeting, particularly the lack of accurate income information; inefficient administration systems in application of exemptions, which often result in misallocation of benefits; and inability of the

poor to make use of the exemptions as a result of several factors including, lack of information about the scheme, fear of stigmatisation and prohibitive opportunity costs.

Many of the issues pointed out above could have been important in failure of the exemption systems in Uganda. Qualitative evidence from several Ugandan health units surveyed by McPake et al (1999), showed that those unable to pay were turned away rather than exempted and nearly all those unable to raise the expected cost simply did not come. Reasons for this may indeed be related to the fact that health workers are poorly motivated and have no incentive to carry out exemptions.

At the same time, there was evidence from the same study that exemptions were made available to those in authority over health workers such as local council and HUMC members. It's a common finding that those who need to be exempted are not, while the benefits are given to the better off members of the community.

From the above points, it is evident that the overall impact of the user fee policy has been negative; because of failure to improve quality of care in facilities alongside higher fees which deter the poor from utilizing health services. Exemption mechanisms have been ineffective in curbing this inequity in access to care. At the same time, revenue collection from user fees has been quite poor and given the high costs of implementing the policy, it can be concluded that the fees contribution to the Public health budget has been insignificant.

### **3.5 Capacity to implement the policy**

According to available research findings, in order for governments to achieve improvement in quality, efficiency and equity through the fee policy, a supportive policy context, policy measures and government's capacity to implement policy effectively are critical (Kutzin 1995; Nolan and Turbat 1995; Bennett, Russell and Mills 1996; Gilson 1997; Mills, Bennett and Russell 2000).

Among the key issue pointed out by the researchers, Uganda could be said to be lacking in several areas, which would in fact inhibit positive out come from the fee policy. These include,

- the lack of management skills especially at sub-national levels where revenue is managed (Macrae et al 1996);

- the lack of well motivated staff with balanced incentives that would encourage adoption of new charging and management practices while discouraging overzealous or illegal charging (McPake et al 1999);
- the lack of information necessary to reach the target groups for the exemption system ( Wamai 1992; Magyezi and Namuyomba 1994; Mwesigye 1995; McPake et al 1999);
- the lack of central leadership, training and guidance on the exemption policy implementation (McPake et al 1999);
- poorly maintained government funding levels resulting in revenue not being used for quality improvement but rather to supplement the gap in funding (Kivumbi and Kintu 2000);
- poor public willingness and ability to pay (Okuonzi 2001) .

### **3.6 Informal fees in Health care**

Unofficial fees or informal payments in the health sectors occur in different forms and have been found to be highly prevalent in Low income and transitional economies around the World. Below is a brief description of what constitutes unofficial fees, where and why they exist as well as some of the key factors that may support their existence. A discussion of the impact of these fees on access and quality of care based of available literature from different countries follows and lastly, the gaps in knowledge about unofficial fees in Uganda.

#### **3.6.1 Definition and types**

Unofficial fees at government health facilities can be defined as unauthorised fee payments that co-exist with 'free care' and formally approved 'official' health service charges collected at public health facilities under the sanction of public policy (Killingsworth et al 1999). Killingsworth et al 1999 also point out that collection of unofficial fees represents a variant of 'rent seeking' behaviour where by, public employees who position themselves as near-monopolists and seek rents by charging fees greater than the opportunity costs of the next best alternative available to the patient.

Unofficial fees/ payments take different forms as research in different countries reveals. The variety of forms of unofficial fees includes, tips, purchase of medicine and supplies, bribes to improve access or quality of care and payments demanded by health workers or institutions (Thompson and Witter 2000). This is a finding common to most of the studies done on informal payments<sup>3</sup>.

Killingsworth et al 1999 categorised unofficial fees into three main categories based on their findings in a research conducted in Bangladesh hospitals. These include;

- Fee-for-service payments- where services (e.g., attending to patients when there is no one else to assist) are performed by facility employee who collects a fee from the care seeker.
- Fee-for-commodity payments-fees charged for supplies or drugs purchased from the open market and presumably free at the government facility.
- Fee-for-access payments-where access or improved access is obtained for the care seeker e.g. procuring a bed for a patient who has already paid the facility's official charge.

### **3.6.2 Unofficial fees: How big is the problem?**

Although unofficial fees are said to be common in many developing and transitional countries, research has only been done in a few countries.

In studies done in Central Europe, it was shown that in some countries, up to half of the patients pay for services that are officially free (Thompson and Witter 2000). Researchers pointed out that this finding reveals that those unofficial fees present a huge loss of revenue for governments. In a Bolivian study, it was found that 40% of the patients surveyed indicated that they had paid fees for services, that were supposed to be provided free of charge and that the average payment was about US\$6.60 (Di Tella and Savedoff 2001). Di Tella and Savedoff (2000) also found that half of the Costa Rican patients affirmed that they had made payments as high as US\$35 for a medical service in a public establishment – a fee that is close to the

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<sup>3</sup> Examples include the Latin American study (Di Tella and Savedoff 2001), a study on the informal economy in health done in the former Soviet union state, east and central Europe by Thompson and Witter (2000) and the Ugandan study of health centres by McPake et al (1999).

average price of private sector consultations and more than 85% of doctors and nurses stated that they knew of cases in which doctors unjustifiably charged patients.

There is no doubt that unofficial fee payments present a very big problem for policy makers in countries where they exist and seem to significantly affect the cost of access to health care.

The amounts of unofficial fees have been found to vary according to several factors e.g., the social economics status of the patient, the condition; medical or surgical for which they are being treated and the service or commodity being provided by the 'rent seeker' (Killingsworth et al 1999).

In Uganda, McPake et al 1999, found that unofficial fees were reported to exist in all primary health units which were surveyed and that the fees charged could be as high as 5 to 10 times the official fees.

### **3.6.3 Why Unofficial fees? Research findings from different countries.**

Experience with informal fees in different countries shows that these payments are increasingly a common response to deficiencies in state health services. This was found to be the case in the former Soviet Union and central and Eastern Europe states by Thompson and Witter 2000). Research in Bangladesh also revealed that unofficial fees were collected because government programs failed to deliver (or were made to fail to deliver) required services, commodities or accessibility under conditions where 'free' or highly subsidised care was provided by the government (Killingsworth et al 1999).

Informal payments have also been found to be highly prevalent in several Latin American health systems. In surveys to investigate corruption in government hospitals in Latin America, patients, doctors and nurses were interviewed to elicit perceptions of corruption in public hospitals. These included theft of medical supplies, absenteeism by doctors and nurses, illegal payments for services, excessive payments for inputs and contracted services (Di Tella and Savedoff 2001).

One consistent feature in the countries where informal payments are rampant is that there is gross under-funding of the health system with decreased staff morale and poor quality of services. Research findings available from Latin America, Bangladesh, the

former soviet states, central and east Europe as well as Uganda all points out key issues;

- poor salaries for health workers;
- shortages of hospital/health unit supplies;
- poor quality of services;
- an inefficient regulatory framework i.e., control of how fees paid officially by patients are collected;

These have been found to be main contributing factors to existence of unofficial fees. In Bangladesh, researchers found that unofficial fees were collected by mainly hospital support staff e.g., ward aides, sweepers, cleaners extra but its not known whether actual collectors of these fees 'front' for invisible beneficiaries and beneficiary 'chains' or merely act on their own impulse (Killingsworth et al 1999).

In Uganda and Latin America on the other hand, qualitative evidence showed that health workers i.e., nurses, medical assistants and doctors (in Latin America) were directly involved in collection of these fees (McPake et al 1999; Di Tella and Savedoff 2001).

#### **3.6.4 Factors that cause the existence of unofficial fees in health systems**

Several factors play a part in driving this informal economy in the different systems. As already discussed above, the poor working conditions and salaries of health workers have been found to be among the key root causes for unofficial fees. Given that the practice is so wide spread across several health facilities in Uganda, it's surprising that government has not investigated the issue to determine the magnitude and impact of this practice. Governments seem reluctant to take steps to eliminate this practice effectively and thus supporting its continued existence. Killingsworth et al (1999), point out that unofficial fee collectors rightly believe that the government will either suspend enforcement against those who provide *ad hoc* versions of missing services or ignore such initiatives.

Given that unofficial fees are one route for spending patients out-of-pocket expenditure, they are likely to result in a reduction in government's revenue generation from implementation of user fees.

The lack of essential services within hospitals e.g., medicines and medical supplies (e.g., gloves) is a major support for the existence of unofficial fees. Killingsworth et al

(1999) found that the reported average per patient unofficial fee payments consisted largely of fee-for-commodity payments (i.e., drugs and in some cases supplies) and this made up 85% of unofficial fees collected.

Care seekers also seem to be reluctant to report the practice and may not consider the practice of unofficial fee collection as a form of corruption, although reasons for this are not clear. In Bolivia, researchers noted that despite the high percentage of patients, who reported to have paid unofficial fees, about 40% of those interviewed felt that public hospitals had little or no corruption.

Some researchers have argued that introduction of user fees could have increased the practice of unofficial fee collection saying that these fees are extorted from patients under the cover of official fees (Okunzi 2001). In contrast to this view, Killingsworth et al (1999) argue that when services are free or heavily subsidised, and are of poor quality, the care seekers tend to have more 'consumer surplus' or disposable income which is taken advantage of by the 'rent seekers' and unofficial fee collection is more likely.

The lack of information by patients about the services and sometimes about what the official fees are makes them more vulnerable as victims of unofficial fee collection. Killingsworth et al 1999 also believe that fee collectors assume that information disparities exist between them (fee collectors) and the patients which can be exploited to the advantage of the fee collectors, provided that the patient's defences can be thwarted or overcome.

It's evident from literature that there is a close association between poor quality of care and existence of unofficial fees.

### **3.6.5 Unofficial fees in Uganda**

The breakdown of health services that occurred during the years of political instability was characterised by severe under-funding of health units, significant reduction of health workers salaries in real terms and perpetual lack of medical supplies (Amandua 2000, McPake et al 1999). As a coping mechanism, an informal economy developed within the health sector as a survival strategy for health workers to supplement their meagre incomes. Qualitative evidence from 10 health units surveyed by McPake et al 1999 revealed the following informal economic activities;

- Mismanagement of drug and supplies
- Informal charging of patients
- Mismanagement of user charges
- Offering treatment in health workers' homes
- Ownership of clinics and drug shops
- Part-time work in other jobs, commonly private clinics
- Agriculture and trade.

Similar findings were reported by Bennett et al (1997).

On the issue of mismanagement of drugs and supplies, several researchers have reported that most drugs were found to have disappeared from health facilities before they were dispensed; Asiimwe et al (1996) reported 80% drug loss. Cockcroft (1996) also tells of a widespread belief that drugs were taken by health workers to sell and supplement their meagre salaries and also that, even when drugs were available, patients had to pay the health workers to get them (Cockcroft 1996 in Hutchinson 1999). The above-mentioned research has generally shown that patients are willing to participate in the informal economy by paying unofficial fees in the hope that this can lead to access to better quality of care.

The new public sector reforms that were adopted by the government beginning in the late 1980s also had significant negative effects on health workers (DSE 1999). Overall income reduction due to pay reforms and staff reduction due to retrenchment and freezing of recruitment were key outcomes of those reforms (DSE 1999). These invariably lead to low morale and development (or continuation) of survival strategies by health workers.

### **3.6.6 Impact of Unofficial fees**

Unofficial fees have several ill effects on the health care system in general but particularly on the patient's ability to access good quality care at a reasonable cost. In some cases, existence of these fees has led to health care becoming completely inaccessible to those who cannot afford to pay these fees.

**Equity:** Unofficial fees have strong implications for equity in access to care. As discussed in the experience from different countries, unofficial fees exist in facilities, which already have poor quality of care especially with regards to availability of medicines and supplies and poor levels of staff morale. It has been found that a lot of these medicines are not dispensed to the patients at the official cost, but that patients are made to pay more for them or are completely denied access if they are unable to pay (Cockcroft 1996; McPake et al 1999; Amandua 2000). This obviously reduces access for those who are unable to pay thus making the health system less equitable.

Killingsworth et al (1999) also found that fee collectors were seemingly more reluctant to charge the rich and influential for their services for the fear of detection. So again this emphasises the fact that the poor and uneducated people are seemingly more vulnerable to unofficial fee collection.

**Efficiency and Quality:** Unofficial fees affect efficiency mainly in the sense that fee collectors may devote less time to their official duties and rather, spend more time carrying out these informal economic activities. This further reduces the quality of care provided in the facility. On the other hand, McPake et al (1999), found that unofficial fees caused accessibility trade-offs; they caused a reduction in financial accessibility but increase the number of hours health workers were available in the health unit. Therefore, for those who paid the fees, the quality of care seemed to be a lot better but generally, the health workers were available for longer hours and this could be seen as increase in efficiency. Of course if the fee collectors spent more time with one patient in an attempt to provide better quality and very little or no time with other (who didn't pay), then this could be considered inefficient use of time. Unofficial fees have a mixed effect on the health workers behaviour depending on the level at which the patient is able to pay (McPake et al 1999). Patients in the Ugandan study also reported abusive behaviour by health workers if the care seeker didn't come with enough cash to pay unofficial fees (McPake et al 1999). There was also evidence to show that those who paid the least fees didn't get all the drugs prescribed. This further confirms that those unable to pay are likely to receive much less attention and poorer quality of care from health workers while those who pay receive much better quality of care.

**Utilisation of services:** From the different research findings one can see that unofficial fees have a negative effect on utilisation for those unable to pay (McPake et al 1999). However, there is no proof that those who are able to pay will continue utilising the services.

