THE 'CASH AND CARRY' SYSTEM ON THE GROUND

THE CASE OF BOLGATANGA HOSPITAL

BY

AMINU SHITTU

A DISSERTATION PRESENTED TO THE DEPARTMENT OF SOCIOLOGY, UNIVERSITY OF GHANA, LEGON IN PARTIAL FULFILMENT OF THE REQUIREMENTS FOR THE AWARD OF MASTERS OF ARTS DEGREE IN SOCIOLOGY

JUNE, 1998

DECLARATION

I declare that this dissertation is the result of my own research work carried out in the Department of Sociology, University of Ghana, Legon under the supervision of Dr. K.A. Senah.

I certify that the materials presented is the record of my original research, except where acknowledgements are made. I declare also that, the research work has never been presented either wholly or in part for any award elsewhere.

.....

DR. K.A. SENAH

(SUPERVISOR)

DATE: 18/3/19

.....

AMINU SHITTU

(STUDENT)

DATE: 16/3/19

DEDICATION

This work is specially dedicated to my wife SHERIFATU AMINU and my younger brothers LIADI SHITTU AYIKI and ISSAH SHITTU for their prayers and co-operation that saw me through this work.

ACKNOWLEDGEMENTS

Many individuals have in diverse ways contributed to the success of this research work and I wish to sincerely acknowledge my indebtedness.

I am indeed most grateful to the Almighty Allah who has guided me through the research. I am particularly grateful to my supervisor Dr. K.A. Senah whose painstaking, useful criticisms and suggestions contributed immensely to the final stage of the work. Without him my way would have been unclear. I am indeed grateful.

I am also grateful to Messrs Joseph I. Kaponde, Yussif Dakudugu and Miss Gifty Kwofie, colleagues at Legon whose advice and suggestions at various stages of the work contributed to its success.

I wish also to thank Messrs Tajudeen Salam, Issah Lawal, Nasiru Saliu Seriki, Ilisasu Lawal, Mohammed Tiamiyu and Mudasiru Fasasi for their immense assistance during the field work. I am also grateful to Mr. Sulle Lawal, Regional Manager of the Inter-mediate Transfer Technology Unit, Bolga, for his deep concern in the research work and various informations made available to me.

I wish also to express my appreciation to my wife and all family members whose co-operation and understanding saw me through the work.

This acknowledgment will be incomplete without mention of District Electoral Officers at the Gt. Accra office of the Electoral Commission. Their support and co-operation made positive contribution to this research.

It is also my candid pleasure to express my sincere appreciation to Miss Sefia Musah, Edith Abbeo and Janet Nyakote for their extraordinary skills and manual dexterity in typing the hand written scripts and the final print.

To all others who contributed in diverse ways I say thank you and may Allah bless you.

While I appreciate all these contributions, I am solely responsible for any short comings connected to the study.

ABSTRACT

In 1992, the Cash and Carry system of health care obtained green light for operations in all government hospitals. This study seeks to research into the operations of the system and how the policy is being implemented at the Bolgatanga Regional hospital.

The study has been divided into five chapters. In Chapter One, attempt was made to identity cost recovery in the health sector as an issue confronting government in the last few years. This has become necessary partly due to poor economic performance and the dwindling share of the national cake. The main tools used for the collection of data were interview questionnaire and focus group discussion.

In Chapter two, attempt was made to review health care financing in Ghana. This Chapter discussed the issue of fees in the health sector and policies initiated by government over the years to accommodate health care challenges. The socio-economic and political structure of the study area was discussed in Chapter Three.

The data obtained from the field were presented and analysed in Chapter Four. Opinion held by respondents indicate that affordability, efficiency and quality of services are important considerations in the utilization of health care facilities. In the final Chapter, the study presents a summary and recommendations which may be useful for policy making.

TABLE OF CONTENTS

LIST OF TABLES

LIST OF FIGURES

LIST OF ABBREVIATIONS

C.S.M	Cereborspinal Meningitis
D.H.M.T.	District Health Management Team
E.R.P.	Economic Recovery Programme
F.G.D.	Focus Group Discussion
G.D.P.	Gross Domestic Product
G.N.P.	Gross National Product
I.D.A.	International Development Agency.
I.M.F.	International Menetory Fund
L.I.	Legislative Instrument
M.C.H.	Maternal and Child Health
M.O.H.	Ministry of Health
N.L.C.	National Liberation Council
PAMSCAD	Programme of Actions to Mitigate the Social Cost of Adjustment.
P.H.C.	Primary Health Care
O.P.D.	Out Patient Department
S.A.P.	Structural Adjustment Programme
UNICEF	United Nations Children Fund
W.H.O.	World Health Organisation

CHAPTER ONE

1.0 INTRODUCTION

Over the last few years, many governments in Sub-Saharan Africa have shown interest in cost recovery in the previously exempt social sectors, such as education and health. Although still politically difficult to implement, a certain amount of cost recovery in both education and health has become increasingly necessary for resource mobilization due to rapid population growth, slow economic growth and budget deficits.

It is indeed an established fact that, providing efficient, adequate and accessible health care system is an essential ingredient for national development. This, no doubt, presents a big challenge to most governments in their pursuit for a healthy society. Like any aspect of national development therefore, the provision of adequate health care becomes a collective task for both government and the governed. However, the quantum of input expected of each party for the realization of a healthy society often remains the centre of dispute.

As has been observed "a health care delivery system has tremendous economic value, and plays a crucial role in the developmental

processes of a nation" (Senah, 1989: 243). Also, an old sage attributed to Aristotle has it that "health of mind and body is so fundamental to good life that if it is the belief that men have any personal rights at all as human beings, then they have an absolute moral right to such a measure of good health that society alone is able to give them". (Addo, 1996:20).

Providing adequate health care for the up keep of society thus becomes essential. However, this provision requires the use of scarce resources - human and material. As a result health financing has been of great concern to developing countries in the past few decades. Probably what is so remarkable about this is that, among other social services, adequate health care requires substantial investment. However this has been observed to be woefully lacking or inadequate. For instance, it has been observed that, between 1974 and 1988, the health care budget in Ghana increased from just 6.3 per cent to 9.0 per cent of national expenditure. Faced with high population growth, such an increment can hardly provide any meaningful health care delivery package. Consequently, per capital government health expenditure declined from US $6 in 1972 to about $1 in 1983 and by 1988 it was only $1.50. It was therefore estimated that by the year 2020, health budget may fall by 60 per cent if rapid population growth is not seriously checked and controlled (Benneh, 1990).

Asenso-Okyere (1993) also notes that, public sector services per capita have not increased appreciably over the years as a result of many factors including high population growth rate. Consequently, though the Ministry of Health (MOH) expenditures between 1986 to 1990 grew over three fold in nominal terms and by 12 per cent in real terms, the real per capita increase was only 3.3 per cent.

Indeed, the Ghanaian economy in the 1970s and 1980s was described as volatile (Waddington and Enyimayew, 1990). Not only did the Gross National Product (GNP) fall by 15 per cent between 1980 - 83, but the balance of - payment was in serious deficit. (Krause, 1991). It was also noted that, per capita G.N.P. fell from US $619 in 1970 to US $411 in 1983. This represents a decline of about 33.6 per cent. On the same note, Asamoa (1996:92) observes that, "government deficit increased in the 1970s while balance of payments deteriorated at an alarming rate". He indicates that government's capital and current accounts were in red from ¢74 million to ¢141 million in 1974. These unfavourable economic trends obviously resulted in the deterioration of many social services including health. Ghana like many other developing countries was thus faced with limited options, one of which is the payment of user charges.

In an effort to arrest the decline of the 1970s and 1980s, the government of the Provisional National Defence Council (PNDC) launched an Economic Recovery Programme (ERP) in April 1983. This programme sought to arrest and reverse decades of decline in the entire economy and to restore living standard of Ghanaians. The ERP thus touched on every significant sector of the economy including health.

Basically, the programme recommended cost-sharing for the health sector. Thus, fees for curative health care became a standard part of the Structural Adjustment Programme (S.A.P.) that followed. This arrangement was intended to ensure the availability of enough resources such as funds, supplies and drugs for the smooth running of health services.

Eventually, in 1985, the Government passed a new Hospital Fee Act. By this, patients were required to pay the full cost of drugs and pharmaceutical services. This has since paved way for the establishment of a "revolving drug fund" referred to as "Cash and Carry". Under it, health institutions were no more to pay revenues collected into government chest but, to retain them fully for drug procurement.

Basically, "Cash and Carry" is a cost recovery mechanism which is increasingly been seen as a means of providing support to the MOH budget and a tool for enhancing internal efficiencies. Others also see the mechanism as regressive and decreases utilization of public health facilities (Gentler and Van der Gaag, 1988).

In whatever perspective this policy may therefore be viewed, the most important issues of concern to many are efficiency and affordability of the system. These have indeed made headline news in the recent past.

