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EXPERIENCES FROM THE FIELD

DO AFFORDABLE FEES REALLY MATTER? THE CASE OF NKOZI HOSPITAL

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Abstract

This paper looks at the pervasive problem of low utilisation of health units for maternal and other reproductive health services. It gives one example of how a poorly performing institution made a turn-around and, driven by the need to improve access to, at least, maternal health services, made major strides in improving the quality of all the other services. The paper highlights the fact that relatively simple financial and organisational arrangements (most of which are relatively easy to redress) could be important barriers for the poor. In Nkozi Hospital, user-fees were reduced and flattened, resulting into a very significant increase in both utilisation and hospital revenue. It also highlights the need for community involvement in the planning of services, the need for human resource development and the importance of continued government support to the private-not-for-private sector.

Introduction

Uganda has poor health indicators and access to health services is very poor. Uganda's population in 1999 was 21million people with an annual growth rate of 2.8%, total fertility rate of 7.0, Life expectancy at birth (in years) was 41.9 for Males and 42.4 for Females (WHO, 2000). The major constraint in health services delivery in Uganda is the low funding level for the health sector, currently at around 50% of what it should be, to ensure full access of the population to the minimum health care services. This situation is made more complex by the fast growing population. Ideally the total per capita expenditure on health for a country at our level of development should be at least 19 US dollars from all sources, but we are at 9-10 USD per capita from all sources. Malaria is the leading cause of ill health in the country.

Of all the patients seen at the Out-Patient Department of all the health units, 29-50% was due to malaria. The disease accounts for 20% of hospital admissions and 14% of all in-patient deaths (Ministry of Health, 2001). According to the Uganda Demographic and Health Survey (UDHS) of 2000/2001, the infant mortality rate (IMR) was 88 and the under five mortality was 152 (Ministry of Health, 2001). Some health indicators are showing some improvement but, according to the Health Management Information System (HMIS), the percentage of deliveries taking place in a health facility has worsened, reducing from 25.2% in 2000 to 19% in 2001/2002 (Ministry of Health, 2003). Earlier on, during the formulation of the first five year Health Sector Strategic Plan (HSSP I), the Ministry had envisaged improving coverage, access, and quality of health services in Uganda as an approach to Poverty Alleviation and fostering economic growth (Ministry of Health, 2000). The plan put measures in place to support peripheral health facilities to meet the envisaged high demand for maternal health services.

Nkozi Hospital is a Private-Not-for-Profit (PNFP) rural 100-bed hospital found in Mawokota South Health Sub-District of Mpigi District, Uganda. The hospital is owned by Kampala catholic Archdiocese and is accredited to the Uganda Catholic Medical Bureau (UCMB) and is managed by the religious congregation of Sisters of Immaculate Heart of Mary Reparatrix with a total staff body of 107, of whom 3 are medical doctors.

The goal of reproductive health services is: making quality maternal health care more affordable and accessible for the catchment population. The question is, how this can be done, given the current funding, policy, infrastructural and human resource levels. How can maternal services be made more accessible to the poor? There is an urget need for a new approach to the improvement of accessibility to Reproductive health services in low resource settings.

Strategic interventions

In order to effectively improve Maternal service delivery in Nkozi Hospital, a detailed participatory situation review was carried out in October-December 1998. The review involved brainstorming discussions involving the Hospital management, staff, patients and the community. Several review meetings were convened in which challenges and barriers to health service provision were identified. Strategic interventions were then designed and implemented in phases.

The following challenges in delivering maternal services were identified:

The cost of delivering maternal and other health services was incresingly high. This made the Hospital management increase the user charges annually. In a very poor catchment population, increasing user charges was clearly to the detriment of the poor.

The percentage of mothers in the catchment area delivering in the hospital and accessing other reproductive health services was lower than expected in both the public and Non Governement (NGO) facilities within the Health Sub-District.

The few mothers who came for maternal services came late and with complications. The outcomes of these late arrivals were high caesarean section rates, puerperal sepsis, still births, long hospital stay and, in turn, high cost to the patients and even higher costs to the hospital.