### **3.6.7 What we don't know about unofficial fees**

1. Since all the research available has only been done in health units at the primary care level, there is no information available on how big the problem of unofficial fees is in *Ugandan* hospitals and what the characteristics of hospitals in which this practice occurs are.
2. There is no information on what the impact of utilisation of higher level facilities is if such fees were charged given that the patient may have little or no other alternative.
3. The question of whether unofficial fees can be justified given their causes, and what mechanisms could be put in place to 'legalise' these fees also needs to be answered.
4. Finally, if such practices are to be confronted, we need to know who the rent seekers are, when, where and how fees are collected.

Such issues will be addressed in the remainder of the dissertation.

## 4. RESEARCH METHODOLOGY

### 4.1 Introduction

This Chapter presents a detailed description of the methodology used in this research. The study was conducted in two districts in Uganda, Kampala and Luwero. Two hospitals were chosen in each of the two districts, one of which was a government-funded hospital and the other a non-government organisation hospital. This was done to ensure that we could assess the situation in relation to unofficial fees in the different sectors, as well as allow for comparison to be made between the findings from the different hospitals. It was expected that the results from the study might differ significantly in the different hospitals, given that the management and policies of the different types of hospitals are different.

In this chapter, we will review the research questions and hypothesis, which is central to the study. A detailed explanation about the study design, study population, sampling, data instruments, data management, biases and limitations follows.

### 4.2 Research Questions and Hypothesis

#### Research Questions

1. Are *unofficial fees* important in the overall cost of health care borne by patients?
2. Are *unofficial fees* critical in increasing the perceived quality of care in hospitals?
3. What are the best mechanisms to incorporate *unofficial fees* in the normal resource control?

#### Research Hypothesis

Unofficial fees are not associated with poor quality of services.

### 4.3 Study Design

A descriptive cross-sectional study was done to answer the above research questions. An attempt was made to determine the magnitude and impact of unofficial fees on patients' expenditure and the quality of care they receive in the different hospitals. This was done using qualitative and quantitative methods to obtain data from service

users, providers and managers. The research data collection was done in the months of April and May 2001. This also happened to be at a time when the government had just abolished user fees in all government health units (effective from March 2001, just before national presidential elections). As a result, government hospitals were still undergoing a process of reorganising of their financing when the study was conducted.

#### **4.3.1 The study population**

This is comprised all patients attending both government and non-government organisation hospitals in Uganda. The population also includes all the staff and managers of the above categories of hospitals in Uganda.

#### **4.3.2 Sampling Frame**

The sampling frame included all the patients attending outpatients departments or recently discharged in-patients in the selected hospitals in the period of April-May 2001. The sampling frame also included all the medical staff of the four hospitals and the hospital managers.

#### **4.3.3 Sampling and sample size**

Purposeful sampling was done in choosing the four hospitals where the research was done. The hospitals chosen represented all the different types of hospitals commonly found in the Uganda. These include a government rural district hospital (GRH), a government urban hospital (GUH), a rural non-government organisation hospital (NGORH) and lastly, an urban non-government organisation hospital (UNGOH). The Government urban hospital has a private wing, which was considered, for the purposes of data analysis, as a separate hospital, which we termed, the government-private hospital (GPH).

The two districts, in which all the hospitals are found, were chosen because of ease of access for the research team. Far away districts would have required more expenses in terms of logistics and time, and this was considered unnecessary given the research questions.

**Table 1: The Sample**

Hospital	Quantitative Questionnaire respondents			Qualitative interviews respondents	
	Out-patients	In-patients	Total	patients	providers
GUH	66	10	76	3	6
GPH	17	5	22	2	2
GRH	86	15	101	3	6
NGOUH	78	20	98	3	6
NGORH	55	10	65	3	5
Total	302	60	362	14	25

The respondents for the quantitative questionnaire were interviewed from either the OPD for outpatients or the wards for the discharged in-patients. Patients were interviewed as they walked out of the hospital or wards and the interviewer continued until he/she had completed his or her assigned questionnaire scripts.

We aimed at interviewing at least 100 patients from each of the four hospitals and this was done for all except the NGORH where a lower number was interviewed because of low hospital utilisation rates (note that the GUH and GPH respondents were all from the Government urban hospital and were separated for the purposes of analysis since the private wing is managed differently from the rest of the hospital).

Sampling for the qualitative interviews was by characteristics, aimed at getting the opinion from different types of hospital staff i.e., doctors, nurses, nursing aides laboratory and pharmacy staff. It was ensured that the staff interviewed in each hospital worked in different departments so that the views of the hospital staff as a whole could be obtained. A hospital manager was interviewed in each of the four hospitals as well. Overall, at least 5 hospital staff members were interviewed in each hospital and at least one doctor, one OPD nurse, one surgical nurse, one medical nurse and one pharmacy staff were interviewed.

In order to allow for triangulation, 3 former inpatients from each hospital underwent qualitative interviews in order to ensure that the patients' views about costs and quality of care were obtained. Again the choice of these patients was by characteristics, to ensure that we got responses from patients who had been admitted on different wards and who could be interviewed at home.

#### 4.4 Data Instruments and Data collection Procedures

##### 4.4.1 Data instruments

**Table 2: Table showing data type and source for each study objective**

Objective	Type of data needed	Source of data	Sample
Types and amounts of unofficial fees	Quantitative and qualitative	<ul style="list-style-type: none"> <li>• Structured questionnaire</li> <li>• Qualitative interviews</li> </ul>	<ul style="list-style-type: none"> <li>➤ 362 respondents</li> <li>➤ 39 respondents</li> </ul>
Factors causing unofficial fees	Quantitative and qualitative	<ul style="list-style-type: none"> <li>• Structured questionnaire</li> <li>• Qualitative interviews</li> </ul>	<ul style="list-style-type: none"> <li>➤ 362 respondents</li> <li>➤ 39 respondents</li> </ul>
Relationship between quality of care and fees	Qualitative data	<ul style="list-style-type: none"> <li>• Qualitative interviews</li> </ul>	<ul style="list-style-type: none"> <li>➤ 39 respondents</li> </ul>
Methodology for measuring U-fees and recommendation	Quantitative and qualitative	<ul style="list-style-type: none"> <li>• Data comparison</li> <li>• Documents</li> </ul>	<ul style="list-style-type: none"> <li>➤ 362 respondents</li> </ul>

##### Qualitative review strategy

For the qualitative research, the data was obtained by conducting in depth interviews with the staff, managers and patients at the different hospitals. Interview guides were used to guide the interviewer during interviews. The guides contained semi-structured questions that covered specific issues under the area of interest.

### **Quantitative review strategy**

For Quantitative research, we used an exit questionnaire to interview patients on their expenditure on that particular hospital visit and their perceived quality of care.

A drug checklist was used to interview pharmacists at the different hospitals and shop attendants at near by drug-shops about cost of some commonly prescribed drugs. This was done in order to obtain information about what patients would pay for the drugs either within the hospitals or outside.

Qualitative and quantitative instruments (i.e., the questionnaire and the interview guide) were pilot tested using people similar to the would-be respondents. The questionnaire and patients interview guide was translated into the local language (Luganda) which was used for the interviews. This was done to ensure that the questions were appropriate and easy to understand. All the issues that came up in the pilot were corrected and the revised instruments were deemed ready for use.

#### **4.4.2 Data Collection Procedure**

As mentioned above, qualitative and quantitative data were collected in all the hospitals. Once the research had been introduced to the hospital managers and permission to conduct the research granted, the data collection process begun.

Prior to commencing data collection, the principal investigator (PI) debriefed the research interviewers about the purpose of the study, the study instruments and how to conduct the interviews and to ensure that all questions are asked and responses recorded. The importance of establishing rapport with the respondent was emphasised. The interview protocol was reviewed with emphasis on two key issues,

1. That informed consent had to be obtained from the respondent prior to commencing the interview.
2. That as much as possible, interviewers would try to build trust with the respondent and assure them of confidentiality prior to starting the interview.

On the selected day of collecting of data, the research team comprising of the principal investigator and 3 research assistants/interviewers arrived at the hospital,

early at the time when out patients departments commenced their day duties. We quickly introduced our selves to the hospital staff in the different departments and explained the purpose of our visit. In all hospitals, the staff members were very receptive and willing to help the team commence work.

For the quantitative interviews, the patients who were identified as having completed their hospital visit were approached by the research interviewers and kindly requested to take part in the study by answering a short questionnaire that would last not more than 10-15 minutes (see annexes for questionnaire).

The interviews started immediately the patient gave their consent. In the case of young patients or those who for one reason or another could not respond by themselves, their attendant was requested to answer on their behalf. On completion of the questionnaire, the respondent was thanked by the interviewer, who then proceeded to interview the next respondent.

The questionnaire Interviews for each hospital were all conducted on the same day. Initially, the Principal investigator assessed the first few scripts that were completed by each interviewer. This was done as a quality control measure and to ensure that no mistakes or omissions were made. Once the PI was satisfied, the interviewer would proceed with more interviews. At the end of each day, the PI went through all the questionnaires that had been completed and checked for any errors,

The principal investigator conducted the qualitative in-depth interviews with the medical staff for each hospital within the same week as the structured questionnaire. These were done with about 5 staff members in each of the hospitals.

The respondents for this part of the study were got by the PI going to the different hospital departments and requesting one of the hospital staff present to participate in the study. Staff from departments offering different services were interviewed and it was also ensured that staff members of different cadres were included.

The PI introduced the study to each of the respondents, reassured them about anonymity of the interview and asked for their consent to participate in the study. Once the respondent had consented, the interview proceeded. An interview guide was used to ensure that all the key questions were asked and discussed and to keep the

interview of track. The respondent was allowed time to discuss the subject and the interviewer probed interesting issues as they were raised. In all cases, the interviewer ensured that she had established rapport and gained confidence of the respondent before proceeding with the interview.

Due to the sensitivity of the issue at hand i.e., unofficial or informal payments, it was felt that the respondents would not be comfortable with the interviews being recorded on tape. So the PI jotted down notes on the responses given by the interviewee. This perhaps contributed to the interviews being quite lengthy but on the other hand, it was a way of ensuring that all the issues that came up were noted and that there were no omissions. The interview included questions on the respondents work experience in the hospital, quality of care provided, costs to the patient, unofficial fees existing and why and what they thought would be done to reduce patients cost.

An appointment was sought with the hospital manager in order to arrange for the interview, which was conducted on the agreed day and time. The interviews were in depth and the issues discussed were similar to those for the other hospital staff except for the fact that they included questions about the sources of funding for the hospital. The manager was also requested to elaborate on ways in which the hospital is addressing the issue of unofficial fees.

More in-depth interviews were done with former hospital patients and were conducted from their homes. This was done one to two weeks after the patient was discharged from the hospital and had returned home.

A key informant, usually a medical staff member was used in each of the hospitals to identify a few patients who had just been discharged and their home addresses and contact details. The patients were contacted by the PI who explained the purpose of the study to them and what their role could be. They were then requested to take part in the study and on consenting, an appointment was set when the interview would be conducted at their homes.

On the day of the interviews, the PI drove to the homes of each of the patients where the interview commenced after a brief review of what the study was about and the respondent had been reassured about confidentiality and anonymity. The issue

discussed included the patient's experience during their recent hospital visit, what they thought of the quality of services, their expenditure during that visit (official and Unofficial) and how they would compare the services and charges at that hospital with other health care providers (see annexes for interview guide).

Notes were taken by the Pi, as the interview progressed and no recording instruments were used.

Immediately after each interview, the PI went through the notes again to ensure that all the issues had been noted and all questions asked. The respondent was thanked for taking part in the study. The notes from the interviews were later typed up and prepared for entry into the data analysis package NUDIST.

## **4.5 Data management**

Preparation for data management began early, at the stage of questionnaire design in the case of the quantitative data. Data management varied for the two types of data (quantitative and qualitative) and below are details of how each data type was coded and analysed.

### **4.5.1 Coding of data**

#### **Quantitative data**

Pre-coding for the closed questions in the questionnaire was done prior to the interviews. All possible responses to the closed questions were defined and numbers assigned to them. For example, If the question asked the respondent to say yes or no, this was pre-coded as yes = 1 and no = 2. These codes were then entered by the interviewer, into the coding box at the right of the question. The codes were later entered into the analysis package STATA for data analysis.

In the case of the questions with response options 'other, please specify or please explain' and for the open-ended questions, coding was done after the data was collected. In this case, responses were listed for each question and then grouped by theme in order to develop an appropriate coding frame. This was done after analysing a random sample of 50 questionnaires in order to identify the different responses and then develop themes (Bowling 1997). Numbers were then attached to each of the themes, these numbers (codes) were later entered into the analysis package.

### **Qualitative data**

For the qualitative data, obtained from interviews with staff and patients, coding was done after the data had been collected and was done with the aid of NUD.IST. The coding process was started by initially developing a coding tree using themes that I expected to arise given the research questions and hypothesis. The tree had two main branches, the government hospitals branch and the NGO hospitals branch under which expected themes under quality of care and cost of care were attached.

The initial coding tree was developed in NUD.IST and after the data had all been prepared and imported into NUD.IST, analysis of each interview (transcript and notes) was done and text units coded to the tree. As this was done, new nodes developed and the tree evolved substantially as more categories arose from the data. Please refer to annexed coding trees (Appendices 4 and 5).

After all the interviews had been reviewed and coded, a few text searches using some of the key words in the interviews were done and this further resulted in coding of some more text units. Once I was satisfied that the coding was complete, I proceeded with analysis of the final coding tree.

Responses from open-ended questions in the structured questionnaire were also imported into the project and coded along with the rest of the data.