1.1 THE PROBLEM

The continuous decline of the global economic order coupled with the inability of governments of many developing nations to grapple with many socio-economic problems, make it extremely difficult for government to offer free medical care services. For Ghanaians, the degree of poverty and the persistent high rate of inflation continue to erode the purchasing power. Hence, when health cost escalates, the effects and implications are enormous. (Asenso-Okyere, 1993).

Until 1985, when user fees were introduced medical care in Government facilities used to be "almost free to all categories of persons" (Asenso-Okyere, 1993:6). Thus, the Hospital Fee Regulations (1985)

came into force on July 19, 1985 when the Government realized it could no more shoulder all the cost of public health care without compromising quality at a time of budget austerity.

Consequently, "the introduction of the 'Cash and Carry' programme has since raised several concerns and reservations among health workers and patients about its implementation" (MOH, 1996: III). It is therefore undisputed that the policy has resulted in mixed feelings. Whereas proponents of the policy claim that "the policy shall deter frivolous use of health facilities and generate revenue which can be used to improve the scope and efficiency of services, opponents claim that user charges are inequitable and cause decline in health services utilization, particularly amongst the most vulnerable groups" (Waddington and Enyimayew, 1990:287).

Also, the policy has witnessed "varied interpretations at points of implementation" (MOH, 1996:5). This for instance, is evident in section 2 subsection 1 of LI 1313 of the 1985 Hospital Fees Act. This section explicitly provides for the full exemption of patients suffering from leprosy and tuberculosis. However, what is not clear is whether these facilities should be made available to such patients when they report with

other conditions such as malaria in addition to their charge-exempt conditions.

Another area of concern to many is the difficulty of exemption for casualty treatment. Thus section 3 sub section 5 of Act 387 of the Hospital Fees Act, provides adequately for emergency cases. In practice however, the MOH has observed that "financial constrains make hospitals unwilling to take full advantage of this provision" (MOH, 1996:5). As a result, patients suffer under the circumstance when they are unable to meet the cost of services. Indeed there are other difficulties in the determination and implementation of some exemptions on grounds of economy, age and gender. These, according to the MOH, do not reflect the current trends and in some cases are not supportive of the health policy (MOH, 1996).

It is also worth noting that, people who consider cost of health care as unbearable find it deterrent. As a result, they either resort to self-medication or traditional health care practices thereby under utilizing public health care facilities. Thus, Attah (1986) notes that utilization of public health facilities in the Imo State of Nigeria declined partially due to high cost. Waddington and Enyimayew (1990:288) also observe that,

"utilization of both rural and urban health facilities dropped dramatically after the 1985 fees increase but went up again later".

In view of these interpretational and implementation difficulties, the need for this research to examine the operations of the policy on the ground as well as its effects on both health services providers and consumers, is necessary.

AIMS OF THE STUDY

The basic concern of this study is to research into the operation of the 'Cash and Carry' System and how the policy is being implemented at the health facility level.

In furtherance of this objective the following specific issues shall be discussed.

1. How do local implementors understand and implement the policy?
2. What effect has the policy on the attitudes of the implementors?
3. What are the effects on the recipients?
4. What opinions have people formed about 'Cash and Carry'.

THEORETICAL PERSPECTIVE

A theoretical frame of reference which this study may want to employ is the functionalist perspective. This has a broad subject matter in social theory and its origin is traced to the Greeks. Functionalism employs a holistic approach to explaining social phenomenon.

History traces the modern doctrine of functionalism to Montesquieu. However, it is probably from Comte (1798 1857) that its recent influence derives. Comte recommended, as one part of Sociological enquiry, "Social Statics". This he explained as the study of the coexistence of social phenomena. Underlying this was the notion that all the institutions, beliefs, and morals of society are interrelated as a whole, so that the method of explaining the existence of any one item in the whole is to discover the law which prescribes how this item coexists with all others. For Comte, this was part of a grand scheme of planning the total reconstruction of Society.

Also, Herbert Spencer (1880 1903) made a significant contribution to the functionalist conception of society. Thus, he made specific proposals, drawing functional analogies between the processes of organisms and society. Though this was not the fundamental concern, Spencer sought to show that sociology should aim to analyse the structure

of societies in order to show how each part contributes to the functioning of the whole. He constructed an evolutionary typology of societies which, like organisms, exhibit varying degrees of structural complexity which can be measured in terms of the number of different types of elements which the structure is composed. Where the structure consisted of a number of like or identical elements, each would turn to be more or less self-sufficient. Where it consists of dissimilar elements, the structure is internally differentiated, there is greater degree of interdependence between the parts. Spencer thus argues that, greater differentiation of structure made for greater integration of the whole, which made it more able to survive by reducing internal disharmony (Rumney, 1966).

However, by far, the functionalist argument owes more to Emil Durkheim than Spencer. In his writings, Durkheim (1858 1917) was influenced by biological thinking. His early views were directly influenced by those of Spencer, whom he strongly criticized.

Thus, in his book The Division of Labour Durkheim made clear distinction between the function of division of labour and its efficient cause. Its function was the integration or reintegration of society while its cause was the increase in "moral density" resulting from population pressure. Durkheim therefore argues that, when there is an increase in

pressure of population and increase in social interaction there is a breakdown of the constraints built into the simple "segmentary" society and an increase in competition which threatens the social order. This increased rivalry and competition is reduced or even controlled by the adoption of specialised tasks which made men dependent upon one another and therefore more likely to accept a morality of mutual obligation.

Our perspective from the foregoing is that, health institutions (modern or traditional) are common in every society and these are organized and directed towards controlling diseases. The essence of this, is to promote a healthy population and hence a healthy working force to enhance development. This therefore makes the health institution, an integral part of the society. It shows its relation and coexistence with other institutions as they function as one.

In recognition of its (health) integrative role in society it has been observed that, illnesses should be socially controlled in order that it does not impair society's functioning. For, it is certain that a society can function only when its inhabitants are healthy. (Parsons, 1951). An unhealthy population therefore, finds life difficult. As a result of this every nation strives for adequate health care delivery system.

Malinowski (1944) also observes that human behaviour and hence the institutions that organise the behaviour of its members into meaningful patterned activities, arise in the first place because of the biological needs of men. He tried to develop a scientific theory of culture on this premises of biological needs arguing that all the manifold activities of men are directly or indirectly related to man's needs which he, as an organism requires in order to survive.

This assumption is based on the fact that the fundamental activities of men are directly and indirectly related to man's needs for survival. But survival can only be reached by promoting proper health care institutions which are principal instruments in providing health care. Man's activities however, have generally affected the operations of health institutions such as hospitals. These institutions have implemented varied policies which have also influenced people's attitudes towards seeking health care. Thus, eventhough 'Cash and Carry' is seen as a burden on people, nonetheless the need for health care makes people to adjust in order to fulfil their basic needs. Hence this implies that, a change of policy on health institution makes people respond by making adjustments in their life patterns.

Conditions may change through policy influence and parts of society may find life difficult. This will certainly call for a readjustment of a sort in order that the individual fits into the various parts of the society. It is in this direction that we see the 'Cash and Carry' policy constituting a change in health institutions and hence affecting people's health care seeking behaviour.

Indeed Twumasi (1975 : 5) also elaborates on the point being made when he asserts that "the whole area of medicine as an aspect of human behaviour would seem to fit directly Malinowski's assertion that human institutions are based upon individuals' biological needs". He notes also that Hertzler (1964) within this vein of thought pointed out that, social institutions are purposive, regulatory and consequently primary cultural configurations, formed unconsciously and or deliberately, to satisfy individual wants and social needs bound with the efficient operation of any plurality of persons. They consist of codes, rules and ideologies, unwritten, and essential symbolic organisational and material implementations. They evidence themselves socially in standardized and uniform practices and observances, and individually in attitudes and habitual behaviour of persons. They are sustained and enforced by public opinion, acting both informally and formally through specifically devised agencies".

Clearly, health care needs and the institution that provides health services is important to man's survival in the society. The operation of such an institution therefore requires purposeful human action or behaviour in order that the health institution performs its expected function for the general upkeep of the society. Indeed, it has already been noted that, "human behaviour (activity) generally involves the manipulation of his environment in order to achieve a purpose" (Twumasi, 1975:4).

It is therefore our opinon that, the introduction and operations of 'Cash and Carry' is an important policy stand in Ghana where "the Government provides about 70 per cent of health delivery services" (Addo, 1996:20). And for the people of Bolgatanga, such a policy has the potential of influencing health care services as well as health care seeking behaviour at the regional hospital. Thus, as far as money or cost recovery is concerned, the ability and willingness to pay is very important to the utilization of the hospital. As has been noted, "ability and willingness to pay as well as the perceived quality determines largely the utilization of health care services" (Vogel and Wouters, 1991:253).