Barriers identified

A number of barriers were identified during the analysis. These could be classified as financial, physical, organisational and cognitive.

Financial barriers

High opportunity costs: Due to poverty and limited knowledge of the expected benefits from delivering in hospital or using other reproductive health services, often the decision to come to hospital was delayed. Several roles (the consumer, patient and resource allocator) were combined into one person. To these was also often added the role of provider if the mother gave birth with little or no assistance. In a situation of poverty, a major trade-off had to be made against other domestic requirements, in order for the mother to come to hospital especially if they did not feel 'sick'. This had also been highlighted earlier in the 2000 World Health Report (WHO, 2000). In the report, it is explained that, often, the choices people make particularly about seeking care, are influenced by the responsiveness of the system and that utilization does not only depend on the accessibility of services, availability of drugs and human resource but also on the consumer's perception of the need or of the likelihood of benefiting from a service.

High formal charges. Given the high costs of service delivery, especially driven by the rising cost of service inputs, the hospital management had taken a decision to charge on a cost-recovery basis, thus rendering the charges high for the rural poor consumer.

Physical barriers

Restricted opening hours: Due to other internal weaknesses and considerations, the hospital's opening hours were restricted to what were perceived to be the 'correct' hours of the day. Thus, it was well known by the users that services were only available at certain times of the day. Many people could not risk to bring a potentially emergency case to the hospital.

Limited maternal services: The hospital was bombed and looted in the 1979 war. Its capacity reduced from 150 beds to a mere maternity centre offering no surgical services at all. Major operations including Caesarean Sections were only re-started in 1996 after a 16-year stint. Surgical services were strengthened in 2001 when a visiting surgeon surgeon started providing monthly specialised services.

Organizational barriers

Unprofessional staff attitudes: The management had registered a significant number of complaints about staff attitudes and practices from patients and their relatives, most especially in the management of maternity patients.

Unpredictable charges: In an effort to streamline the cost recovery, the hospital management had introduced fee-for-service charges. This had the effect of rendering the services unpredictable to the users. Unpredictability clearly prevented patients/mothers accessing maternal services. Patients required several visits to the cash office to pay for the different services, and by the end of the day one would have interacted with the cashier 4 to 10 times for registration, drugs, laboratory fee, consultation fee, etc

Poor referral: There was poor referral from lower level units (especially public facilities) and Traditional Birth Attendants (TBAs) to Nkozi Hospital. This was due to Lack of stewardship: Internally, the management realised a deficiency in stewardship with lack of a shared vision for the hospital, lack of uniform goals and coherence in action. There Hospital management structure was ambigious with poor distribution of senior and mid-level management responsibilities. This was a perfect recipe for conflict and assumption of responsibilities, which occasionally spilt into the management of patients. Reversal of each other's prescriptions was not unheard of.

Non-use of available information: The Hospital management committee was not adequately using available analysed statistical evidence in decisionmaking. There was lack of performance indicators, a long term strategic plan and the management of the departments was not adequately strengthened.

Lack of a broad outlook to the patient: The staff did not conceptualise the socio-economic issues related to patients attending services but were only concerned about the clinical issues and how to avoid making losses for the hospital. Staff were not able to identify reasons why people were not using the services but instead put all the blame on the ignorance of mothers, the long distances and poverty. They did not realize that their weaknesses and management inadequecies were major contributing factors to the low attendance and were actually the main reasons why people never came back for services.

Poor human resources management: There were major inadequacies in human resources management. The most affected category were the midwives.

Poor flow of patients: We noted that there was lack of a proper flow of patients in the hospital which was cumbersome, tiring, confusing and inconveniencing to the patients.

Poor financial management: There were poor internal financial control mechanisms in income and expenditure management, leading to high runing costs which were in turn borne by the patients who were therefore paying for our managerial inefficiency.

Cognitive barriers

Lack of information on services: Patients were not informed clearly of what services were available, at what times and at what price. Only user-fee schedules were displayed on all noticeboards and other strategic places of the hospital.