#### **4.5.2 Data Cleaning**

Data cleaning occurred right through the processes of data collection. The questionnaires were assessed at the end of each data for any inconsistency and errors in recording responses. Such issues were corrected immediately and where this was not possible, the script would be considered incomplete and would be discarded.

On entering the data (codes) into STATA, the program was used to identify any errors or omissions that had been made during the coding or entering of the codes which were then corrected.

As for the interview scripts and notes, the PI reviewed each interview notes as soon as possible after the interview and typed up the notes. These were saved as text documents in word form from which they were later imported to NUD.IST. Early review and typing of the notes ensured that this was done with the interviews still fresh in the

PI investigator's mind and that any points that had not been recorded during the interview were included.

#### **4.5.3 Analysis of data**

Data analysis for both quantitative and qualitative data was done using the computer software, STATA and NUD.IST respectively.

##### **Quantitative data**

Simple descriptive analysis was done and presented using simple tables, cross-tabulations and graphs. Examples of outputs include, demographic profile of respondents by hospital, estimated average expenditure of patients by hospital, estimated average expenditure that is classified as unofficial fees, Quality of care characteristics by hospital, etc.

Further detailed analysis was done to develop correlation between different variables e.g. correlation between existence of unofficial fees and type of hospital. An analytical review of the results was done and presented as part of the discussion of results.

##### **Qualitative data**

Following the coding of data text units, the coding tree had evolved substantially as described above. The tree was then analysed and the texts coded under each node were re-analysed. The nodes were then categorised and final themes arising from the data recorded. The themes that developed covered issues such as,

1. the types of unofficial fees in the NGO vs. government hospital;
2. reason why unofficial fees were charged/paid in the different hospital;
3. how unofficial fees were charged or paid;
4. who was paid and who was paying unofficial fees and so on.

So from the analysis, we were able to describe what happens with regards to unofficial fees as well as explain reasons for these and differences between hospitals.

#### **4.6 Biases and Limitations**

Potential biases and limitations that need to be considered in the study include the following,

1. The Sampling of the hospitals as mentioned earlier was purposive and here accessibility to the hospital was one of the factors that were considered in this choice. Its possible therefore that the situation with regards to patients expenditure and unofficial fees in particular could be different in the hospitals located in far away districts. There may be district differences in patients' expenditure with patients from more accessible districts (nearer to Capital City) spending more. In the choice of the hospitals however, all types of hospitals (by funding and location) were included in order to try and make the sample as representative of Ugandan hospitals as possible. More so, given the research questions, this may not be an important bias as the aim of the study was to determine the existence, types and quantities of unofficial fees and whether and how they impacted on quality of care.
2. Another potential bias could arise from the fact that hospitals generally conduct different special clinics on different days of the week. For this reason, the patients that come to the hospital on different days may be different in their characteristics, particularly their diagnoses and therefore their expenditure may be different. This would mean that it is possible that results could be slightly different in the different hospitals if for example, on the day the survey, there had been a surgical clinic and therefore more surgical patients would have be included. This problem was not encountered in the three hospitals; the NGO hospitals and the rural district hospital because, in those hospitals there are no special clinics as such and all patients can be seen everyday. However in the much larger Government urban hospital, caution had to be taken to address this issue by subdividing the sample to ensure that all types of patients were included. Patients coming into the special clinics were interviewed as well as those that came to the general outpatient department. The ratios used here however may not have been accurate as we only estimated them and no precise figures were available to calculate them.
3. The structured questionnaire survey was done within the hospital setting and this could have introduced some bias in the sense that some patients may have felt uncomfortable to discuss some of these sensitive issues particularly about the unofficial fees and quality of care. As a result of this, some information may have been missed. The interviewers took time to reassure the respondents that the

information given was confidential and that they would not be discriminated against by the hospital staff if they spoke out. However, this may not have been sufficient to get the patients to tell the truth about what they knew was happening with regards to unofficial fees. The in-depth interviews conducted from the patients' homes were done in order to provide more information that may not have been obtained from the quantitative questionnaire survey. These patients were more likely to provide more accurate information given that there was no fear of discrimination in the hospital. Unfortunately, due to limitations in funds and time, it was not possible to conduct the quantitative survey from patients' homes.

4. The other limitation could arise from the fact that the study was designed to capture information from people who were attending the hospital and therefore totally left out those that didn't use the hospital facilities. There is a possibility that those would-be patients don't use the services because they are put off by the high unofficial fees, poor quality of care or both, and this would mean that the study would fail to capture this information
5. Given the sensitivity of the issues being investigated, the possibility of respondents being reluctant to discuss and provide accurate information was high and hospital staff could be unwilling to admit that unofficial fees are collected from patients as this could be seen as incriminating. Building rapport and confidentiality prior to the interviews was therefore critical although this may not have been sufficient to ensure that respondents give accurate information.
6. Lastly, choice of the patients to take part in the qualitative interviews highly depended on how far the patient lived from either Luwero district town or Kampala City. Patients who lived deep in the villages were not considered for these interviews. For this reason, it's possible that some information could have been missed. However, although the selection of these patients was based on information from key informants in the hospitals, the likelihood of getting inaccurate information from the patients was low given that they were interviewed from their home environment where they felt freer to discuss the issues at hand.

## 5. RESULTS

### 5.1 Official Expenditure in Hospitals

The two government hospitals the GRH and the GUH offer free health care and therefore official health expenditure by patients in these two is zero.

On the other hand, the Private section of the Government urban hospital i.e., the GPU and the two NGO hospitals charge a fee for services offered to patients. Table 3 presents a summary of findings on the amounts spent for which the patients received receipts. We considered official expenditure to be that for which receipt slips were given.

**Table 3: Money spent per hospital visit for which receipts were given**

Hospital Type	Average	Median	Least amount	Highest amount	Number of respondents
GR	0	0	0	0	101
GU	0	0	0	0	76
NGOR	18,156	13,000	0	60,000	64
NGOU	33,613	14,000	0	336,000	96
GPU	150,790	95,000	5000	380,000	22

From the above, we can deduce that the median expenditure was highest for the Government private wing (GPU) while median expenditure in the two NGO hospitals were much lower and almost similar.

### 5.2 Unofficial expenditure in hospitals

Unofficial fees were assessed quantitatively by asking respondents to the questionnaire, what amounts of money if any had been paid during the hospital visit for reasons (spelt out in the questionnaire) other than official costs of care. We expected to be able to determine the different types of fees as well as estimate average amounts paid for each type.

We also assumed that the difference between the total amount spent and that amount for which receipts were issued could be considered to represent unofficial fees spent in each hospital.

A qualitative assessment was also done during the in-depth interviews with patients and provider. In this case, the respondents were asked if they knew of any unofficial fees being paid in the hospitals (a description of what would be classified as unofficial fees was given). They were also asked what they thought the reasons for these charges occurring were, and who the collectors and victims were. The patients were also asked if they had paid such moneys, the amounts and who they had paid the money to.

Results:

### 5.2.1 Quantitative evidence of unofficial fees

#### *Unofficial fees spent in each hospital*

**Table 4: Difference between average of overall hospital expenditure and average amounts for which receipts were given**

Hospital type	Average	Median	Least amount	Highest amount	Number of patients who reported paying excess	Number of observations
GR	59.40	0	0	4000	2	101
GU	2171.053	0	0	30,000	15	76
NGOR	1004.69	0	0	51,300	8	64
NGOU	1009.37	0	0	40,000	24	96
GPU	54681.82	7,500	0	700,000	17	22

We made the assumption that all money paid for which receipt slips were not given would represent unofficial payments. While this could generally be true, there could have been instances where receipts were not given for some payments, particularly, payments for drugs. From the table above, the median amounts were zero for all hospitals except the GPU, which implies that the number of those for whom there was a difference in payments were very few. There was gross under-reporting and this is also shown in the table by comparing the number of patients who reported having paid an excess with the total number of respondents from each hospital.

Due to this evident under-reporting, these results cannot be generalised with the exception of the GPU, where the median amount for which no receipt was given is 7500/= and a high percentage of patients (77%) reported having paid excess.

These results could imply that patients from the GPU were more willing to report their expenditure compared to patients from other hospitals. However, this could also have been due to a technical problem in that many of the patients in the GPU may not have been given receipts for the payments, particularly for medicines even though they were official.

**Table 5: Table showing patients reporting presence of unofficial fees in the different hospitals**

Type of hospital	Unofficial fees		Total
	No	Yes	
govt-rural	99 98.02	2 1.98	101 100.00
NGO-rural	57 87.69	8 12.31	65 100.00
NGO-urban	73 74.49	25 25.51	98 100.00
govt-urban	59 77.63	17 22.37	76 100.00
govt-private	5 22.73	17 77.27	22 100.00
Total	293 80.94	69 19.06	362 100.00

Pearson chi2(4) = 72.5246 Pr = 0.000

The data as shown in the table above reveals that very few people in the sample reported to have paid fees that had been classified as unofficial fees from the quantitative data. Overall, significantly more people did not report having paid any form of unofficial fees compared to those who reported (P value = 0.000)

The following tables show summarised findings of the different types of unofficial fees (UG Shillings) in the government and non-government hospitals, the number of respondent and the mean of fees paid by those respondents.

**Table 6: Gratuity payments**

NGO hospitals					
Variable	Obs	Mean	Std. Dev.	Min	Max
gratuity	15	6333.333	7961.216	1000	30000

Government Hospitals					
Variable	Obs	Mean	Std. Dev.	Min	Max
gratuity	7	7428.571	6023.762	2000	20000

Only 15 and 7 patients reported paying gratuity in NGO and government hospitals respectively. The table however shows that the on average, patients in government hospitals paid more than those on the NGO hospitals. Interestingly, further analysis revealed that all gratuity payments were reported in urban hospitals (15% in NGOU, 13.6% in GPH and 5.5% in GUH).

**Table 7: Fees for commodities**

NGO Hospitals					
Variable	Obs	Mean	Std. Dev.	Min	Max
fee_comm	3	2433.333	737.1115	1600	3000

Government Hospitals					
Variable	Obs	Mean	Std. Dev.	Min	Max
fee_comm	20	27175	42958.14	1500	200000

Only 3 and 20 patients reported paying fees for commodities in NGO and government hospitals respectively. The table shows that the average amount spent by patients in government hospitals was 27,175 shillings. This is much higher than that for the NGO hospitals. Further analysis however shows that patients in the private wing of the government hospital (GPH) paid a lot more than those in the general wings (GUH) whose expenditure was comparable to the NGO hospital patients.

**Table 8: Fees for access**

NGO Hospitals					
Variable	Obs	Mean	Std. Dev.	Min	Max
fee_accs	5	2200	570.0877	1500	3000

Government Hospitals					
Variable	Obs	Mean	Std. Dev.	Min	Max
fee_accs	5	3200	1643.168	2000	5000

Only 10 patients in the study reported paying fees for access, 5 of which were from NGO hospitals and the other 5 from government hospitals.

**Table 9: Fees for service**

NGO Hospitals					
Variable	Obs	Mean	Std. Dev.	Min	Max
fee_serv	12	5500	8151.966	1000	30000

Government Hospitals					
Variable	Obs	Mean	Std. Dev.	Min	Max
fee_serv	11	10000	11515.21	2000	40000

Only 12 and 11 patients reported paying fees for services in NGO and government hospitals respectively. The table however shows that the on average, patients in government hospitals paid almost twice as much as NGO hospital patients for this.

Gross under-reporting is evident from the above because of the several issues mentioned earlier particularly the sensitivity of the issues that was being investigated and the possibility of respondents were reluctant to discuss and provide accurate information. Nevertheless the results give us some idea on the situation in the different hospitals. In both government and NGO hospital, all the different types of fees are reported.

Many more patients from the government hospitals reported paying fees for commodities (drugs especially) compared to those from NGO hospitals. Further analysis also shows that significantly many more patients from the government hospitals reported receiving only some or non of the prescribed medication and had been advised to purchase the medications privately because it wasn't available (see table 6 and figures 6 & 7 below).

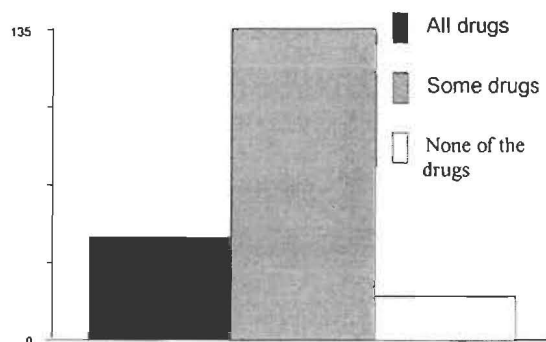
**Table 10: Table showing reported availability of prescribed drugs in the government and non-government hospitals**

Hospital	Reported availability of prescribed drugs in hospital pharmacy by patients			Total
	All drugs	Some drug	None of t	
NGO	151 92.64	12 7.36	0 0.00	163 100.00
GOV	45 22.61	135 67.84	19 9.55	199 100.00
Total	196 54.14	147 40.61	19 5.25	362 100.00

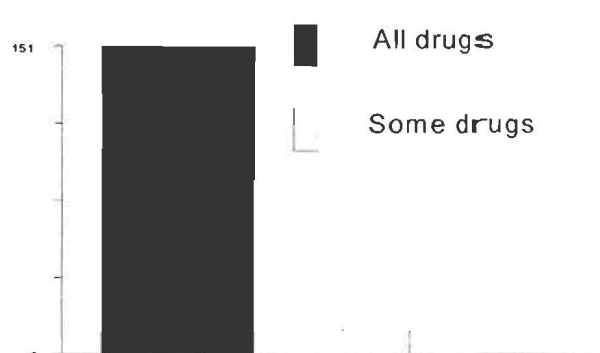
Pearson chi2(2) = 177.4194 Pr = 0.000

**Graphs showing availability of prescribed drugs in NGO hospitals and Government hospital as reported by patients (drugs received from hospital pharmacy)**

**Figure 2: Government hospitals (GRH, GUH, GPH)**



**Figure 3: Non government hospitals (NGOR, NGOU)**



Although at the time of the interviews, most respondents hadn't yet spent any money on commodities such as drugs, we can assume that they would unavoidably spend that money soon after they left the hospital at near-by drug shops and pharmacies. This expenditure would be considered unofficial expenditure related to the current hospital visit since the patients should receive all their medication free of charge from the hospital.