In a deprived community such as Bolgatanga therefore, the obvious issue of concern with regards to 'Cash and Carry' is affordability. In

other words how the people will be able to afford the cost of utilizing the hospital so as to enjoy good and quality health services for the general upkeep of the society becomes important. Indeed, the health institution needs to function efficiently under such a policy in order to supply enough labour force and relate positively with other institutions.

It is therefore, the position of this study that, for society to function properly the various segments or institutions need to be fairly co-ordinated and corelated. And for the health institution, it should reasonably supply productive labour force to carry out various important tasks. It is therefore in this respect that Archampong (1990) observed that, national development is closely bound up with the health of people, who generate the wealth of the nation. No meaningful development can therefore take roots unless it involves a change in the living circumstances of the people concerned, that is the people in the area of development activity.

1.5 LITERATURE REVIEW

Since the early 1970s, health financing has attracted the attention of policy makers, economists and other social scientists. This interest has been generated by the economic misfortunes of developing countries and especially, the limited option available to them. Added to this is the

pressure from international donors such as the World Bank towards privatization and some form of free market economy to allow the interplay of supply and demand in the public health sector (Creese, 1992). In many cases therefore, developing countries have had to introduce user charges as a way of alleviating the burden of funding health care though this approach is Western-derived. Thus Kidson (1993) observes that, the approach is quite disappointing and inappropriate as it does not lay adequate emphasis on elements of the developing country systems. Also, the nature of health care in these developing countries make the classical economic theory inappropriate (Adjei, 1995).

In an apparent attempt to justify the need for user charges or cost recovery in health care, the World Bank in a technical report (No. 82, 1988) for selected West African countries namely, Senegal, Cote d'Ivoire, Mali and Ghana points to the deplorable nature of health care of these countries. It notes that this has been aggravated by declining health budgets, deficiencies in supplies of drugs and equipment, longstanding inefficiency and misallocation of resources. (Vogel, 1988).

It thus remains undisputed that, the global economic recession of the late 1970s and the early 1980s led to further strain on the economy of many developing countries with already high debt burden.

The consequences of this poor economic trends led to the reduction of public sector allocations to the health sector (Wouters, 1991). In Africa, per capita GDP for example has rather grown slowly. Thus between 1967 and 1988, growth in GDP averaged 3.4 per cent. This barely exceeded the rate of population growth for the same period (World Bank, 1989). Increasing number of Africans are therefore forced to share shrinking national pie in real terms.

The effect of this trend Vogel (1989) observes, is the reduction in per capita spending on health care. Thus, it has been noted that per capita government expenditure on health for sub-saharan Africa for the period 1975 - 1985 increased from US $6.15 to $7.56 in 1980 and declined to $6.62 in 1985. This implies, between 1980-1985, there was a "decline of 12.4 per cent in health expenditure" (Vogel, 1988:168).

In Ghana, it was noted that between 1980-1985, public health expenditure declined by 33.7 per cent and for Senegal and Cote d'Ivoire the decrease was 49.5 per cent and 53 per cent respectively (World Bank, 1989). Also, shortage of foreign exchange needed to purchase inputs such as drugs and equipment added a further strain or pressure on the health sector and the consequent deterioration. As a result, observations in Kenya which is applicable to Ghana indicate that chronic financial

stringency has resulted in frequent shortages, non-maintenance of equipment and under-payment of personnel have seriously eroded the quality of services provided in the public health care system (Ellis, 1987).

In Ghana, there has been no significant improvement from the recessions of the 1970s and 1980s. Consequently, funding health care remains an urgent problem and hence user charges becoming an attractive alternative of finding resources for health care. (Goodman and Waddington, 1993).

A justification for such approach appears to be that firstly, user fees will instill appreciation by consumers (patients) of the true value of health care provided free or subsidized at points of use. This subsequently will ward off frivolous use of health care facilities (Creese, 1991). Secondly, despite free health care, people do pay for health services. As a result studies have shown that, price elasticity of demand for health care is less than 1. Hence, fees for medication would increase revenue substantially, without deterring the use of the services (Mills and Lee, 1993). In almost all cases therefore, health managers envisage that hospital fees will help improve quality of care. As a result little consideration is given to the people's 'ability to pay' or 'afford'. Meanwhile, consideration of quality has important implications not only

for achieving market equilibrium or market efficiency, but also affordability. Specifically, "efficient and effective health care programs are not necessarily affordable" (Wouters, 1991:260). It was also observed that, affordability depends on whether total revenue exceeds total costs. Where quality improvements are costly but not perceived by patients to be necessary, the facility is likely to experience a drop in utilization and net revenues. On the other hand, it has been noted further that, if quality improvements are valued by patients, utilization and willingness-to-pay may increase, resulting in positive net revenues.

As has been generally observed, studies on demand and supply of health care show that, "quality, like price affects the market equilibrium" (Wouters, 1991:258). Hence, differences in the perception of quality by providers and consumers may hinder reconciliation of demand and supply. On the demand side, willingness to pay depends on the perceived quality of care such as patients' compliance and acceptability in addition to other socio-economic and demographic factors. On the supply side, the marginal cost of providing health care depends on provider requirements for the quality of care. (Donabedian, 1980).

Some studies have observed also that improvement in health services and quality of care is not sufficient to lure patients to the hospital

if they can not afford the cost of the services. Asenso-Okyere, (1993:14) therefore notes that "demand for health services depends upon the elasticity (responsiveness) of price for health services and other prices as well as income elasticity". This implies that people tend to consume more health services when the price is low or when their incomes rise. It has been shown therefore that, the price elasticity of demand for health services is high for low income groups than it is for the high income groups. Gentler and Van der-Gaag (1988) note in Cote d'Ivoire that the responsiveness of the use of clinic and hospital services to the price of the services for the lowest income quartile was between three and six times that for the highest income quartile. These results indicate that user fees are regressive and they substantially reduce the utilization of health services by the poor.

Studies in Ghana also indicate a drop in utilization immediately after user fees were introduced (Vogel, 1988). Thus, Waddington and Enyimanyew (1989) report the attendance behaviour of outpatients at a health centre and two health posts in the Ashanti-Akim District of Ghana after the introduction of user fees in 1985. Within the first six months of the introduction of user fees, attendance at the health centre declined by 50 per cent. Thereafter an increase was observed until the end of 1987 at which time the rate was about 15 per cent above the level achieved at the

time of introduction of the fees. The rural health post experienced severe decline in attendance and these rates have never recovered to pre-fees levels. Asenso-Okyere (1993:14) thus observes that, "the basic social security that was inherent in the orthodox health delivery system for rural people was lost with the introduction of cost recovery or cost sharing".

However, some other studies report of increase in utilization in Sierra Leon (Sierra Leon/UNICEF 1989), Guinea and Benin (U.N. 1990) after the introduction of fees with simultaneous improvement in service quality. Analyses of changes in utilization after implementation of cost sharing or user fees programs have thus been of uneven quality, making definitive conclusion difficult to draw (UNICEF, 1990).

Adjei and Aryee (1995) also note that, though quality of care may be a powerful factor, the cost may equally be important for those who do not have the means to afford it. Consequently, it is important to note that user charges have multiple effects. Fees may generate revenue from patients who judge the service to be worthwhile at the going price. At the same time however, it could divert patients who either cannot pay for the services or judge the services to be less desirable as compared to some other alternative sources (Creese, 1991).

In other respect, some studies observe that other considerations outside quality of care affect utilization of health facilities. Thus Owusu and Ablordey (1993) note that, low utilization of health services have been the result of people's preference and satisfaction for herbal medicines as against orthodox ones. Principally, this is due to cost and the belief that some ailments are incurable at the hospitals. Waddington and Enyimayew (1989:306) also note the use of herbal medicines in the Volta Region of Ghana. This practice is prevalent because in the opinion of the people, their (herbalist) stocks "tend to be good". Yoder (1989) indicates that despite the wide spread of scientific medicines, 80 percent of the Swazi people patronize traditional medicines once a year.

On the whole, economic literature on health care indicate that quality is an important determinant of utilization patterns and that people's willingness to pay has a relationship with the quality of services they receive. Hence Vogel and Wouters (1991) indicate that people will not come to pay (fees) if they do not perceive improvement in the quality of care they receive. It therefore implies that, patients shall appear willing to pay for higher quality service patterns.

It is indeed, in this vein of thought that, demand studies, focusing on price and income elasticity of user fees on the utilization of health

facilities and cost studies, have indicated that the quality of service is an important and significant factor in the design of health care financing mechanism. In whatever respect or consideration that utilization of health institution may be viewed therefore, hospitals with improved quality of care shall have more potential of attractiveness.

Our focus in this review has been the effect of economic recessions on health financing in developing countries and the limited options available to them. User fees have been identified as an attractive alternative. However, the effect of this is not limited to the consumer but the service providers as well. Also, quality and utilization of health services have been seen to be largely related. Consequently, the position taken by this review is that, utilization of health services can be well understood not only from the view point of health service providers but patients as well, considering the socio-economic and cultural realities.