Unresponsiveness to community needs: The situation review analysis also indicated that the hospital system was unresponsive to the community. The community lacked ownership of the hospital and had minimal role in the management and day-to-day running of the hospital. The role of the community was disregarded and considered more as 'an evil better kept away' and, feeling excluded, the local politicians and community leaders fought and sabotaged the hospital management.

Interventions implemented to minimize and eliminate the barriers

Managerial measures to minimize the barriers to healthseeking behaviour were implemented from January 1999. Intensive efforts were put into minimising the organizational barriers. Measures were put in place to ensure real and perceived affordable good quality health care. The unprofessional staff attitudes and prcatices in the management of patients were tackled head-on in a multi-dimensional participatory approach.

Delegated Funds(DF) from the Government of Uganda to the hospital had been started in 1997. These funds initially contributed less than 10% to the Hospital budget and this was deemed a great opportunity. The DF were annually

increasing. A conscious decision was taken to use them to significantly subsidize the user-fee collections. This benefit was eventually passed on to the patient with the reduction in user-fee charges and, later, by flattening the user charges in 2000/2001 FY.

In a specific attempt to improve the delivery of maternity services, we improved on the cleanliness in the maternity ward. We obtained a manual vacuum aspirator, ensured early timely management of patients, ensured that we care, improved availability of drugs and involved ward staff in the understading of service targets and how to achieve them. The Antenatal Clinic (ANC) was integrated with the immunization department so as to provide comprehensive maternal and child health (MCH) services. Birth planning was included in the ANC visits and patients were reminded of the cost implications of pregnancy right from the first antenatal visit. The idea was that a mother could come for ANC, get health education, immunise the under-five child and meet the post-natal mothers in the same clinic. A flat fee of 500= Ugshs(25 US cents) for ANC visits was established with a standard package of drugs for all mothers attending ANC including Sulfamethoxazole-Pyrimethamine (Fansidar®), Iron supplements and Folic Acid. The Fansidar® was provided in line with the national policy of Intermittent Presumptive Treatment (IPT) of malaria in pregnancy.

Although the material inputs into a Caesarean section alone cost the Hospital about Shs. 185,000/= (USD 100$), we realized that increasing the charge further in order to recover this would not significantly increase the hospital revenue. Instead, it would effectively prevent mothers from attending the maternity services, increase the number of complicated deliveries, increase the number of runaway cases (escapees) and create a negative attitude against the hospital. More revenue was thus targeted through increasing the number of normal deliveries and increasing the turnover of patients. It was a big challenge to make maternal services in the hospital more valued by the users in terms of cost, time, outcomes and service.

Unpredictable formal and informal charges were minimized with effective financial controls and staff motivation ensuring that staff valued their patients and their jobs. At night staff tended to care less and had a poor attitude towards patients. Efforts were made to ensure delivery of the same quality of services 24 hours a day (night and day). OPD services used to close at 5 pm. This was extended to 8:30 pm.

The staff in a hospital are a major component in the improvement of reproductive health services. We recognised that all key programmes must always aim at involving all Nurses, Doctors, Paramedicals and support staff. They are all key in the improvement of health service delivery in the health facilities. We managed to involve the staff in planning and implementing the interventions and giving them a feedback. The response was phenomenal. Staff were involved in attitudinal change by having an identity badge with a name and photograph, ensuring smartness on duty, confidence at work, improving language and communication skills and encouraging patients to give a feedback on discharge.

Staff who failed to change staff-patient communication were identified by fellow staff and patients. Those who persistently failed to change despite advice and guidance were either transferred to the back office operations or new positions were created where they did not deal directly with the external public. Severe punitive measures were hardly deployed.

Through the local political leadership, religious leaders and community meetings, the new user charges and flat fee structure were communicated to the public. Communtiy mobilization started with creating community ownership of the NGO Hospital, a concept which was originally not appreciated as an opportunity to them. We also took effort to assure all of them of their importance as stakeholders of the hospital.