Below is a table showing retail rates in Uganda Shillings at which commonly prescribed antibiotics were sold at the time of the study in pharmacies and drugs shops near the hospitals as well as pharmacies for the NGO hospital

**Table 11: Table showing comparison in price of common medication in NGO hospital and Drug shops near the government hospitals**

Drugs	NGOR	NGOU	Urban D/Shop	Rural D/Shop
Gentamycin inj.	800	600	1000	1000
Chloraphenicol Oral	100	50	50	100
Chloraphenicol inj	800	1000	1000	2000
Amoxycillin Oral	100	80	100	100
X-Penicillin Inj.	350	350	350	500
IV fluids	1500	1500	1500	3000

From the above, one can see that oral medications (tablets/capsules) are priced generally similarly, however, injection drugs and Intravenous fluids are generally more expensive in the rural shops.

It can therefore be concluded that patients from rural hospital who would need such medications, e.g., those who have severe illness or those who have had surgery would end up spending so much more on medication and supplies, compared to those from the urban government hospital or the NGO hospitals. Fees for commodities would therefore be considered to be higher for those in rural hospitals.

At the same time, the above information can help us to estimate what patients would spend on, for example a prescription of a common antibiotic, when not provided free of charge from the hospital.

A prescription for an adult for Amoxicillin would consist of 1 to 2 capsules taken three times daily for 5 days. The patient would therefore have to buy between 15 and 30 capsules and costing between 1500 and 3000 UG shillings (at 100 shillings /capsule).

From clinical experience in Uganda, a high percentage of the patients (of at least 60%) attending the hospitals OPD would be given a prescription for antibiotic. We can conclude therefore that each of those patients would spend at least 1500 (minimum cost of a dose of 15 capsules costing 100sh each) as unofficial fees, spent on purchasing drugs that should have been provided free in the government hospital.

## **5.2.2 Qualitative Evidence of unofficial fees in hospitals**

### ***5.2.2.1 Types of unofficial fees in the hospitals***

In stark contrast to the quantitative data, patients and providers interviewed from the government hospitals all reported that they were aware of different types of unofficial fees existing in these hospitals. They also mentioned a wide range of reasons and explanations about how these fees come to be charged or paid.

Patients from both hospitals mentioned that they were aware of fees being paid for,

1. drugs and medical supplies like intravenous fluids, gauze, gloves extra, that should have been provided freely;
2. fees for access to different services particularly radiology services e.g., X-rays and Ultra-sound scanning;
3. fees for services to be provided by medical staff which should not be paid given that the hospitals were officially offering free health care, with the most common service being paid for being surgery (Caesarean section, hernia surgery, emergency surgery following an accident were all mentioned);
4. gratuity paid by patients either in kind (especially in the rural hospital) or cash.

Patients in the GRH generally felt that the hospital personnel were corrupt and withheld medication from the patients so that they could buy the medicine either from

the drug shops and clinics owned by the very same hospital personnel, or buy the drugs from them on the wards.

*" They tell us to go and buy the medicine in certain clinic". "I think that they are send us to their own private clinics, we are told that treatment in the hospital is free but when we get there, it's not".*

*"They don't give any drugs and refuse the clinical students to give us, they always keep the drugs locked up and say that the we (patients) must buy the medicine"* said one patient at the rural hospital.

There was also a common feeling among patients that one would not be helped or treated quickly if they didn't pay money to the staff. They particularly mentioned that it was very hard to have surgery in the hospital if one didn't pay the doctors to do it. Two of the patients reported that they had to pay money in order for the doctors to operate them and one even had to plead with the doctor to reduce the amount for her.

*"Some of the doctors ask for money before they do any operations". "The doctor asked me if I had come prepared, if I had brought any money",* said one patient.

Another patient reported having paid the doctor over 30,000/= so that he could buy the drugs to be used during the operation.

In the urban hospital, all the forms of unofficial fees mentioned above were reported by patients as being common and all of them had paid one or more of such fees. Even one patient from the private wing mentioned paying twice in order for her X-ray to be done. The 1<sup>st</sup> payment of 10,000/= was made to the hospital cashier, this was official as she was a paying patient. The second payment of 13,000/= was made to a nursing aide working in the radiology department who suggested the payment to enable the patient gets her X-ray done (she had been told that there were no films to do the X-ray).

*"The nursing aide said to us, " there is always a way, if you have something, we can give these people who do the X-rays and they will do it for you"" . " She said that that money was for paying the man who would do the X-ray and some for the one who would read and write the results".*

The patients who mentioned having paid gratuity fees said that they did so after a service had been provided to them and that it was because they were indeed grateful and wanted to show appreciation to the hospital staff who had treated them well.

The providers in the two government hospitals all mentioned that they were aware of unofficial fees happening in the hospitals. Common means included all those mentioned by the patients, i.e., gratuity payments, fees for access to services especially laboratory and radiology, fees for commodities especially drugs, intravenous fluids, gloves extra, and lastly fees for services especially surgery.

A provider in the urban hospital is quoted as saying that,

*"Unofficial fees are very common and apart from paying for supplies and drugs, patients sometimes have to pay even to be given a bed or for the nurse to administer the drugs to them". "Also this practice is very common in the labs where patients have to pay for tests, especially those done in the side labs of the wards".*

Another provider said,

*" Unofficial fees exist most commonly in the form of payment for drugs and supplies however, payment for better access also happens although it's done very quietly".*

Interestingly, providers from both government hospitals mentioned that patients very often try to bribe the staff so that they can get them to provide a better service. Most of them believed that it's this behaviour by patients that actually induces charging or payment of fees for access as they become impatient and want to by-pass queues.

On fees for commodities, one provider said that most patients have to buy medical supplies like Intravenous (IV) equipment, IV fluids, drugs and other supplies like

gloves and gauze. He estimated that at least every patient who went to the hospital had to buy a thing or two.

Both providers and patients interviewed felt that other than gratuity, other forms of unofficial fees were much less common in the private wing (GPU). Patients were usually billed only once for all the services and commodities, and didn't need to buy any of the medical supplies unofficially, as was the case in the rest of the hospital.

In the case of NGO hospitals, all patients and providers interviewed said that they were aware of only one form of unofficial fees, which are gratuity fees. The patients received all their medication from the hospital pharmacy almost always and were billed once. As for gratuity payments, they mentioned that these fees were paid by the patients at will, and as a sign of appreciation for the services they had received. They mentioned also that gratuity was usually in kind, in the case of the rural hospital and was usually in form of gifts brought for the staff after the patient was discharged.

One provider at the rural NGO hospital said,

*"Occasionally patients give gratuity to staff but mostly in kind e.g., food, chickens extra, as a token of gratitude for having taken care of them while they were ill".*

When asked about the other forms of unofficial fees particularly the fees for services and fees for access, all respondents from the NGO hospitals said that such fees didn't exist. They mentioned that patients do try to bribe staff but staff don't charge patients.

*"As far as unofficial fees are concerned, it's the patients who try to entice staff into bribing them but this is strongly discouraged by staff and they don't accept"* said one provider at the rural hospital.

Most of the providers in rural NGO hospital felt that sometimes patients get impatient and want to bribe to speed up the process.

One provider said, *"Patients who come here for the first time also want to bribe because they think that this is like those other hospitals out there where one needs to bribe first before they are served".*

Further analysis and comparison of research findings from both qualitative and quantitative data reveals a striking difference in evidence in the existence of unofficial fees in government hospitals. In the qualitative interviews, almost all the respondents reported unofficial fees of different types; fees for access; fees for commodities; fees for access and gratuity were all reported as occurring commonly in those hospitals. On the other hand, there were very few reports from the quantitative data (questionnaires) of such fees being paid.

Gaining the patients' and providers' trust and confidence during the in-depth interviews was recognised as a very important factor that could indeed have determined how much information is gathered. Given that issues that were being discussed were "hidden", people may not have been comfortable with discussing them openly with strangers, until a level of trust had been built between the respondents and the interviewer. This is likely to be the reason why there was such apparent under-reporting of these cases in the data obtained through quantitative interviews. There wasn't enough time to allow establishment of the required level of trust between the interviewer and the respondent as interviews lasted only about 15-20 minutes on average and the questions were structured rather than open-ended.

However, data from the open ended questions revealed that there was a lot of dissatisfaction among many of the patients from government hospitals at the lack of drugs, and many of them expressed their frustration with not getting medication when they visited the hospitals. They also mentioned that they would buy the medication from shops after they left the hospital. So there was consistency in the data with regards to fee-for-commodities (i.e., drugs and supplies), obtained from interviews and the questionnaire survey in confirming their existence and magnitude.

As for the other types of unofficial fees, in particular, the fees-for-access and fees-for-service, patients who responded to the questionnaire survey seemed reluctant to discuss them. We were therefore unable to obtain reliable information on their existence and magnitude from the survey and the results could not be generalised as

very small percentages of patients reported paying the different types of fees. This total contrast to that gathered from qualitative data.

These findings reveal the importance of methodology in investigating 'hidden' issues like unofficial fees. In the context of this research, it appears that qualitative methods of data collection seem to be more effective in obtaining key information. However it is possible that if the quantitative methodology had been employed in patients' homes, more accurate data could have been obtained. This is because away from the hospital, patients may be more comfortable to reveal sensitive information. This however was not possible in this study given the limitations of time and finances available for the study.

#### ***5.2.2.2 Amounts of unofficial fees commonly charged/paid***

From the interviews with both staff and patients in government hospitals, the amounts commonly charged could be deduced from the information they gave. For example, in the case of laboratory services in the urban hospitals, one provider reported that people were aware that the lab staff charged between 3000/= and 5000/= for a simple lab test such as malaria blood slide.

In the case of X-rays, the patients who we interviewed from the Government urban hospital reported that they had paid 5000/= for the X-ray and had also been charged 2000-3000 for the x-ray report to be made. However in the case of the rural hospital, the x-ray unit was not operational at the time of the study and patients who had to have this test were referred to the NGO hospital in the area where they would be charged 7000/= for the x-ray. In the cases where this happened, patients complained a lot about other indirect costs they incurred during the process of getting to the other hospital. These costs were usually 2 to 3 times the cost of the actual investigation /test.

As far as charges for surgery are concerned, the qualitative data shows that this varies a lot and could depend on the surgery to be done, the patient and the doctor. In the case of the patient we interviewed from the government rural hospital, she reported to have been initially charged 40,000/= because she had two hernia (20,000/= for each).

However, on pleading with the doctor and explaining that she couldn't afford as she was poor and widowed, the fee was reduced to 13,000/=.

In one case in the urban hospital, a nurse told of a case where a general patient (not private patient) was charged 100,000/= for an operation and the money was paid in at the surgeon's clinic prior to the operation. From this, one can see that the amount of money charged unofficially for services varies a lot.

It seems that the amounts charged for access to different services are quite similar to charges by private providers. In many of the examples that were given, the amounts charged seem to lie between NGO hospital rates and private clinic/hospital rates. X-rays for example cost 4,000/= in NGO hospitals and about 10,000/= in private (for – profit) clinics and we find that the amounts charged unofficially ranged between 7000-8000/=. The same can be said for almost all the other services. The amounts charged seem to be semi-private.

In the case of fees paid for commodities, again these depend on which commodities are being purchased and from where. When we investigated the cost of medication in drug-shops near the urban and the rural government hospitals, we found that the prices of drugs varied a lot and were generally higher in the rural areas.

One health care provider interviewed said,

*"Generally, patients spend more now if they have to buy the drugs on the open market". "They are sold at higher prices than they were here in the hospital during cost-sharing".*

Many of the patients who were interviewed from the two government hospitals said that they purchased the medications and other supplies mainly from near-by drug shops. A few of the patients however reported to have bought some of the medicines and supplies from the hospital personnel.

As discussed earlier, combining qualitative and quantitative information available to us can enable us to gain insight into how much patients spend when they fall ill and as a result of government hospitals failing to provide a complete service. With this information, we can get a sense about the impact of unofficial fees on patients' expenditure. From the questionnaire survey, median incomes for patients attending

different hospitals were obtained as shown in table 6 below. With this information we can conclude that patients from the rural government hospital are most affected by paying unofficial fees as these fees can range from 10% (e.g., fees for commodities) of their monthly income to as much as 100-200% (e.g., fees for services) of their income. Government rural patients are likely to pay more than others both in real terms and as a percentage of their monthly income.

**Table 12: Estimated monthly income of respondent's household**  
(Uganda shillings)

Hospital Type	Median income /month	Least income/month	Highest income /month	Observations
GR	15,000	0	150,000	84
NGOR	30,000	0	200,000	59
NGOU	150,000	40,000	980,000	78
GU	120,000	20,000	950,000	69
GPU	450,000	50,000	1,850,000	20

### **5.2.2.3 Who is paid unofficial fees in hospitals?**

Evidence from interviews showed that a wide range of medical and non-medical personnel in the hospitals collected fees unofficially.