1.6 RESEARCH METHOD

Data for this research were collected from two main sources namely: primary and secondary.

At the primary level, data were obtained through questionnaire administration by the researcher. A structured questionnaire was designed and questions asked related to the basic objective of the study.

Though this approach has its limitations in terms of cost time and interview bias, it was used due to its advantage of ensuring that respondents answer all questions. It is also considered appropriate and useful for all categories of population, especially low-education and rural folk. It further provides rich information and sense of security since data collected is based on face to face interaction with respondents. Margin of errors may therefore be minimal.

In the secondary level, various literature of the economics of health care provided useful information. These were largely obtained from the MOH library at Adabraka, Accra, the Medical School library, Korle Bu, Accra, and Bolgatanga hospital among others.

In addition to these, focus group discussion (FGD) was considered appropriate and useful to the study. This is because, this approach in recent years has gained increasing acceptance as a research methodology in the field of health. Thus, Senah (1997:40) notes that, "this methodology has been accepted by applied researchers in the fields of

health and population as a means of gaining greater insight into those human behaviours relevant to morbidity, mortality and fertility".

Much as this approach has some strengths, there are weaknesses too. On one hand skeptics point to the fact that FGD are not appropriate if quantitative, population-based measures of behaviours are required and that number of people interview are usually small and hence their responses could be influenced or biased by hearing the opinion of other members. Results from FGD can therefore hardly be generalized.

On the other hand, advocates of FGD submit that, the approach can yield results similar to those obtained from surveys. Others also argue that, there are many field situations in which statistical precision may not be an issue. Rather, the main goal is to obtain programme-relevant data on attitudes, beliefs and behaviours that can be obtained relatively quickly and at low cost.

The researcher, in view of these advantages, held useful discussion with the hospital pharmacist, a senior medical officer and groups of nurses on duty in various wards. All these discussions were tape recorded.

1.6.1 SAMPLING PROCEDURE

In view of the difficulty in reaching every single character of a population under a study, sampling has become necessary since it can provide a fair representation of shades of opinion of the entire population. Thus, sampling is the use of definite procedures in the selection of a part for the express purpose of obtaining from its description or estimates certain properties and characteristics of the whole. (Kumekpor, 1989:121). In sampling therefore, the main objective is to select a portion of a universe so that, the results obtained may be generalized or extended to the whole population.

In this respect, our sampled respondents were persons who are either health care service providers or consumers. Our sample procedure therefore varied, depending on whether an individual belonged to the group of providers or consumers.

For the health care service providers, the hospital pharmacist by virtue of his position was purposively sampled. This was in recognition of the role expected of him as far as the operation of 'Cash and Carry' is concerned. The choice was therefore at the discretion of the researcher.

Also, of the four senior medical officers at post at the time of the research, one was randomly selected for a discussion. This approach was to provide all the senior medical officers equal chance of being chosen or excluded. The underlying principle was thus the simple law of chance or probability.

The last target respondents among the service providers were the nurses. In this respect, of the eight wards in the hospital, three were randomly selected. Those that eventually emerged were children, maternity and emergency wards. In all these wards, four to six nurses on duty took part in the discussions.

On the whole, these discussions were quite cordial and this is largely attributable to the introductory letter from the Department as well as the concern expressed by the hospital patron. Reception was quite warm and co-operation very high.

With consumers of health services, these were also divided into two viz, patients at the OPD or on admission and those persons at home who have directly or indirectly (through relations) paid for user services.

In the first category, respondents at the OPD were randomly sampled. Thus respondents were selected purely by accident. Though this approach is sometimes considered unrepresentative and biased, it is nonetheless commonly used by social workers due to its advantage of low cost, convenience and quick results.

For the patients on admission, four wards out of the eight in the hospital were randomly selected. Though this approach also has some element of bias from the researcher it was considered appropriate due to its convenience and time saving.

By the close of the ninth day, seventy respondents had been interviewed at the hospital. Below is the breakdown of the various points or units

QUESTIONNAIRE DISTRIBUTION AT THE HOSPITAL

SECTION	NO OF QUESTIONNAIRE	PERCENTAGE
Out Patient Department (OPD)	20	28.6
Children's Ward	15	21.4
Emergency Ward	15	21.4
Maternity Ward	10	14.3
Male Surgical Ward	10	14.3
Total	**70**	**100**

For the second category of respondents (those at home), the town was divided into seven sections for purposes of identification. House numbers and major roads were used in this identification.

Of these seven sections identified, four were randomly selected and questionnaire distributed on a quota basis. Though this may be quite unrepresentative, it had to be used because, available records do not reflect present populations of the sampled areas due to new settlement plans in Bolgatanga. A quota sample of twenty questionnaire per area was therefore considered appropriate with the assumption that, this will provide a fair representation of shades of opinion in the respective areas.

In each of the four areas selected, a systematic random sampling of houses at intervals of three was adopted. This principle was to allow the spread of questionnaire across each section and to capture various shades of responses. In each targeted house therefore, one to three inmates were interviewed depending on the size of the household. The basis of selection of respondents was a simple random sample. This approach thus provided an equal opportunity of being chosen or left out.

In all 49 households were interviewed and each interview took between twenty to thirty minutes depending on how respondents understood the questions and readily provided answers.

Below is the distribution of questionnaire in the sampled areas:

QUESTIONNAIRE DISTRIBUTION IN SELECTED AREAS

AREA	**NO. OF QUESTIONNAIRE**	**PERCENTAGE**
Junior Staff Quarters	20	25
D-Line/Zongo	20	25
Sawaba	20	25
Estates	20	25
TOTAL	80	100

1.6.2 QUESTIONNAIRE ADMINISTRATION

There were two sets of questions. The first set was a question guide intended for health workers during focus group discussions. The second set was a structured questionnaire meant for the consumers of health services.

In the first instance, group discussions were held and questions were posed to respondents as appeared on the question guide. All responses were then tape recorded and these were played back at the end of each day to ascertain and record what had been discussed. However, there were follow-up questions which were outside the question guide. Such questions were generally to clarify or allow further explanations on some issues raised. For example it was such deliberations that brought to light the fact that nurses hardly enjoy any refund for health services. Some claim they had never enjoyed it though bills or receipts are usually collected.

In the second category, discussions were quite smooth. The researcher asked respondents questions as appeared on the questionnaire and recorded their responses accordingly. This approach was intended to cater for persons who could not read or write. It was also to avoid possibilities of misunderstanding, misinterpretation and deviation from

questions. The researcher thus exercised enough control over the interview situation. Generally, the understanding of Frafra and Hausa which are commonly spoken in the town greatly enhanced the interview. However, the few educated respondents who felt it more convenient to fill the questionnaire by themselves at their leisure, were allowed to do so. Arrangements were therefore made to collect such questionnaire later.

On the whole, both the group discussions and interviews were quite cordial. This is attributable to the rapport always established before the commencement of any discussion and the researcher's ability to use the local medium of communication.

1.7 FIELD EXPERIENCE

The twenty-four days of field work could not have been without experiences and limitations. The initial response was generally warm. However, the value attached to the research was rather discouraging. Indeed, my own inference is that low literacy levels coupled with feeling of insecurity contributed to respondents' lack of appreciation of the value of the research. For example, in two households respondents felt I was a police detective. However, my experience with the local lingua franca was a timely saviour. Some amount of rapport had to be established

following series of questions from respondents about the objective of the research.

On a quite note, I had to allay fears of many respondents in order to obtain their responses. Infact, in some cases, respondents were not prepared to sacrifice a few minutes for discussion. The impression gathered was that, they feared to commit themselves as some thought names and personal information would be requested. However, with the inpatients, response was readily provided. Infact, in some cases, patients took me for a medical officer who needed some information to enhance their treatment or offer any assistance. Also, it became clear that my presence had some influence on responses given. This was possible due to the in-built rapport and the creation of relaxed atmosphere which convinced respondents to co-operate.

It was further clear that the interviewer questionnaire was very helpful in the data collection especially, when dealing with such a low level educated population. For example, some respondents had difficulties in reporting exact monies paid when they visited the hospital. Time, therefore had to be taken to ask and add up the various amounts paid at various points from the OPD till points of purchasing or paying for drugs. In some cases approximation had to be made. Age reporting

was also realized to be poor. Thus physical appearance, number of children and other considerations were helpful in determining or estimating respondents' ages. Though the approach was quite costly in terms of time needed for questions, explainations and clarifications where necessary, it was still appropriate due to its quick results and the tendency of avoiding much errors, misinterpretation and misunderstanding of questions.

CHAPTER TWO

HEALTH CARE FINANACING IN GHANA

In this chapter, the focus shall be a comprehensive account of various efforts by policy makers over the years to accommodate the cost of health care. Such an exercise is important in order that we understand fairly the constraints of the health sector and how governments have had to deal with them.