Since the hospital also headed a Health Sub-District, with lower level health units under it, referral mechanisms from the lower units and TBAs were improved. Customer-oriented services were designed in flow and time. With input from exit interviews showing the unfairness of a fee-for-service strategy, a flat fee structure was introduced. A lower and flat fee structure for normal deliveries was thus set at 12,000= UgShs (USD 6$) from an average of 45,000= (USD 23$) and a caesarean section was fixed at a flat charge of 45,000= UgShs (USD 23$). This worked out well. Staff had to be brought on board to understand why they worked so much for a post operative mother and yet the patients were paying much less.

The successful outcomes:

A number of successes were registered. These could be summarised as:

- A motivated output-oriented work force
- Reduced cost of outputs
- Increased hospital revenue
- Increased utilisation of maternal services
- Increased hospital deliveries, ANC attendance and maternity admissions
- Better community involvement in the management of the hospital

Graph 1 shows that the number of deliveries in the hospital progressively increased. The Caeseran section rates reduced which is an indication of confidence and appreciation of the services delivered by the Hospital resulting in early and timely healthseeking behaviour.

In **graph 2**, it is noteworthy that despite the flatening and extensive reduction in user-fee charges for the normal deliveries and caesarean sections, the annual revenue from the deparrtment has increased. More staff were recruited and the martenity department was awarded the internal *"Best Performer of the Year"* award for 2003, which was also introduced as part of the management improvement.

The average charge per patient in the maternity ward has reduced and continues to reduce, an indication of responsiveness to community demands. **Graph 3** shows that the interventions implemented have not only been effective in improving access for reproductive health services, but the measures have also been effective in incresing acces to OPD and other services offered by the Hospital (Nkozi Hospital, 2003).

With the increasing workload, staff emoluments have also been improving with improving performance, responding accordingly to the increasing government subsidy.

The new challenges

Despite these improvements, new challenges have been created for the management of the hospital. These include:

- Maintaing the quality of services withincreasing workload
- Maintaing consumer confidence
- Maintaing the work force motivated
- Sustaining the achievements

Lessons learnt

How much an individual has to forfeit to get a service really matters. In the available resources, health managers need to acquire managerial skills in order to maximize the benefits of these meagre resources by improving access for the poor. Management skills, attitudes and practices are a critical aspect in making maternal health services accessible, especially to the poor. Even when financial resources increase, without adequate managerial capacity of hospital managers, access to maternal services will remain a dream- at least for the poor. As regards stewardship management principles must be revamped not only for Reproductive health services but also in the general delivery of health services. Resources are limited and will always be, the issue is how to achieve A lot of emphasis needs to be put on the organizational barriers that prevent patients from seeking health care. Health managers need to consider important and aspire to capture customer loyalty, defined as 'customer behavior characterized by a positive buying pattern during an extended period measured by means of repeat frequency of utilisation of services and willingness to pay' (De Wulf, 1998). This loyalty will be characterised by a positive attitude towards the health unit and its products or services. Since customer attitude is difficult to measure for financial and practical purposes, customer retention will be used as an our main indicator of customer loyalty.

In order to make maternal services more accessible, a number of thoughtful interventions in all the sectors of service delivery in the Hospitals/health units need to be implemented concurently (not only reduction/ removal of cost/user charges). Health managers need to keep in mind that mothers are often not patients. They are consumers of our services, and businessoriented consumer satisfaction measures must be deployed in health care as well.

At this stage when we are grappling with poor reproductive health indicators, we need to reposition reproductive health services in the minds of the catchment population, not by advertisement but by active Health Education and Promotion, good ethical practices and improved staff attitudes.

The roles of all Health Unit stakeholders should be highlighted and and all of them brought on board. In the hospital, the gate keeper, the cashier, the receptionist, cleaner, compound upkeep staff should all be brought on board as well as the clinical and midwifery staff. Patients may not be coming to the hospital because of the rude gatekeepers.

Health services need to be quickly responsive to the needs of their community. Regular exit interviews to assess service delivery to the community, and other relevant and appropriate means of receiving information for the community need to be employed. The management ought to endeavor to react to the community feedback. Drugs and supplies, emergency services must be available and where not available an explanation should be given to the users. Health managers will benefit from keeping in mind that the community observes our work and makes unanimous decisions, by voting with their feet.

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