The health providers interviewed reported that non-medical staff e.g., cleaners and nursing aides were known to collect fees under the pretence that they were doing it on behalf of the clinical staff. Some people mentioned that some of these non-medical staff would at times masquerade as medical personnel and pretend to help the patient, in which process they would collect money from the patient.

*"Usually with unofficial fees, the doctors don't usually get this money, it's usually the support staff (cleaners and nursing aids) who take the money and they ask for it under the pretence that the doctor is the one who demanded for it",* said one staff member in the government hospital.

However others felt that other hospital personnel were also involved. One provider sums it all up by saying,

*"These practices seem to be quite common among nurses, laboratory personnel and support services e.g. cleaners and nursing aides".*

From the discussion above, examples have already been given where different hospital personnel are reported to be involved in this practice.

From interviews with patients and a few of the hospital staff interviewed, doctors were also reported to be involved in cases particularly where fees for service were collected e.g., fees paid for surgery.

Medical staff from both government hospitals also reported knowledge of such practices by doctors. They also mentioned that sometimes patients were charged from private clinics and then operated upon from the hospitals as general patients and officially paying nothing to the hospital. In such cases, the patient would pay the doctor the fee before coming to hospital and as a result, the patient would be operated before those who may have been waiting much longer for operations.

One of the doctors interviewed had worked in both of the government hospitals had this to say,

*" Its common knowledge that patients are booked for operations in private clinics, they pay there but are operated from within the public hospital".*

In the case of gratuity, the patient pays who ever they feel they should thank for the services provided.

The information we obtained shows that virtually all cadres of medical staff are involved in the practice of collecting unofficial fees. Its also evident that lower cadre staff or non clinical staff commonly charge fees for access to services or deceive the patient that they are providing a service and take money.

Many example of fees-for-access being paid to non-clinical staff were obtained from interviews. An example is where a nursing aide charged a patient in order for her to be able to negotiate with the Radiology staff to do the X-ray for the patient. In that case, the nursing aide also mentioned that the radiology staff would also have to be paid for the service and the patient had to give her that money as well.

In this example, the nursing aide charged her amount (fee-for-access) as well as an amount on behalf of the service provider (fee-for-service). This could be a clear example of where lower cadre or non-medical staff, front for medical staff in charging fees.

The information we obtained reveals that the problem of unofficial fees is quite deep rooted and involves all types of medical personnel. This is an important point when designing ways of getting rid of the problem.

As for who was affected by existence of unofficial fees, we conclude that all patients attending government hospitals were generally affected. The absence of drugs and supplies at these hospitals resulting in payments of fees for commodities affected all patients. On the other hand, qualitative data show that surgery patients were more susceptible to being charged at higher rates than those who didn't have surgery. This was illustrated by the different examples cited by both providers and patients. It has also been shown that patients in the rural hospitals are likely to pay more for commodities compared to those in the urban hospitals since these are more expensive in rural areas on the open market.

However, we found no evidence from either qualitative or quantitative data that could point to richer people being charged fees more or less frequently than poorer individuals. On the other hand, it's evident from the qualitative interviews that patients who were in a better off financially were less opposed to paying unofficial charges if they felt that they got better quality of care that way. It seems that ability to pay increase tolerance for unofficial fees.

### ***5.2.3 Quality of care and relationship with unofficial fees***

In this section, the results of the assessment of perceived quality of care as well as an assessment of a few key indicators are presented. The problems identified could result from several factors, one of which is hospital financing. However, existence of these problems is likely to in turn influence existence of unofficial fees.

#### ***5.2.3.1 Perceived Quality of care***

Asking the respondents from the quantitative arm of the study how they would rate the quality of services provided by medical staff, ward staff and other hospital staff enabled us to assess this.

Interviewees were asked what they thought of the quality of services offered at the hospital and to explain why. This was done for patients as well as health care providers in each of the hospitals.

Results from the quantitative data don't show significant differences in the rating by respondents from the different hospitals. 52% of all respondents gave a rating of very good while 43% rated the services as good.

There was also no significant difference in rating between people from different income groups.

On the other hand, results from qualitative data reveal big differences in the perceived quality of care between patients attending government hospitals and those attending NGO hospitals.

All the patients interviewed from the government hospitals felt that the quality of care was quite poor in several aspects. Several reasons are given to explain their view on the quality and these included the following.

1. *The lack of drugs in the hospital.*

Patients and providers alike voiced the problem of frequent absence of drugs in the government hospitals and felt that this had a big negative impact on the quality of care. Most of the respondents mentioned that they found the lack of medication in the hospital to be much more common at the time of the study than it was before when they used to pay hospital fees as part of cost-sharing.

Patients from the rural government hospital mentioned that incomplete doses were quite commonly given and the patient would be asked to buy the rest of the drugs to complete the prescribed dose.

One of the patients interviewed from the rural hospital had this to say,

*"Sometimes we are given a half or a quarter of a tablet to swallow, panadol for example". "What can this do for you when you are in pain? "*

The medical staff felt that the quality of care is greatly compromised by this and that patients are frequently given inadequate or inappropriate medication.

*"Some times patients are given half doses of drugs because of scarcity of medicines and quite often, some return with relapses or severe illness due to either incomplete,*

*inappropriate or lack of treatment". " I get bored and demoralised when I cannot do anything for the patient" said one medical staff in the GRH.*

### *2. Unavailable medical staff.*

This issue also came up often from patients at both government hospitals who felt that the medical staff were too busy and, quite often, just not available to attend to patients need. Some of the patients also said that the staff were sometimes rude and unconcerned about the patients situation. However, many appreciated the fact the medical staff were indeed over-worked because the patients were very many.

### *3. Long waiting time*

All the patients interviewed from all hospitals felt that the waiting time between arriving in the hospital and receiving treatment was too long. Many mentioned that they had waited several hours in the OPD before being seen by a clinician. The hospital staff also mentioned this as a problem and this was reported in all hospitals but those in the government hospitals felt that the problem was worse in their hospitals than in NGO hospitals.

Some patients expressed a lot of frustration with this. *"If I had gone to a clinic, maybe my child would have been treated faster". "I feel that it's better to pay and be seen faster, like it was with cost sharing",* said one patient.

Other issues pointed out by health care providers interviewed in the government hospitals are the severe shortage of staff, poor staff salaries and incentives leading to low morale and heavy workload resulting in poor quality of services provided particularly by nursing care. All these have a negative effect on the overall quality of care provided in the hospital and encourage the practice of charging patients informally.

Services provided by the private wing in the government hospital (GPU) were however more satisfactory to both patients and providers and all felt that the quality of care was a lot better there because all the above mentioned problems hardly existed there.

Health care providers from the NGO hospitals felt that the quality of care was quite good as facilities and drugs were always available, the medical personnel devoted to their work and that patients' needs were generally well taken care of.

The common issues that they all felt compromised the quality of care were under staffing particularly among the nurses and low salaries (even lower than those in government hospitals), resulting in low staff morale and a high turn over of nurses with many leaving to find better paying jobs.

### 5.2.3.2 Key indicators of Quality of care in hospitals

A brief assessment of the key quality of care indicators was done as part of the questionnaire survey. These included,

- time patient waited before receiving treatment (shown in table 7);
- the time spent with the clinician (shown in table 8);
- availability of prescribed drugs in the hospital pharmacy;
- physical examination by the clinician (shown in table 9).

Results:

**Table 13: Time patient spent waiting to be attended**

Type of hospital	Less than 30 minutes	30 min -1 hour	1 - 2 hours	More than 2 hours	Percentage
GR	42.57	45.54	7.92	3.96	100.00
NGOR	72.31	23.08	3.08	1.54	100.00
NGOU	52.04	36.73	5.10	6.12	100.00
GU	48.68	42.11	7.89	1.32	100.00
GPU	31.82	36.36	22.73	9.09	100.00
Total	31.82	36.36	22.73	9.09	100.00

There is a significant difference in the time patients waited in the different hospitals and this was statistically significant; Pearson  $\chi^2(12) = 29.2805$  and  $Pr = 0.004$ .

On further analysis, we found that there was also a significant difference in the time patients waited depending on whether they went to NGO hospitals or government hospitals, with the former waiting much less (60% waiting less than 30 minutes) than

the later (40% waiting less than 30 minutes) Pearson chi2 (3) = 11.6694 Pr = 0.009.  
Please refer to table 8 below.

**Table 14: Time spent with clinician**

NGO hospital	Less than 5 minutes	5-10 minutes	More than 10 minutes	Total
YES	20.25	32.52	47.24	100.00
NO	41.21	32.66	26.13	100.00
Total	31.77	32.60	35.64	100.00

Patients attending NGO hospitals spend significantly more time with the clinician than those who go to general government hospitals, Pearson chi2(2) = 23.5968 Pr = 0.000.

Patients going to the GPU hospital spend the longest time with clinicians with 77% spending more than 10 minutes.

88% and 96% of patients attending the Rural NGO and the Urban NGO hospitals respectively reported to have received all the prescribed drugs from the hospital pharmacy. This is compared to only 16%, 32% and 22% of those in the GRH, GUH and the GPU hospitals respectively. These results are highly significant; Pearson chi2(8) = 194.6147 Pr = 0.000

87% of patients who reported that they had not had a physical examination were from government hospitals compared to 12.8% from NGO hospitals. This was highly statistically significant; Pearson chi2(1) = 18.3168 Pr = 0.000. Please refer to table 9 below.

**Table 15: Physical examination by clinician**

Physical exam. done	NGO hospital	Government hospital	Total
YES	48.92	12.82	45.03
NO	51.08	87.18	54.97
Total	100.00	100.00	100.00

### *5.2.3.3 Effect of paying or not paying unofficial fees on quality of care*

From the interviews we conducted as well as the questionnaire survey, we found that payment or failure of payment of certain types of unofficial fees could affect the quality of care a patient received significantly.

For example, in the cases where a patient was required to buy their own medications because there were none in the hospital, those who bought the drugs were better off than those who couldn't. Several examples of this are cited from interviews.

Medical staff felt that certainly the ability to buy ones own medication or medical supplies, greatly improved their ability to take care of the patients if the required medication wasn't available.

*" I had to wait until morning to do an emergency Caesarean section because the patient couldn't get IV fluids earlier",* said one doctor at the GRH.

From that, one can see that the quality of care; in terms of timing of the operation was greatly affected by inability of the patient to get intravenous fluids as they were not available in the hospital.

Medical personnel said that it was common for patients not to afford medications and this affects the quality of care greatly.

*"Many patients fail to buy the drugs and they come back in a worse condition because they didn't get any treatment". "What is one supposed to do for such a case",* said another sister in the GUH.

The patients also expressed the same frustration towards that problem and felt that even inability to pay for such fees like fee-for-service or fees-for-access greatly affected the quality of care they got. Many agreed that payment of such fees was critical in order to receive better quality of care.

*"If you don't have money for the operation, you can stay in the hospital for a very long time with all your pain". "You can even stay for two weeks without being worked on",* said one patient we interviewed.

On the other hand, some providers, particularly the medical staff felt that payment of fees for access or fees for services may compromise the quality of services given to the other patients. One doctor interviewed felt that the triage system for sick children on the ward was not as effective because some times less ill patients were seen before very ill ones possibly because they had paid staff to get through the queues faster. Another example is one where patients who couldn't pay failed to access services like radiology while those who paid were attended to.

All respondents generally felt that payment of such fees when required greatly improved the quality of care that one received although sometimes this was at the cost of other patients care, particularly in the case of fees-for-service or fees-for-access.

This situation raises lots of issues about how to address the problem. As discussed, certain fees especially fees-for-commodities are crucial for patients. We could thus argue that these fees are justifiable, given that government seems unable to provide sufficient funds to provide medications in the hospitals on a continuo basis. However, one questions how justifiable fees for access or service are and how they can be eliminated from the system given that they seem to greatly compromise ability for poorer patients to access care.

#### **5.2.4 Causes or Reasons for unofficial fees**

Most providers interviewed in the government hospitals had similar factors they thought were important in causing existence of unofficial fees. These include,

1. Lack of essential drugs and supplies in the hospital resulting in patients being advised to buy them on their own in order to receive treatment as was discussed earlier.

2. Unsatisfied patients (service users expectations); as a result of the poor perceived quality of care among patients attending the hospitals, there is an attempt by patients to try and improve the quality of care they receive by trying to tempt staff into taking bribes as an incentive to provide better care.

Many of the staff we interviewed in all the hospitals voiced this problem and examples have been cited above. The commonest explanation given was that patients frequently do this in an attempt to reduce the time they wait before they are attended to. Long waiting time is a problem that both patients and staff in all the hospitals acknowledged and seems to be a problem in government and NGO hospitals alike.

Generally, all factors pointing to poor quality of care are a cause of poor patient satisfaction and ultimately result in inducing of bribery by patients. However, some staff and patients also felt that bribery was induced by the staff themselves who felt that they could supplement their meagre income that way.

3. Uninformed patients i.e., some patients are not aware of what services they are supposed to receive free of charge and as a result, are taken advantage of by hospital staff who want to collect fees.

One provider cited an example where patients were being charged for laboratory services on the ward and for x-rays not knowing that they were not supposed to be paying money for those services.

In the interviews conducted for patients in the urban hospitals, we also came across one patient who thought she had paid for the X-ray officially.

One of the patients interviewed also said that he couldn't be cheated in the hospitals because he is well informed about where he has to get his treatment.

This illustrates the fact that patients who are less informed about what to expect from the hospital are likely to be cheated or exploited. There were several examples illustrating this point from the interviews that we conducted and this is an important issue that can be addressed in developing strategies to reduce the problem.