In Ghana, health services are generally provided by a number of agencies or institutions including MOH, quasi-Government institutions, private medical practitioners and non-governmental organisations. However, the MOH is the single largest provider and it accounts for about 70 per cent of health delivery services (Addo, 1996). Consequently, funding health care as well as other social services has been a major expenditure item in Government annual expenditure since the 1960s. For example, social services took 31 per cent of the government estimated expenditure of £G144 million in 1963 / 64 fiscal year. (Birmingham et al, 1966).

In spite of Governments' desire to provide adequate funding to social services, the economic crisis of the 1960s posed serious

constraints. Thus Ninsin, (1989:6) observes that "by 1965 the economic crisis was becoming severe and the material conditions of majority of Ghanaians were showing serious signs of deterioration once more".

This crisis indeed continued into the 1970s and reached its peak in the early 1980s. As a result, health like other social services suffered greatly. Waddington and Enyimayew (1990) thus observed that the economy was volatile and unfriendly. Per capita income had fallen by one-third between 1974 and 1982. Population outgrew food production and inflation had reached three digits in the early 1980 116 per cent in 1981.

These economic crises naturally affected the health sector performance. Consequently, as Cornia and Stewart (1987) observed, infant mortality which was approximately 80 per 1000 live birth in the mid 1970s rose to about 100 in 1980 and 115 in the drought year of 1982 / 83. Hospital attendance dropped to about one-third between 1979 83. Medical supplies situation also deteriorated with drug such as chloroquine and aspirin in short supply. General infrastructure had broken down leading to loss of public confidence in health care services. This period also experienced a decline in skilled personnel. Thus, the number

of medical doctors fell from 1648 in 1980 to 810 in 1985. By 1988, the number had risen to 980 (Ewusi, undated).

In view of these constraints, Government found it extremely difficult maintaining its level of funding for health services. Consequently, the need to launch the ERP/SAP was inevitable.

ECONOMIC RECOVERY PROGRAMME (ERP)

In an effort to reverse the decades of precipitous decline and improve the macro-economic environment, the Government launched in April 1983, the ERP/SAP. This programme was in two phases; phase one covered 1983-86 and phase two, 1987-89.

According to Asamoa (1996) the ERP sought to arrest and reverse the decades of decline in productivity. It aimed at controlling inflation, rationalize exchange rates, and rehabilitate ruined productive and infrastructural facilities. Above all, the ERP sought to mobilize the needed domestic and external resources to restore the living standard of Ghanaians. The macro-economic environment was generally the focus.

In the health sector the programme focused on the rehabilitation of infrastructure and the provision of increased supply of drugs and other medical materials. In furtherance of these objectives, the ERP recommended cost-sharing. This entails the paying for user services in order to enhance cost-recovery on the part of the government. This recommendation therefore requires consumers of health services to pay the full cost of drugs. The purpose of this was to ensure the availability of enough resources (funds) for the smooth running of health services, especially drug supplies.

On the whole, the impact of the ERP was quite immense. As Asamoa (1996 : 102) observed, "conditionalities involve included; devaluation of the cedi, reduction in subsidies on food, petrol and agricultural inputs, trade liberalisation and better management of public expenditure". Redeployment of redundant labour therefore followed and the health sector like others suffered budget cuts. As a result, adequate health financing was a serious constraint. Consequently, the MOH had no option but to depend on foreign aid. Thus, from £1 million in 1984, foreign aid to MOH rose to £11.5 million in 1990 (World Bank, 1990). The table below shows the quantum of foreign aid to the MOH.

FOREIGN AID TO MOH (1984 - 1990)

YEAR	AMOUNT
1984	£1 million
1985	£3.4 million
1986	£7.9 million
1987	£9.2 million
1988	£13.7 million
1989	£13.5 million
1990	£11.5 million

Source: World Bank 1990.

It is obvious from the above that, the health sector is heavily financed externally. Indeed, up to 70 per cent of the Government current health budget is from foreign sources.

In spite of the difficulties of the ERP, the programme nonetheless chalked some successes. It has been observed for example that, GDP increased annually by 6.3 per cent between 1983-86. Inflation declined from three digits to a range of 12-15 per cent. Rehabilitation of some infrastructure also took off. (Asamoa, 1996).

However, these improvement did not make significant impact on the living standards of Ghanaians. Hence the introduction of the Programme of Actions to Mitigate the Social Costs of Adjustment (PAMSCAD).

This program was conceived in 1987 from a report of the Government of Ghana and the UNICEF in an effort to reduce the suffering on the people resulting from the implementation of Structural Adjustment Program (SAP) in 1983 (UNICEF, Accra 1987).

PAMSCAD was estimated to cost ç14.3 billion equivalent to US $83.88 million (Asamoa, 1996). Of this amount, the foreign component was US $37.63 million representing 44.9 per cent.

Beneficiaries of the program included rural households with low productivity, areas with poor access to social services, retrenched workers and the unemployed.

Principally, the health component of PAMSCAD centred around the following:

(i) De-worming primary school children

(ii) Supplementing feed and nutrition education

(iii) Hand-Dug wells and low cost sanitation

(iv) Sale of Essential Drugs at Health stations by community health workers.

Indeed, this programme could to a large extent alleviate the social pressure of the ERP regime if meticulously translated into reality. However, the project is said to have suffered from technical uncertainties. The co-ordination and monitoring framework was bureaucratically top-heavy and the resource base was quite fragile.

2.3 HOSPITAL FEES

In Ghana, the history of hospital fees can be traced to the Easmon Committee appointed by the military junta (NLC) that overthrew the Nkrumah government in 1966. This committee in its report to the government recommended that hospital fees be raised and collection strictly enforced (Easmon Committee; 1969). This was in response to the fact that health like other services, placed heavy burden on the economy (Senah, 1989).

In an effort to divest the state of some social responsibilities, the NLC in February 1968, introduced a statutory dispensing fee of 30 new pesewas in addition to the token hospital charges already in existence (Senah, 1989). Though this directive had to be shelved following public outcry, it was gazetted as NLC Decree 360 in January 1969 and to be effective from October 1, 1969 when the military junta would have handed over power to an elected civilian government headed by Dr. K. A. Busia.

Eventually, another public outcry resulted in the suspension of the decree and the consequent setting up of the Konotey-Ahulu Committee. This body was charged with investigating all matters relating to hospital charges. As a result, the committee observed that the cost to government in respect of drugs dispensed freely was very great. The committee on that note, recommended that, for the generality of patients including civil servants, out-patients care and treatment (including ante-natal care) should no longer be free, and that something be paid towards the cost of drugs dispensed in government hospitals and clinics. (Konotey-Ahulu report, 1970).

In 1971 the Hospital Fee Act 387 was passed. This act set low fees for curative services and the rationale was to reduce excess demand or

what some people call 'frivolous' demand. Revenue raising was not the key issue (Waddington and Enyimayew, 1990).

Also in July 1983, fees were raised. For the adult non-specialist outpatient consultation, five cedis per head was required and children were expected to pay 50 per cent of the adult charges plus three cedis for each drug prescribed. Also, cost of investigations varied from two cedis for routine laboratory services such as blood groupings to twenty cedis for X-rays (MOH, 1983). In this period, "non-Ghanaians were for the first time discriminated against" (Senah, 1989:253). They were required to pay anything ranging between 100 and 120 per cent of the rates for Ghanaians.

In spite of this rise in fees, it was still evident that the Government needed something more drastic in view of falling per capita government expenditure on health, population growth and persistent requests for better health care services.

Consequently, in response to these constraints, the MOH in a circular indicated the inability of the state to provide free medical care (MOH 1985a). The circular pointed out that, little impact had been realized of the 1983 fees. This is because all revenues collected were paid

into the consolidated fund and this did not influence the MOH's normal budgetary allocation. Also, fees charged according to the circular were smaller than the real cost of services. Funding was therefore inadequate. Hence, MOH recommended additional fees be generated to arrest the declines of health services.

In July 1985 therefore, hospital fees were substantially increased, partly on the recommendation of the World Bank (World Bank, 1985). As a result, the MOH envisaged revenue generation to the tune of 15 per cent of its total recurrent expenditure in 1986-1988 (Vogel, 1989).

The table below reveals the MOH cost recovery as a percentage of recurrent budgets from 1985-1992.

YEAR	MOH RECURRENT BUDGET (IN MILLION CEDIS)	USER FEES RECEIPTS (IN MILLION CEDIS)	USER FEES AS % OF RECURRENT BUDGET
1985	3,765	194	5.2
1986	6,497	520	8.0
1987	6,856	851	12.4
1988	9,833	977	9.9
1989	15,833	1,160	7.3
1990	20,242	1,140	5.6
1991	22,557	1,342	5.9
1992	24,705	1,646	6.7

SOURCE : MOH 1992

Although, the MOH observes that the 1985 proposed fees were considerably high, nonetheless they were considered economical (MOH 1985a). Attempt was made to achieve a careful balance between realistic fees and ability to pay on one hand, and the need for Government to provide some form of care. For example, outpatient fees were graduated in favour of the rural dwellers, meaning patients in rural areas pay

comparatively less than patients in urban areas. Despite this, the 15 per cent target promised was not achieved.