4. Hospital staff with poor morals; some staff feel that they need to cheat patients in order to get the extra income they need to supplement their low salaries.

Many of the staff we interviewed from the NGO hospitals felt that this was indeed one of the biggest problems. They pointed out that they (staff from NGO hospitals) were paid at lower rates than government health workers and felt that low salaries didn't justify hospital staff cheating patients.

Staff from the Rural NGO hospital pointed out that even the patients knew that staff in that hospital are Christians and don't accept bribes.

Some of the others interviewed also felt that there were better ways of making extra income than to cheat patients. One nurse in the GUH mentioned that she was forced to start a small chicken farm in order to supplement her salary but that she was aware that others resort to extortion of money from patients.

Another staff member of the GRH also agrees with this and she pointed out that those who cheat poor patients by refusing to serve them until they have paid, don't have the smallest "moral fibre" in them.

5. Reluctant administration to tackle the problem; abusers of the system are not prosecuted even if they are known so the practice continues.

Staff in the two government hospitals felt that even though it was common knowledge that patients were being charged illegally, the management hadn't done enough to curb the practice. The managers we interviewed as well as some of the staff mentioned that selling of drugs had been banned in the two hospitals and the staff didn't generally sell drugs. That was the only example of a policy being passed which aimed at reducing corruption and exploitation of patients.

On the other hand, NGO hospitals seem to be more vigilant in ensuring that all forms of unofficial fee collection are eliminated. Several examples were given by the managers of the two NGO hospitals about how they had handled cases where members of staff had been found to be collecting fees from patients.

In the rural hospital example, the manager reported that the staff member had been expelled after it was discovered that he was charging patients illegally.

*"We has one case in 1997 where one of our medical staff was treating patients from his house while using the hospital equipment to do their tests". "This person was immediately expelled and such behaviour hasn't been known to happen since",* said the manager from one of the NGO hospitals.

This example shows that these cases have been handled more vigilantly when they existed in the NGO hospitals as compared to government hospitals where the practice is rampant and yet no bold measures have been shown to be taken by management to bring an end to the problem.

6. The culture of expressing gratuity by giving presents or money is a common practice and could explain why gratuity was common in both government and NGO hospitals even though other forms of unofficial fees were hardly reported in the NGO hospital. On the other hand, one might argue that health workers may make an extra effort to offer a good service to those from whom they expect a 'tip', just like waiters in a restaurant.

This is indeed plausible and was exemplified by a case reported by one of the patients interviewed at the GPH where a nursing aide helped the patient get her X-ray done by informing them that they had to pay the radiology team but didn't charge a fee for her self. She went ahead to help them and when she brought the X-ray results from them, she waited expectantly to be given 'something', which the patient did. Cases like this can be very difficult to discern and differentiate from those where the health worker is genuinely being helpful and offering their best service.

### **5.2.5 Impact of Unofficial fees on health care in general**

#### ***5.2.5.1 Equity in access to health care***

Using the definition of equity; equal access for equal need, our research findings show that unofficial fees have a very significant impact on equity in access to health care.

From the study data, we can show that there are inequities in access to quality care between people of equal need. For example, we found that rural based patients i.e., those attending either the GRH or the GUH could be classified in the same social-economic class and thus can be said to have equal need for health care and equal ability to pay. However, those attending the NGO hospital seemed to get much better value for money in terms of access to more cost-effective quality care. This can be shown by the significant differences in quality of care in the two rural hospitals as well as the difference in costs of commodities or services, given that many of the government patients have to purchase these items through payment of unofficial fees. These services or commodities paid for by government hospital patients, have been

shown to be more expensive and therefore the patients would get less value for money for their out-of-pocket expenditure.

If we take the example of where patients in the GUH pay unofficially for X-rays to be done, those we interviewed reported that they paid 4000/= to 5000/= for the X-ray as well as 2000/= to 3000/= for the results' report to be written. These patients ended up paying between 6000/= and 8000/= shillings for an X-ray which would cost them only 4000/= at the NGO hospital.

This highlights the possibility that patients at the government hospital who could have afforded to pay for services at the same rate as that charged at the NGO hospitals could be denied access to the service, because of the higher costs of the same service resulting from unofficial charges.

Furthermore, the data shows evidently that patients at government hospital who didn't receive their medications, medical supplies or tests from the hospital would end up spending more for the same, compared to those in the NGO hospitals since costs are higher on the open market (please refer to table 5 showing costs of common antibiotics).

The difference is likely to be more significant between the GRH patients and the NGORH patients compared to that between patients attending the urban-based hospitals because as discussed in earlier sections, drugs and medical supplies are generally more expensive on the open market in rural areas. The expense of rural patients is even further heightened by the much higher transport costs in the rural areas compared to urban areas, as well as the lack of choice (monopoly by a few providers) between providers for a given service.

Both providers and patients from the rural government hospital felt that patients ended up spending so much if they were referred elsewhere for services that were not available at the hospital. The commonest service for which patients were referred was radiology and most patients went to the NGO hospital in the area. The main issue pointed out was that the patients spent a lot of money on transport costs moving between these two hospitals. This resulted in the overall cost incurred by the patient to have the test done being double or triple that for patients at the NGO hospital.

" When we refer them for X-ray, they can spend about 10,000/= on the test including transport, while an ultra sound could cost them as much as 20,000/=", said one of the providers we interviewed at the GRH.

#### **5.2.5.2 Efficiency and utilisation of health care resources**

Efficiency in utilisation of health care related out-of-pocket expenditure can be shown from the data we obtained to be lacking by far for expenditure incurred by government hospital patients compared to NGO hospital patients as a result of unofficial fees. The different types of unofficial fees may cause inefficiency in expenditure for example,

1. Fees-for-commodities e.g., costs of drugs bought from drug shops were shown to be high and much more in some cases than the costs of the same commodities in NGO hospitals. The patient in the NGO hospital would therefore get better value for money buying the same medication than a government patient who is forced to buy the drug from the open market.
2. Fees for service were also shown to be unnecessarily high when charged in the government hospital. A malaria test for example costs only 1500/= in the NGO hospital but patients and providers we interviewed from the Government hospital reported that laboratory staff unofficially charged 3000/= to do the test.

The money collected from the patient would benefit only that lab attendant and wouldn't even be used to pay for the reagents used to perform the test. This shows that government hospital patients' out-of-pocket expenditure is not useful to the hospital and yet even fewer patients have access to that service because the majority are unable to pay 3000/= for that test. When this is compared to out-of-pocket expenditure by NGO hospital patients, the 1500/= that is paid, is used to buy the reagents and therefore the hospital benefits by being able to sustain provision of the service. At the same time, more people are able to pay 1500/= for the service and thus more people have access.

3. Fees-for-access on the other hand are an avenue of loss of out-of-pocket expenditure that hardly benefit anyone other than the collector and this results in compromised quality of care for other patients. We found from the qualitative data that patients who paid fees for access did so to reduce the time they spent

queuing for different services in the hospital. This type of payment can be equated to a consultation fee like that charged in the private wing of the GUH and which is used by the hospital to employ more staff so that all patients attended to faster. Fees-for-access are very inefficient ways to use patients' out-of-pocket expenditure. Also given that in many cases these fees are charged by non-clinical staff (e.g., hospital support staff) and the medical staff are unlikely to benefit, there is no incentive for the medical staff to provide a better service or stay longer in the wards or clinics than they normally do.

As a result of poorer quality of services, patients using services of government hospital are faced with having to choose between spending more in order to improve access to better quality or withholding expenditure and having to settle for what is provided i.e., poorer quality services. However, in many cases, patients have little choice and are forced to spend, especially if drugs are not given or a fee for service is demanded as in the examples cited from the qualitative data.

Where unofficial fees are charged and patients cannot afford to pay, their treatment may be delayed, for example if they are unable to purchase drugs immediately or where they are unable to raise the money for fee-for-service quickly. This delay in treatment has consequences, which could include, prolonged illness and suffering or worsening of the clinical state i.e., illness becoming severe.

These consequences in turn have resultant consequences, for example, prolonged illness resulting in decreased productivity (in economically active individuals) while in the case of severe illness, consequences may include,

- Need for more expensive medication and or hospital admission to treat the condition;
- Complications from the illness, which require further clinical management;
- More time away from work leading to further decrease in productivity;
- Death.

All these have financial implications, which in many cases mean that the patients or their family have to spend more (out-of-pocket) and therefore further increasing inefficiency in use of out-of-pocket expenditure.

These issues were raised by many of the staff and patients from the government hospitals that we interviewed and many examples have been cited in earlier discussions.

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## 6. CONCLUSIONS AND RECOMMENDATIONS

### 6.1 Introduction

This research project was about establishing facts about two issues;

1. Determining what unofficial fees exist in Ugandan hospitals and how important they are in affecting patients expenditure;
2. Determining how critical unofficial fees are for quality of care provided at the different Ugandan hospitals.

With these facts obtained, recommendations for policy could be drawn as well as recommendations for future undertakings of analysis of unofficial fees.

In this section, we summarise the evidence obtained on unofficial fees in Ugandan hospitals and derive conclusions about this. Then we present recommendations for management and policy regarding unofficial fees.

### 6.2 Summary of Evidence

**Table 16: Summary of evidence**

Objective(s)	Findings for Government hospitals	Findings for NGO hospitals
Types of unofficial fees	All 4 types; Fees-for-commodities; Fees-for-access Fees-for- service; Gratuity payments	Only one type; Gratuity payments
Amounts of unofficial fees	Amounts vary a lot depending on type; Fees for commodity: depend on item and location (more in Rural areas), prices on the open market.  Fees for access: depend on who was charging but commonly ranging between 3000-5000 (qualitative information)  Fees for service; Depend on what service and seem to be related to costs of services in the private sector. Highest for Surgery  Gratuity: Both in cash and in kind, depended on the patient (social class). Gifts in kind commoner in rural areas	Gratuity: Both in cash and in kind, depended on the patient (social class) e.g., in rural hospital, mostly gifts were given especially in the harvesting season

Objective(s)	Findings for Government hospitals	Findings for NGO hospitals
Why unofficial fees (causes)	<ul style="list-style-type: none"> <li>• Lack of drugs and medical supplies</li> <li>• Poor staff morals and need to supplement their income</li> <li>• Patients expectations- wanting to access better quality</li> <li>• Uninformed patients –not knowing what is available free</li> <li>• Cultural practice of giving gifts</li> <li>• Reluctant administration</li> </ul>	<ul style="list-style-type: none"> <li>• Cultural practice of giving gifts</li> </ul>
Relationship between quality of care and U/fees	<p>A strong relationship exists,</p> <ol style="list-style-type: none"> <li>1. Quality much poorer in Government hospitals and as a result, the causes above are more common leading to unofficial fees.</li> <li>2. Payment of unofficial fees helps to improve quality for individuals, especially in accessing services and drugs</li> </ol>	<p>No relationship between gratuity payments and quality. Gifts or money were given after service, sometimes long after.</p>

### 6.3 Conclusions

Unofficial fees are a critical problem affecting virtually all patients particularly in government hospitals and have been shown to have a big impact on patients' access to care as well as its quality. The following conclusions are drawn from the study.

1. Unofficial fees are charged indiscriminately to all patients, irrespective of whether they have the ability to pay or not. This results in a problem of reduced access to care for those who are unable to pay the money. There are no exemptions for payments of unofficial fees once the collector decides to charge. Unofficial fees therefore impact greatly on equity in access to health care in Uganda.
2. Unofficial fees significantly affect the overall cost of health care borne by the individual since the amounts charged are usually high and comparable to charges in the private sector especially for services. Unofficial fees in fact completely defeat the government's aim of providing free care at the point of delivery of the service. They can result in patients paying even much more than they would if the government hospitals charged a uniform fee.

Since the causes of unofficial fees are so rampant in government hospitals, we can safely say that most patients in government hospitals pay unofficial fees in one form or another. This implies that unofficial fees form a large pool of patients'

out-of-pocket expenditure. Controlling unofficial fees would significantly improve efficiency of utilisation of patients' out-of-pocket expenditure.

3. Fees for commodities are in many cases justifiable, as the hospitals are underfunded and run out of drugs very often. However, cases where drugs are sold to the patient from within the hospitals raises questions about whether the pharmacies run out of medication genuinely because the supplies are inadequate or because the drugs are being stolen and resold by staff. The important thing to note is that the sole purpose of patients coming to hospitals is to get better and this is in most cases not possible without drugs. Therefore the need to buy medication unofficially when drugs are not available is justifiable.

4. Unofficial fees have a very significant effect on the quality of care provided to the individual as well as to other hospital patients.

For the individual, those who pay fees benefit by getting prompt services and possibly even better quality of the service that's provided. Unofficial fees are an incentive for providers to provide a better and quicker service.

For those who cannot pay or who delay in paying, unofficial fees become a barrier to access to required services. Failure to pay a fee for surgery to a doctor who demands it usually results in the patients having to wait endlessly to be operated. There is also a possibility that the operation may never take place unless another doctor who doesn't charge the fee does it.

Those who are able to pay service fees are likely to be given priority and treated faster than those who don't are. Quality of care in the hospital as whole is affected by unofficial fees, since staff, collectors of unofficial fees, have little incentive to care for patients who don't pay them. This also shows how unofficial fees affect equity, as patients with equal need end up having different access to quality of care.

## 6.4 Recommendations

### 6.4.1 Recommendations for Policy makers

Policy makers and health care managers are faced with a big challenge of addressing the problem of unofficial fees. As discussed in earlier sections, unofficial fees have a very big impact on equity in access to health care as well as on efficiency of use of out-of-pocket expenditure.

Given the limited financial resources available to the government, it's important to maximise benefit from any money spent by individuals and this can be done through controlling unofficial fees. The success of NGO hospitals in avoiding these practices is clear and government hospital managers and policy makers can learn from this and design mechanisms to check the practice. The following are some of the things that can be done.

1. Government hospitals should develop a system of ensuring availability of medications within the hospitals at all times. Opening up a section in the pharmacy where drugs are sold at subsidised prices to patients would be one way of doing this. By doing this, availability of drugs in the hospital would be ensured and patients would have a place to purchase medications when the general hospital pharmacy runs out of drugs. This would be a viable solution to solving the problem of lack of medicines in the hospital while at the same time ensuring more efficient use of patients' out-of-pocket expenditure, since the prices would be controlled and subsidised and patients wouldn't have to go out looking for drugs on the open market. However, for this system to work, very good management strategies would have to be developed to ensure that the new section of the pharmacy is run separately and accountability is ensured. The community members and patients need to be informed and if possible involved in setting up the system so that there is no suspicion (patients thinking that free government drugs are being sold instead).

This strategy can only be successful if a very good management system is developed and implemented effectively.

2. Improving quality of care for patients could further be done by providing more incentives for staff to give a better service. Of the things that can be done,

increasing the number of staff who attend to patients is crucial so as to reduce patients' waiting time and over-working the staff. This should be accompanied by providing staff with adequate amounts of medical supplies to handle the large number of patients that they have to see daily. Merely increasing staff salaries doesn't seem to be sufficient in boosting staff morale but on the other hand, improving their general working conditions may make a significant difference. This is evident from the fact that although NGO hospital staff are paid less than those in government hospitals, they generally feel that their working conditions are better and have better morale for their work.

3. Improving flow of information to all stakeholders particularly, the patients and the communities they come from is very important. Users of government services need to know what services are available to them and at what price, so that they are not cheated in the hospital by being charged for services that are supposed to be free.
4. The hospital management and policy makers need to come up with a strong stand against the practice of collecting unofficial fees. There is need to punish culprits so as to send out strong messages that the practice is unacceptable. If this is done, those who charge patients illegally may be discouraged, as they would be at risk of losing their jobs.
5. The policy makers also need to be realistic about what services they can afford to provide free and those that they can't. Prior to abolition of cost sharing, hospitals were generally able to provide services for radiology on a continuous basis. However, since abolition of cost sharing, the services have been provided intermittently and quite often are not able to sustain them. As a result of this, patients needing these services have had to be referred elsewhere. This usually results in the patients, especially rural patients, having to spend much more on transport and other indirect costs on top of the cost of the x-ray in the private sector or the NGO hospital where it's done. This way, patients' out-of-pocket expenditure is used inefficiently and there is further wastage of resources such as patients' and medical staff time.

If services that can't be sustained by government hospital budgets could be provided through a system of cost sharing, sustainability of service provision could be ensured as well as improvement in spending of out-of-pocket expenditure. This would also improve equity in access to quality care among the Ugandan population as a whole by ensuring that services can be obtained at the same cost to everybody if they cannot be availed free by government. It has been shown from earlier discussions that patients, especially those from rural areas are forced to pay much more in order to access certain services if the hospital cannot provide them free, which is commonly the case.

It would be important however, that all stakeholders are involved in determining which services patients can cost share as well as setting out strategies for management of the systems put in place.

NGO hospitals are able to provide more sustainable services at relatively low costs through cost sharing and this is something that government policy makers can use so as to improve. Selective cost sharing would be a way to ensure that essential services are provided free while more expensive services are provided at a low cost but which would ensure sustainability.

#### **6.4.2 Recommendations for Research Methodology for analysing unofficial fees**

In this study, we used both qualitative and quantitative methods to gather evidence on unofficial fees in hospitals. As discussed in the results' section, most of the information obtained through the quantitative methods was not statistically significant in showing evidence of existence on user fees in the hospitals. At the same time, analysis of the two data sets revealed that there had been under-reporting of issues from the quantitative data compared to the qualitative evidence.

The main difference in the two methods of collecting information that could explain the difference in data collected lies in the type of interviewing method used. Given that the issues being discussed were sensitive or 'hidden', in particular, about unofficial fees, people seemed reluctant to open up and discuss issues genuinely. We observed that it took a while for this to happen and only when the interviewee felt comfortable with the interviewer were issues discussed openly. The qualitative

interviews were in depth and allowed for lengthy discussion of issues compared to the short to-the-point questions used in the quantitative questionnaire survey.

The other difference was that the survey questionnaire interview lasted only 10 to 15 minutes, allowing just enough time for the questions to be completed. On the other hand, the qualitative interviews lasted as long as it took to discuss all the issues and were arranged by appointments so that the interviewee was comfortable with using up more time for the interviews and they were not rushed.

These differences seem to be key in explaining the different evidence obtained and show that qualitative methodology is best suited for obtaining information on hidden issues such as unofficial fees. It is thus recommended that in the Ugandan context, the main research methodology used to collect information on unofficial fees should be qualitative rather than quantitative, in order to obtain complete information. Within this methodology, different methods can be used to collect the data such as in-depth interviews, focus groups and simulated-patient methods extra.

## REFERENCES

- Abel-Smith, B. and Rawal, P. "Can the Poor afford "free" health care: A study of Tanzania." *Health Policy and Planning*, 7 (1992) 329-41
- Akin, J.S. Fees for health services and the concern for equity and the poor, World Bank PHN technical series No. 86-10. 1986.
- Akin, J.S., Guilkey, D.K. and Denton, E.H. Quality of services and demand for health care in Nigeria: A multi probit estimation. *Social Science and Medicine*, 40 (1995) 1527-1537
- Amandua, J., "The Problem of Dual Employment of Health Workers in Uganda." *Uganda Health Bulletin*, 2 (2001) 5-7.
- Asiimwe, D., Mwesigye, F., McPake, B., and Striefland, P., " Informal Markets and Formal Health Financing Policy." Makerere Institute of Social Research, Kampala; Uganda Ministry of Health; London Institute of Hygiene and Tropical Medicine; and Royal Tropical Institute, Amsterdam. (1996)
- Bennett, S., Russell, S. and Mills, A., " Institutional and Economic Perspectives on Government Capacity to Assume New Roles in the Health Sector: A Review of Experience. PHP Department Publication No.22. London: London School of Hygiene and Tropical Medicine (1996).
- Bennett, S., McPake, B. and Mills, A., "The public/private mix debate in health care". In, Bennett, S., McPake, B., and Mills, A. (eds) *Private health providers in developing countries: serving the public interest?* London, Zed Press (1997).
- Bitran, R. Household demand for health care in Santo Domingo, Dominican Republic. HCFlag, Research Report No.9. Stony Brook, New York (1989)

Cockcroft, A., "Performance and Perceptions of Health and Agricultural Services in Uganda: A report based on findings of Baseline Services Delivery Survey." World Bank, CIET International, Economic Development Institute, Washington, D. C. (1996).

Creese, A., "User Charges for Health Care: A Review of Recent Experience." *Health Policy and Planning*, 6 (1991) 309-319

De Ferrati, D., " Paying for Health Services in Developing Countries: A call for realism. *World Health Forum*. 6 (1995) 99-105

Demographic Health Survey Report (1995-96).

Di Tella, R. and Savedoff, W. D., " Shining Light in Dark Corners". Chapter 1 in Di Tella, R. and William D. Savedoff, eds. *Diagnosis Corruption: Fraud in Latin America's Public Hospitals*. Latin American Research Network. Inter-American Development Bank: Washington, DC. (2001)

DSE Publication, Public Service Reforms and their Impact on Health Sector Personnel. Round Table, Berlin, 13-15, October, 1999

EPRC and Management Systems and Economic Consultants. " Tracking of Public Expenditure on Primary Education and Primary Health Care." Makerere University. (1996).

Gertler, P., van der Gaag, J. The willingness to pay for medical care: Evidence from two developing countries. World Bank and John Hopkins University press, 1990

Gilson, L., "Lessons of User Fee Experience in Africa: A Review Paper." *Health Policy and Planning*; 12 (1997) 273-285

Gilson, L., Russell, S. and Buse, K., "The Political Economy of user Fees and Targeting: Developing Equitable Health Financing Policy." *International Journal of Development*, (1995).

Griffin, C. Welfare gains for user charges for government health services. *Health Policy and Planning*: 7 (1992) 177-180.

Hotchkiss, D. R. "The tradeoff between price and quality of services in the Philippines". *Social Science and Medicine*. Volume 46. No. 2 (1998) 227-242

Hussein, A. K. and Mujinja, P. G., " The Impact of User Charges on Government Health Facilities in Tanzania." *East African Medical Journal*. 74 (1997) 751-757.

Hutchinson, P., " Health Care in Uganda; Selected issues." World Bank Discussion Paper no. 404 (1999)

Jitta, J., "Quality of Health Care in Uganda Health Services." Health Systems in Africa, University of Copenhagen and the Enreca Health Network: Copenhagen, (1998) 35-47

Jitta, J. and Van der Heijden, T., " Economic Survival Strategies for Health Workers in Uganda." Study Report, Child Health and Development Center, Makerere University, Kampala (1993).

Killingsworth, J.R., Hossain, N., Hendrick-Wong, Y., Thomas, S. D., Rahman, A., Begum, T., " Unofficial Fees in Bangladesh: Price, Equity and Institutional Issues." *Health Policy and Planning* 14 (1999) 152-163.

Kivumbi, G.W. and Kintu, F., " A Review of Exemptions and Waivers from Health Care Charges in Uganda." A study report submitted to UNDP/WHO/World Bank; Special program on Research and Training in Tropical Diseases (2000).

Kutzin, J., " Experience with organizational and financing reforms of the Health Sector." Current Concerns SHS paper no. 8, WHO/SHS/CC94.3. Geneva: World Health Organization (1995).

Langseth, P., "Civil Service Reform: A General Overview." In S. Villadesn and F. Lubanga, eds., *Democratic Decentralization in Uganda: A New Approach to Local Governance*. Kampala: Foundation Publishers (1996).

Lateef, K. S., " Structural Adjustments in Uganda: The Initial Experience. In *Changing Uganda: The Dilemmas of Structural Adjustment and Revolutionary Change*. James Currey, London. (1990) 20-42.

Lavy, V. and Germain, J. Quality and Cost on health care choice in developing countries. Living standards measurement study working paper 105. World Bank, Washington DC. 1994

Litvack, J. and Bodart, C., "User fees plus Quality equals Improved Access to Health Care: Results of a Field Experiment in Cameroon." *Social Sciences and Medicine*, 37 (1993) 369-383

Macrae, J., Zwi, A. B., and Gilson, L., " A Triple Burden for Health Sector Reform: 'Post' Conflict Rehabilitation in Uganda. *Social Science and Medicine* 42 (1996) 1095-1108

Magyezi, R. and Namuyomba, M., *Implementing User Fees in Mukono District Health Units, Mukono District Service Project; AMREF Kampala* (1994).

McIntyre, D., "Alternative Health Care Financing Mechanisms: A review of Literature." Health Economics Unit, University of Cape Town, (1997).

Ministry of Finance and Economic Planning, *the 1991 Population and Housing Census: Final Results*. Government of Uganda., (1992).

McPake, B. "User charges for health services in developing countries: A review of economic literature". *Social Science and Medicine* 36 (1993), No. 11 1397-1405

McPake, B., Asiimwe, D., Mwesigye, F., Ofumbi, M., Ortenblad, L., Streetland, P., Turinde, A., " Informal Economic Activities of Public Health Workers in Uganda:

Implications for quality and accessibility of care." *Social Science and Medicine* 49 (1999) 849-865.

Mills, A. and Gilson, L., " Health Sector Reforms in sub-Saharan Africa: Lessons of the last 10 years." *Health Policy*, 32 (1995) 215-43.

Mills, A., Bennett, S., and Russell, S., "Health Sector Reform and the Role of government." In *Reforming the Health Sector*. Kegan Paul, London, (2000).

Ministry of Finance, Policy and Economic Development, Uganda Poverty Status Report: Uganda Poverty participatory assessment. The Republic of Uganda. (1999).

Ministry of Health, Three Year Health Plan frame; MOH Uganda (1993)

Ministry of Health, "Inventory of Health Services in Uganda for the Year 1996." Entebbe (1996).

Ministry of Health, Fee-For-Service implementation guidelines: Management Guidelines for Health Units. The Republic of Uganda. (1997).

Ministry of Health, A report on HIV/ AIDS in Uganda, Published on the official MOH web-site (date 10<sup>th</sup> June 2001), The Republic of Uganda (1999)

Ministry of Health, Health Policy Document. The Republic of Uganda (2000)

Ministry of Health, Health Policy Document. The Republic of Uganda (2001)

Mwambu, G.M., "Health care decisions at the Household level: Results of a Rural Health Survey in Kenya." *Social Science and Medicine* (1986) 22: 315-319

Mwesigye, R.F., " The Effect of User Charges on Quality of Curative Services: Perspective of Uganda's Rural Health Units." Health Planning Unit, Ministry of Health Indaba, Uganda (1995).

Norlan, B. and Turbat, V., "Cost Recovery in Public Health Services in sub Saharan Africa." World Bank, Washington (draft paper), 1995

Ocom, F., " Quality of care in Mukono district, Uganda." Dissertation for a Masters' Degree in Public Health, Makerere University, Kampala. (1997)

Okuonzi, S. A. and Birungi, H., "Are Lessons from the Education Sector Applicable to Health Care Reforms? The Case of Uganda." *International Journal of Health Planning and Management*, 15 (2000) 201-219

Okuonzi, S., " Your Money or Your Life? Myths and Realities of Cost Sharing." *Uganda Health Bulletin*, 2 (2001) 38-45.