As indicated in the table above, the highest revenue realized was 12.4 per cent in 1987. This is below the 15 per cent target set. Hence, Dakpallah (1988) notes that the exemption of MOH staff and their relations account for 21 per cent of revenue. This no doubt partly accounts for the short fall in target set. Forster (1988) also observed that, the non collection of particular fees and the increasing replacement of cost of drugs created the short falls and hence the inability to meet target set.

For purposes of ensuring the appropriate use of revenues generated by MOH, health posts, health centres and hospitals were required to keep 50 per cent of all revenues at the institutional level. This was intended to supplement normal budgetary allocation and enable each institution to purchase minor needs such as stationery and disinfectants and undertake maintenance and repair of minor equipment (MOH 1985a). Such funds were not to be used for any capital project. They were meant to "improve the immediate environs" (MOH 1985b).

In July 1986 however, the initial arrangement of keeping 50 per cent of revenues generated was amended. The new rule now requested that, health centres or clinics should spend only 25 per cent of retained money, while District and Regional hospitals spend 50 per cent. Psychiatric hospitals were however permitted to spend 100 per cent of revenue generated.

In 1992, the cash and carry policy (the subject matter of this study) obtained green light for operations nationwide (MOH 1996). This policy is basically a modification of the earlier cost recovery idea which was to ensure that hospital revenue went back to government central treasury to augment the overall government budget.

Under this new programme, patients or users of health facilities are required to pay fees which could be for consultations, drugs, dressing, diagnostic tests or all of these things. Eventually the full fees (100 per cent) paid are expected to be retained by the hospital and forwarded into a drug fund. It is this fund that is often referred to as the "Revolving Drug Fund". The purpose of this is to enhance further procurement of Essential Drugs and other medical supplies for health facility users.

Though this policy requires the charging of fees and retention of all revenues collected, the policy makes room for some exemptions in Act 387. These include:

1. Exemption based on disease such as leprosy and tuberculosis.
2. Exemption on particular services. For example medical examinations.
3. Exemption for laboratory services.
4. Exemption for casualty treatment-emergency
5. Exemption for particular class of persons. For example the aged/students.
6. Exemption based on employment status and age.
7. Exemption for maternity.

(MOH 1996)

In terms of performance, Cash and Carry has generally been recognised as an efficient and reliable cost-recovery mechanism. As observed by MOH (1994) it is a most reliable source that has generated sufficient income to cover recurrent costs of health institutions. Hence, between 1992 and 1994, revenue realised increased from Ç2.7 billion to Ç4.3 billion. This represents an increase of 59 per cent. As a result of this, the Ministry is able to finance about 70 per cent of its drug procurements.

The table below shows the performance of Cash and Carry in terms of revenue generation countrywide.

MOH REVENUE GENERATION BY REGION (1992 - 1993)

REGION	AMOUNT GENERATED		PERCENTAGE INCREASE
	1992(Million Ç)	1993(Million Ç)	
Gt. Accra	366	406	11.0
Volta	205	252	25.0
Eastern	296	485	65.0
Central	129	203	57.0
Western	320	337	5.0
Ashanti	270	655	142.0
Brong Ahafo	150	307	104.0
Northern	55	76	38.0
Upper East	63	102	62.0
Upper West	48	73	52.0
Korle-Bu	450	910	98.0
KATH	310	409	31.0
TOTALS	2.7 Billion	4.3 Billion	59.0%

SOURCE : MOH 1994

It is clear from the above that revenue generation is quite remarkable. In the first year of the operation of the policy, whereas the Upper West Region recorded the lowest revenue generated (Ç48 million), Korle-Bu hospital recorded the highest (Ç450 million). A year later, the trend repeated itself. However, in terms of overall per centage increase, whereas the Western Region recorded the lowest (5.0%), Ashanti Region recorded the highest (142.0%).

2.4 BAMAKO INITIATIVE

In response to the rapid deterioration of the public health system in developing countries, UNICEF proposed a series of policy reforms often referred to as the Bamako Initiative.

Launched in 1987 by African Health Ministers, the Initiative intends to explore all possible ways of generating additional resources for health care financing (Wyles, 1989). Accordingly, UNICEF (1988) reports that, the Initiative aims at ensuring access to affordable essential health services for the people, while retaining costs. It also hopes to restore consumer confidence in the public health system by improving the quality of services and delegating greater decision-making power. It seeks further to foster better health by promoting behavioural change at household levels.

As Sam-Adjei, Ofori-Adjei and Asiama (1990) observed, the Bamako Initiative was designed to encourage maximum community involvement in primary health care (PHC) for improving quality of life for women and children through provision and sale of basic essential drugs supplies in order to build up a system of user financing and cost recovery and to establish a revolving drug fund which together with

support from the district and higher levels will ensure sustained health care.

Basically the Initiative is to achieve these objectives by encouraging community financing of essential health services and ensure the supply of basic drugs. It therefore involves the prescription of essential drugs and the setting up of a revolving fund to replenish such drugs.

Presently, the project is being adopted in various developing countries of Africa, Asia and Latin America. The Initiative continues to gain momentum and is increasingly being recognised as one of the most cost effective, sustainable approaches to revitalizing health care (UNICEF, 1995).

In Ghana, the program is still being experimented with. However, Ofori-Adjei and Amoa (1990) observe that one of its action is to mark up the prices of essential drugs and set up revolving funds which will be used for the replenishment of drugs and local operating costs and the revitalization and expansion of maternal child health services (MCH), maintenance of universal immunization and control of diarrhoea diseases.

The Districts, are the management units of this Initiative. On the whole, the operation of the Bamako Initiative and Cash and Carry (in Ghana) are interpreted to complement each other. They are therefore part and parcel of the Essential Drug Programme.

The Bamako Initiative has however, attracted criticism in international medical journals. Critics doubt the success of the programme as a result of:

(i) Lack of managerial skills at the community level.

(ii) Cost recovery may disqualify many of the poor rural folks.

(iii) Difficulties of obtaining foreign exchange for purchase of drugs.

(iv) Tendency to over prescribe drugs in order to accrue more revenue for salaries and maintenance facilities.

Also, the political implications can not be completely avoided. In addition, the issue of drugs appear over emphasised though it has been widely documented that, many of the health problems in third world countries, are not the question of drugs administration. Rather, it is the result of a complex interference of socio-cultural, economic and political considerations.

In response to these, favourites of Bamako Initiative indicate that, the reality in much of Africa is that, attempts at provision of free health care have resulted in inadequate or non-existent services for the poor and most vulnerable. Also, the idea of compensating providers of health and other services is a concept that is understood and accepted in much of Africa (MOH/WHO Nov. 1990).

2.5 HEALTH INSURANCE

In view of the escalating cost of health care and its effect on the poor and the most vulnerable groups, alternative sources are being considered and experimented with. One of such alternatives is the Health Insurance scheme.

This is a way of raising money in the form of premium for health care. Thus, the mechanism ensures a periodic payment by the insured person when well in order to guarantee his or her protection from future illness by an acceptable provider (Abel-Smith, 1992).

In Ghana research has gone into the possibility of a National Health Insurance Scheme since 1985. A number of recommendations have therefore been made to the MOH though, these are yet to be fully

implemented because of problems of organization, management of the scheme and its design (Asenso-Okyere, 1993).

The scheme is expected to be managed by a privately-run central agency, National Insurance Company, which would receive fixed premiums for both children and adults, rural and urban dwellers and contract services (ambulatory and hospital) with both public and private providers. The insured will therefore enjoy free services with three dependants at the facilities of designated providers. Re-inbursement to private providers would be through a fee - for services payment system for ambulatory care and itemized billing for hospital care.

It has therefore been proposed that initial coverage for the scheme be limited to identifiable groups such as private cocoa farmers registered with Ghana Cocoa Board, employees of the formal sector registered with the Social Security and National Insurance Trust (SSNIT) and Civil Servants. Policy holders are not to contribute.

Presently, the Eastern Region is being used for a pilot study. This programme started in 1995 and it requires persons in formal employment to pay a monthly premium usually deducted at source. Such amount are then transferred to the Insurance Fund which is eventually used to take

care of individual contributors and a number of their dependants when they fall sick.

By this arrangement, it is hoped that should the scheme prove successful in the Eastern Region, it will be extended nation wide. Meanwhile it is worthy to note that, a scheme of this nature is reported to have worked well at Nkoranza in the Brong Ahafo Region. The Catholic mission has been instrumental in this scheme as far back as 1980 when premium collected was Ç400. Presently, contributors pay about Ç1000 per month and this has given significant benefits to individual contributors.

However, it is worthy to note that individuals covered by insurance take fewer precautions to prevent illness. But those who become ill use more resources in treatment than they would if they were to bear the full cost of treatment. (Vogel, 1990).

On the whole, a National Health Insurance scheme has been recognised as a laudable idea. Together with other means of financing health care, it would greatly enhance efficient and better health care services.

CONCLUSION

Discussion in this chapter has been problems of health financing in Ghana. Efforts by successive governments to accommodate health cost were discussed. Attempt was made to review how the economic crisis of the 1970s and early 1980s affected the health sector.

The issue of fees was identified as an old phenomenon dating back to the Easmon Committee appointed by the NLC military junta in 1968. The chapter also focused on the ERP/SAP. This was a major programme by government to address problems of the macro-economic environment. In the health sector however, attention was focused on the rehabilitation of infrastructure and the provision of increase drugs supply and other medical materials. It is this policy that has eventually given birth to the Cash and Carry System.

The Bamako Initiative was also seen as another effort by government of developing country to respond to the deteriorating public health system. This initiative explored possible ways of generating additional resources for the health sector and ultimately it intends to ensure access to affordable health services. Health insurance is yet another avenue identified as a means for health financing. However, both

the BI and the health insurance scheme are still being experimented with in Ghana.

CHAPTER THREE

THE STUDY AREA

INTRODUCTION

This chapter is dedicated to providing a general overview of Bolgatanga. This is done so as to offer the reader a comprehensive outlook of the social, economic and political institutions of the study area. The focus therefore shall be, its location, role as an administrative capital, infrastructural facilities and various social amenities. Also to be discussed is the state of health facilities available with the Regional hospital being the focus.

Bolgatanga is located in the North-eastern part of Ghana. It is the regional capital of the Upper East Region. The district has various governmental and non-governmental agencies or organizations. These organizations perform various functions and together they contribute significantly to the socio-economic development in the district and the Upper East Region at large.

STUDY AREA
BOLGATANGA DISTRICT
EDGED GREEN

Bolgatanga is about 810 km from Accra the nation's capital. It occupies a land area of about 142.34 acres (about 439 sq.).The town is quite close to Ghana's boarder with Burkina Faso. It is a distance of about 32 km.

Traditionally, Bolgatanga is the native land of the Frafra whose language is Nankani. However, there are presently quite a number of other ethnic groups such as the Dagomba and the Akan. There are also the Kotoli of Togo, Moshi of Burkina Faso and the Hausa and Yoruba of Nigeria. These are mostly found in the muslim settlements such as the 'D line', 'Zongo' and 'Sawaba'. The main languages spoken in the town are Hausa, Frafra and English.

It has generally been noted that, many towns in Ghana started as villages. Settlement of people took quite a gradual process on account of several factors. Prominent among these are occupation, commerce and economic activities (Dickson and Benneh, 1970). The existence and interplay of these factors contribute largely to the growth of towns. Also, when an area has an advantage of good roads and transportation network that link it to surrounding areas, it has an advantage of central location. Thus Bolgatanga, like Tamale and Kumasi gained their present status

through their central location (Dickson and Benneh, 1970). They refer to them as "cross-road towns".

Historically, the central location of Bolgatanga, facilitated commercial activities which started around 1937. This was the time when motor vehicles were able to travel to the town. As a result, the town has since grown rapidly. In 1970, Bolgatanga had a population of about 18,896 and by 1984 it had grown to about 31,500. Presently, with the national average growth of about 2.8 per cent annually, the population is estimated to be about 227,568 (MOH, 1995).

The growth of Bolgatanga can be traced to the colonial era. During the colonial administration, the Gold Coast was divided into provinces and the entire stretch of the northern territories of the country was regarded as one administrative province. The seat of administration by then was Tamale, presently the Northern Region capital.

After independence, the Northern territories were divided into districts following the emergence of new ideas as to how the country should be administered for purposeful development and better life for Ghanaians. Consequently, Bolgatanga, in 1965 became a district administrative capital. The result of the arrangement was also the birth of

nine (9) administrative regional capitals with Bolgatanga being made the seat of the then Upper Regional administration. However, the country presently has 10 regional administrative capitals following the creation of the Upper West Region out of the then Upper Region in 1984.

Since the establishment of such an arrangement (in 1965) Bolgatanga has been performing the function of a district and regional capital of the Bolgatanga district and the Upper East region respectively. The Upper East Region is the smallest region in Ghana. It has six administrative districts namely; Bolga, Bongo, Sandema, Zebilla, Bawku and Navrongo. In spite of its small size, Bolga has seen many changes (development) in terms of infrastructural facilities. These facilities enable it function as an administrative capital (district and regional).

3.1 SOCIAL AMENITIES

Bolgatanga like many other towns in Ghana has been provided with a number of social amenities. These have given the town an urban outlook. First and second cycle institutions have been provided for the enhancement of circular education. At the first cycle level, there are 85 primary schools and 47 Junior Secondary schools as at the beginning of the 1997/98 academic year. The principal actors at these levels are the

Missionaries and the Government. However, the latter has the majority share. At the second cycle level, there are five (5) secondary schools, two (2) vocational, two(2) secretariat and one (1) technical. All these are state funded institutions.

There are also six banks operating in the district. These include: Social Security Bank, Ghana Commercial Bank, Standard Chartered Bank, Agricultural Development Bank, National Investment Bank and the Co-operative Bank.

Bolgatanga is also hooked to the national communication network through the Upper Regional Administration (URA) radio station. The Government in 1984 commissioned this facility and it helps to link the two sister regions Upper East and Upper West through the major local languages.

The town further enjoys 24 hours electricity services from the national power grid. This facility has enhanced the supply of piped water as well as activities of various small scale businesses such as millers, hair dressers and hoteliers.

The main source of pipe borne water to the town is the Vea Dam located about 9 km. away. The dam is also used for farming purposes. Other sources of water are boreholes and dugout wells. According to IDA as at December 1995, 407 bore hole had been sunk and 331 of these were operational. In addition 16 dams and 13 dugout wells are sources of water to the people.

There are also a number of health institutions to cater for the health needs of the people. These are made up of government, quasi-government and private bodies. For example, the M.O.H (1996) reports of a regional hospital, two health centers, three health posts and two clinics. The two clinics are however privately owned.

3.2 SOCIAL ORGANIZATION

Bolgatanga is a fast developing town. It has both modern and traditional features. However, it is difficult to draw a clear line of demarcation between these two. Thus it is common to find in the community traits of urbanism as well as rural life. A kind of transitional process can therefore be discerned. This is especially evident in certain traditional practices that are now changing in the face of modernization.

For example, residential structures are being changed from the traditional thatched houses to those of modern ones roofed with aluminium sheets.

The town is characterised by various sections and people of different backgrounds inhabit these areas. There are also few residential areas. These include areas such as those at Estate, Junior Staff Quarters at Tanzui and SSNIT flats at Tunesobulgo. These are mostly found at the outskirts of the town. Whilst some of these residential structures are owned by Government others are privately owned. Occupants of these residents are mostly the elite. This is a small group of people, with its population sparsely distributed in the town. The elite are usually made up of indigenous and migrants of different educational backgrounds. They are usually found in the formal or Government establishments with a few of them in the private sector.

Settlements in the heart of the town are however different. These are mostly 'Compound' houses and are occupied by both the indigenous people and migrants who live as tenants. In some cases, these migrants own the houses especially, those in the heart of muslim settlements.

Households are usually made up of people related matrilinially or patrillineally. Thus, a household may have a husband and wife, their

children and persons related to either the man or the woman. Foster children may be found as well. All these together live under one roof with the eldest male acting as head of the household.

In terms of family sizes in the two types of households mentioned, whereas inmates of the residential areas may range between two and ten, those of the compound houses have between ten to forty inmates. The latter are mostly in the informal sector while the former are in the formal.

The town originally was dominated by traditional worshippers or believers. Every clan or house has its own god or gods. However Islam and Christianity are now wide spread. Whereas muslims dominate in the heart of the town, christians have taken the residential areas. In spite of this, traces of traditional worshippers can be found sparsely distributed within the township and the villages.

On the whole, one can conclude that the social arrangement is a mixed one - partially traditional and modern.

3.3 POLITICAL ORGANISATION

Traditionally, the political set up of Bolgatanga is characterised by four paramountcies. These are headed by the Bolga Naba, Nangodi Naba, Sakote Naba and Tongo Rana. Each of these have a number of

sub-chiefs. Whereas the Tong Rana has 20 sub-chiefs, the Bolga Naba has 16 and the Nangodi and Sakote Naba have 11 and 8 respectively. All the sub-chiefs are enskined by their respective paramount chiefs. Hence they owe allegiance to them.