Okuonzi, S. and Lubanga, F. X. K., "Decentralization and Health Systems Change in Uganda." Ministry of Health and Ministry of Local Government, Entebbe, Uganda (1997).

Russell, S. and Gilson, L. " Cost recovery in Government Health Services: Is Equity being abandoned? An International survey." London School of Hygiene and Tropical medicine, London (1995)

Russell, S. and Gilson, L. " User Fee Policies to Promote Health Service Access for the Poor: A wolf in Sheep's Clothing? " *International Journal of Health Services*, 27 (1997) 359-379.

Shaw, P. R. and Griffin, C., "Financing Health Care in Sub-Saharan Africa through User Fees and Insurance" World Bank, Washington (1995).

Silverman, J., "Public Sector Decentralization: Economics Policy Reform and Sector Investment Programs." World Bank Technical Paper Number 188, Africa Technical Department Series, Washington, D. C. (1992).

The New Vision, 17<sup>th</sup> February 2001, " Cost-Sharing ends." Uganda's National Daily Newspaper (2001).

Thomas, S., Killingsworth, J., Acharya, S., "User Fees, Self-selection and the Poor in Bangladesh." *Health Policy and Planning*, 13 (1998) 50-58.

Thompson, R., and Witter, S., "Informal payments in transitional economies: implications for health sector reform." by R. *International Journal of Health Planning and Management*, 15 (2000).

UNICEF. Children and Women in Uganda: A Situation Analysis. Kampala, Uganda. (1989).

Walt, G., Health Policy: An Introduction to Process and Power. London, Zed press, (1994)

Walt, G., and Gilson, L., "Reforming the Health Sector in Developing Countries: The Central Role of Policy Analysis." *Health Policy and Planning*, 9 (1994) 353-370

Wamai, G., " Community Financing in Uganda: Kasangati health Center Cost Recovery Program, A Two Year Report; 1988 to 1990." UNICEF, Kampala (1992).

World Bank, World Development Report: Knowledge for Development. Oxford University Press, Oxford. (1998).

World Bank, "A Proposal for Comprehensive Development Framework-Draft Paper, (1999).

World Health Organization, World Health Report: Improving Health systems Performance (2000).

Tigwalana, D., " Financing Health for All? Pros and Cons of User Fees in Uganda." *Uganda Health Bulletin*, 2 (2001) 46-49.

## APPENDICES

### Appendix 1: QUESTIONNAIRE FOR PATIENTS

#### *Personal / Demographic data*

1. Age \_\_\_\_\_
2. Gender:   Female = 1  
              Male   = 2               \_\_\_\_\_
3. Home Address: District \_\_\_\_\_
4. Occupation (**Record occupation of parent or guardian in the case of child patients**)

Occupation	code
Professional, semi-professional and technical occupations	01
Managerial, administrative or executive	02
Clerical and sales	03
Transport, delivery and communications	04
Service occupations	05
Farming and related activities	06
Production foreman, supervisor	07
Production workers, semi-skilled occupations	08
laborers	09
Other occupations (specify)	10

5. What is the Household size? \_\_\_\_\_

6. What is the number of earning adults in the household? \_\_\_\_\_

7. What is the education status of respondent? (**Indicate relationship of respondent to patient in the case of children**)

None =1

Some education =2

Completed primary education =3

Secondary education =4

High school and beyond =5 \_\_\_\_\_

#### *Income and Expenditure*

8. What is the main source of energy used for cooking in the home?

Fire wood =1

Charcoal =2

Paraffin =3

Electricity =4

Gas =5 \_\_\_\_\_

9. What is the main source of energy used for lighting in the home?

Paraffin =1

Candle =2

Electricity =3 \_\_\_\_\_

10. What is the main source of water used in the home for day to day activities?

Piped water inside house =1

Tap water in the homestead =2

Fetches from a tap outside homestead =3

Fetches from a spring or other water source outside the homestead =4 \_\_\_\_\_

11. What is the average household monthly income? \_\_\_\_\_

12. What is the estimated monthly household expenditure on food? \_\_\_\_\_

**Health care utilization**

13. How many times in the last year did each of the household members seek health care? List each member who used health services with their age

Household Member	Age	Number of times seeking Health care in last year
1		
2		
3		
4		
5		
6		
7		
8		
9		
10		

14. Where does the household normally seek health care?

	Provider type	Reason for choice of provider
Most frequently used provider		
2 <sup>nd</sup> most frequently used provider		
Least frequently used provider		

***Perceived quality of service at current visit***

15. How would you rate the quality of service given by Medical doctor/ Nurse, Other hospital staff and ward staff? Use the coding below

Very Good =1

Good =2

Fair =3

Poor =4

Very Poor =5

a) Medical doctor or Nurse \_\_\_\_\_

b) Other hospital staff ( laboratory, pharmacy, cashiers) \_\_\_\_\_

c) Ward staff ( for in-patients) \_\_\_\_\_

16. How much time was spent waiting to be attended to

30 minutes or less =1

30 minutes to 1 Hour =2

1 to 2 hours =3

More than 2 hours =4 \_\_\_\_\_

17. How much time was spent with the clinician

Less than 5 minutes =1

5 to 10 minutes =2

More than 10 minutes =3 \_\_\_\_\_

18. Did the clinician carry out a physical examination before prescribing treatment?

Yes =1

No =2 \_\_\_\_\_

19. Availability of prescribed drugs in the hospital pharmacy.

All drugs available =1

Some drugs available =2

None of the drugs available =3 \_\_\_\_\_

20. Where would you go the next time you have a similar health problem and why?

\_\_\_\_\_

***Fees paid at Current Visit***

21. How much money did you expect to pay at the hospital before you arrived? \_\_\_\_\_

22. Why did you expect to spend that amount?

\_\_\_\_\_

23. During this visit, when were you informed of what you were to pay and by whom?

\_\_\_\_\_

24. What is the total amount of money you have spent during this visit? \_\_\_\_\_

25. How much money did you pay during this visit where a receipt was issued?

\_\_\_\_\_

26. How much has been paid out for the following reasons,

- a) Payment for access to desired quality of service that is not routinely provided e.g. Less time in queue or access to better bed on the ward \_\_\_\_\_
- b) Payment for commodities when unavailable e.g. Drugs, medical supplies \_\_\_\_\_
- c) Payment for provision of service e.g. Paying to be seen by Doctor or Nurse \_\_\_\_\_
- d) Gratuity \_\_\_\_\_

27. In your own opinion, do you feel that paying any of the above fees (26 a-d) affected the quality of care that you received at the hospital?

Yes =1

No =2

27b. If yes, what payments/fees affected the quality and how?

---

28. What services / commodities would you be willing to pay for over the current official costs of medical visits at the hospital?

---

29. In your opinion, how affordable are services at this hospital compared to other health service providers that you have used before?

---

30. What was your source of money used to pay for services at this visit?

Own income (out of pocket) =1

Medical insurance =2

Employer =3

Borrowed =4

Raised by family/friends=5

Sold possessions =6

---

Thank you so much for you participation

END

## **Appendix 2: PATIENT'S CONSENT FORM**

### **Interviewer's statement**

I am a member of a team of researchers who are carrying out a study to assess the costs incurred by patients to access health care and the quality of care provided at different hospitals in Uganda.

We would like to ask you a few questions about the costs and quality of care that you have received during this hospital visit.

We will only take a few minutes of your time and all the information you give is confidential. No reference will be made about you as a respondent during the reporting of the results.

We would be very glad if you would accept to be part of our study. I assure you that whether you accept to participate in this study or not, your access to services at this hospital will not be affected in any way.

Do you accept to take part in this study?

**YES / NO (circle the response)**

**If yes, proceed with the interview**

### **Appendix 3: INTERVIEW GUIDE FOR HEALTH CARE PROVIDERS' AND MANAGERS' INTERVIEWS**

#### Introductory note by interviewer

We are part of a team of researchers who are carrying out a study to assess the costs incurred by patients for access to health care and the quality of care provided at different Hospitals in Uganda. We would like to ask you a few questions about your views on the costs and quality of care in this hospital.

We will only take a few minutes of your time and all the information you give is confidential. The results will be presented in a manner that reveals the views of Ugandan Health care providers in general and no reference will be made about you as a respondent.

We would be very glad if you would accept to be part of our study.

Do you accept to be part of this study? YES / NO  
(Circle the response)

*If yes, proceed with interview*

#### Interview Key questions

1. What is your position and what are your duties at this hospital? How long have you been working here? (Specify the different positions/duties held and the time spent in those positions)
2. What are your views on the quality of care provided at this hospital? Does it differ in the different departments and if so, why? How would you compare the quality of care provided here with that at other hospitals?

3. What are your views and knowledge about different costs that patients incur to seek health care at this hospital? What are the different costs and how would you compare them to those at other hospitals?
4. What unofficial / informal fees do you know to exist in this hospital and what are your views on possible reasons for their existence? **(A detailed definition of unofficial fees should be given at this stage)**
5. In your opinion, how do these unofficial fees affect the quality and cost of health care that patients receive at this hospital?
6. What would you suggest could be done to control costs incurred by patients without compromising the quality of care?

Closing interview

We would like to convey our sincere gratitude to you for accepting to participate in the study. The information you have given us will be very beneficial for the study.

Thank you once again.

\*\*\*\*\*END\*\*\*\*\*

## Appendix 4: INTERVIEW GUIDE FOR PATIENTS IN-DEPTH INTERVIEWS

### Interview Key questions

1. What was your experience of the quality of care provided in \_\_\_\_\_ hospital during the period you were admitted there? From your experience, is the quality of care different in the different departments of the hospital where you attended ?
2. How would you compare the quality of care provided in that hospital with that at other hospitals where you have attended previously?
3. What was your expenditure like during your stay at the hospital? What were the different costs/ charges you had to incur and who did you pay?
4. From your experience, what unofficial / informal fees were you charged and how did you feel about those charges? Who were these fees paid to? **(A detailed definition of unofficial fees should be given at this stage)**
5. In your opinion, how did these unofficial fees affect the quality and cost of care that you received at this hospital?
6. What would you suggest could be done to control costs incurred by patients while ensuring good quality of care?

### Closing interview

We would like to convey our sincere gratitude to you for accepting to participate in the study. The information you have given us will be very beneficial for the study.

Thank you once again.

\*\*\*\*\*END\*\*\*\*\*

## Appendix 5: INITIAL CODING TREE FOR QUALITATIVE DATA

### Index Tree

#### Hospital care

##### government hospital

##### quality of care

##### perceived quality

##### patients

lack of drugs

Rude and unfriendly staff

late treatment

##### over crowding

cleanliness wards

quality of care comparison

very busy staff

##### providers

cleanliness on wards

late or inadequate doses

under-staffing

comparing quality with others

nursing care

staff morale

poor staff incentives

over-worked staff

hospital supplies & drugs

lack of facilities like X-rays

too many patients-over crowding

##### cost of care

##### official costs

free

fee for service

transport costs

other indirect costs

##### unofficial fees

amounts

richer people

poor people

overall amounts

types

bribes by patients

gratuity

fee for commodity

fee for access

fees for services

##### why unofficial fees

poor staff morals

poor staff incentives; low salaries

reluctant administration

##### who is paid these fees

##### effect on quality

##### who is affected

**NGO hospital**

quality of care

perceived quality

patients

waiting time

caring staff

medical staff always available

cleanliness

available medical facilities

drugs available

providers

staff morale

heavy work but low pay

hospital supplies & drugs

overall quality

comparing with others

under-staffing

Devoted staff

patients waiting time

heavy work lord-few doctors

hospital equipment

cost of care

official costs

fee for service

source of money

transport costs

billing systems

poor patients

unofficial fees

amounts

richer people

poor people

types

gratuity

fee for commodity

fee for access

fees for services

## Appendix 6: FINAL CODING TREE FOR QUALITATIVE DATA

### Index Tree

#### Hospital care

##### government hospital

##### quality of care

##### perceived quality

##### patients

lack of drugs

Rude and unfriendly staff

late treatment

caring staff

unavailable staff

over crowding

cleanliness wards

quality of care comparison

overall quality

very busy staff

##### providers

long waiting time for patients

cleanliness on wards

late or inadequate doses

under-staffing

comparing quality with others

nurse-patient relationship

nursing care

staff morale

poor staff incentives

over-worked staff

hospital supplies & drugs

overall quality

lack of facilities like X-rays

too many patients-over crowding

poor staff morals

poor quality of lab services

##### cost of care

##### official costs

free

fee for service

transport costs

other indirect costs

##### unofficial fees

amounts

types

bribes by patients

gratuity

fee for commodity

fee for access

fees for services

##### why unofficial fees

ignorant patients

Unsatisfied patients

poor staff morals

poor staff incentives; low salaries

reluctant administration

who is paid these fees  
effect on quality  
who is affected

**NGO hospital**

quality of care

perceived quality

patients

waiting time  
caring staff  
medical staff always available  
overall quality  
cleanliness  
available medical facilities  
drugs available

providers

staff morale  
heavy work but low pay  
hospital supplies & drugs  
overall quality  
comparing with others  
under-staffing  
nurse-patient relationship  
Devoted staff  
good teamwork  
patients waiting time  
heavy work lord-few doctors  
hospital equipment

cost of care

official costs

free

fee for service

source of money

transport costs

billing systems

poor patients

unofficial fees

amounts

types

gratuity  
fee for commodity  
fee for access  
fees for services  
patients bribing staff