Two functionaries are important in the political set up of the Frafra. These are the Tendana and the Na (Naba Singular). Tendana on one hand is in charge of and responsible for the land. He is the chief Priest of an area by virtue of the functions he performs. His principal functions are to sacrifice to the land, purify it and prevent war. The Naba on the other hand is the territorial ruler. He and the land owner "Yidana" work hand in hand to promote peace and administer justice at the local level.

Other functionaries of some importance are the sectional and compound heads. The former refers to individuals who head particular sections of the society. They are responsible for the day - to - day general observances of the norms of the group. The latter are individuals responsible for all the inmates of a compound. They are usually refered to as "Yidana" and is made up of the compound head, the wife, his younger brothers and their wives and children. The "Yidana" is often responsible for the religious services of the family group.

However, it must be mentioned that these traditional arrangements have been subjected to serious changes as a result of modernization; colonization has affected the traditional roles of local political functionaries. Consequently, ever since Bolgatanga became the administrative capital of the Upper Region and now Upper East, the establishment of modern institutions such as the Regional Administration, the District Assembly, the Police Service and the Judiciary, the powers of the local functionaries have changed gradually. For example, the chiefs have lost both administrative and judicial control just as it happened in other parts of Ghana. The police and the judiciary now handle most civil cases. These institutions have made local functionaries, like anyone else, equal before the law.

Indeed, the entire political and administrative planning, control and management of the township no more lies in the hands of the local functionaries. The state has fully taken these through the District Assembly, a body representing Government at the District level. This body is generally responsible for the development and management of the social infrastructural facilities and sanitation. It helps to implement general government polices in line with its developmental goals. In terms of structure, the District Chief Executive heads the District political administration. Below him is the District Director of Administration.

There is also a District assembly, which passes all bye-laws in the District. Also present are the various district heads of department who run the day to day affairs of the District.

Inspite of these influences, the local functionaries are recognised in matters of ancestral rites and traditional festivals. They are used in mobilizing communal labour and are often consulted before the execution of community development projects. Some of them serve as nominated members of the Assembly thereby, engaging in various deliberations for the development of the town.

3.4 ECONOMIC ORGANISATION

As mentioned earlier, Bolgatanga is located in the north-eastern part of the country. The land is relatively flat and lies in the savannah belt of the country. Its climate is characterised by low humidity, single rainfall regime and high temperatures.

The rains are very irregular from May to October and are sometimes very torrential leading to occasional flooding which could render inhabitants homeless. The average yearly rainfall varies from 900 to 1050 mm. The rainy season is followed by severe North-East Trade

winds often refered to as the harmattan. This is usually the dry season and it stretches from November to April. The period is often associated with high temperatures sometimes reaching 40°C.

Subsistence farming is the basic unit of the economy. This is characterised by crop farming and livestock rearing. The major crops cultivated are maize, millet and groundnut. Legumes and vegetables farming is also done on small scale. Lands for farming are often family ones and are inherited. A member of the family can therefore cultivate unoccupied land. Every member of the family (mostly men) have a right over family land but, it is also possible for an ordinary resident to acquire land for farming by entering into various terms of agreements with the land owners.

Quite a number of women are engaged in farming activities to support their families. However, their role is largely in sowing of seeds and harvesting of crops. They are also engaged in the processing of edible oil from sheanuts and spices for parkia (dawadawa). Other areas of women's economic activities are pottery, weaving of baskets and hats. All these areas are sources of income in support of various families.

Livestock rearing is also common. These include cows, goats, sheep, donkey and horses. These are often kept for festivals, marriages and domestic consumption. They are usually considered as family property though it is possible for individuals to acquire them on their own.

Fowls and ducks are reared in small numbers. These could be inherited or acquired from individual efforts. They are generally used for domestic comsumption, various ceremonies and festivals or sold to supplement household budget during the lean season.

In recent times, rice, tomatoes and soya beans have become cash crops for the people. Farming of these have been possible due to the Vea and Tono irrigation dams. The dry season is often the period when serious farming takes place around these dams and this has generally been a good source of jobs to many people.

It is also worth noting that times have changed and tradition is gradually giving way to modernity. Hence, there has been a shift from the traditional socio economic arrangement to one of cash earning economy. This is due, in part, to Western education and migration. As a result, Bolgatanga being a district and regional capital, has a number of

governmental and non-governmental agencies. These have served as sources of employment and wage earnings to many people of varied backgrounds.

There are also a number of self-employed artisans such as dress makers, designers, mechanics and hair dressers, among others. The work of most of these have been enhanced by the regular supply of electricity. Sections of the young folk also engage in crafts. Weaving of smocks, making of local huts and various leather works (purse, handbags, wallets, talisma) are sources of income to many people.

Trade is another source of income to some households. This is the pre-occupation of many women. Commercial activities take place every three days from the last market day. Comparatively, Bolgatanga has a big market and most of the surrounding villages buy their needs from it.

On the whole, the economy of the town could be said to be a mixed one. It comprises the formal and informal small scale business and a large traditional agricultural set up.

3.5 HEALTH CARE DELIVERY

The main actor of health care services in Bolgatanga is the Government through the MOH. There is a District Health Management Team (DHMT) and it is this body that is responsible for the operational planning and supervision of service delivery.

Bolgatanga has eight (8) of such D H M T and these are refered to as sub-district health teams. For purpose of efficient and fast delivery services, the town has been divided into catchment areas and each sub-district health team is responsible for service delivery in the respective area.

On the whole, the D H M T has been quite successful in its operation. This can especially be seen in programs of AIDS control, Maternal and Child health and Family Planning. Indeed the URA Radio FM Station has been an important tool in transmitting various educative programmes using the local dialects.

3.5.1 HEALTH FACILITIES

Bolgatanga has a regional hospital with its foundation dating back to 1949. Though originally built to cater for the health needs of the few

Europeans in the then Upper Region, the hospital has seen massive expansion since 1952.

Administratively, the structure of the hospital provides it with a core management team made up of a Medical Superintendent, a Health service administrator and a Principal Nursing Officer. Besides these, the other functional management team includes the Accountant, the Pharmacist, Catering Officer, Dental Surgeon, a representative of the Regional Health Directorate and District Assembly.

Facilities available in the hospital include, the X-ray Department, pharmacy unit and an Electro Cardiogram unit (established in 1993) Appendix A and B show the department and medical units of the hospital.

The hospital has eight ward facilities. These are; male medical, male surgical, female medical, children's ward, isolation ward, maternity and gynaecological ward. Each of these wards has different bed capacity ranging between a minimum of thirteen (13) for male medical and maximum of forty - five (45) for the children's ward.

In addition to the regional hospital other health facilities include two health centers and three health posts. These are in the suburbs but

are under the administration of MOH. There are also two clinics. These are within the heart of the town but, whereas one is owned by the police service, the other is privately owned.

It is clear that public health facilities are generally skeletal. Even the Regional hospital which provides over 70 per cent of health care services faces a number of problems. For instance, with a bed capacity of 187 as at December 1995, there were only 11 medical officers and only one was a specialist (MOH) 1995. Appendix 'C' shows the staff strength at the hospital.

Also, very little can be said about private body's contribution to modern health care since only one private clinic exists. There are however a number of chemical shops spread over the town. These serve as sources of self - medication and abuse of drugs. Pharmaceuticals such as antibiotics and pain killers can easily be obtained from these shops and drug peddlers.

Apart from these, sections of the public also make use of traditional medicines. Generally, the contributions of these, to health care delivery is highly appreciated. Thus the herbal clinic at Zaare is well

known for the treatment of various kinds of ailments. However, when complications arise, patients are eventually sent to the hospital.

3.5.2 HEALTH PROBLEMS.

Health problems in the town are basically tropical ones. Morbidities are mostly associated with parasitic and environmental factors. These account for most deaths. For example, of the 28,119, causes of outpatient morbidity registered at the hospital in 1995, malaria was the highest with 5,846 cases. Of these 3,414 were males and 2,432 females. Appendix 'D' shows other causes of morbidities. MOH report for 1994, also indicates that malaria is the highest cause of morbidity.

It has also been noted that, the big valleys quite close to the town provide ideal habitats for insects which transmit filarial diseases such as elephantiasis. This disease is very common among the rural folk. In addition goitre, a disease associated with iodine deficiency and hernia or hydrocele are other common disease. Also, because the town falls in the Cerebrospinal Meningitis (CSM) belt of West Africa (80°N), the disease is common during the hot season (March - June). As a result, annual epidemics are quite common as it happened in March 1997.

Malnutrition has been quite endemic among children in the town. This is largely attributed to inadequate food supply especially during the dry season (MOH, 1995).

Alcoholism is another health problem. Consumption of alcohol or local beer called "PITO" and imported gin from southern Ghana called AKPETESHIE is very high especially among the local people.

Sanitation is also a health problem. Households produce solid waste which the District Assembly is unable to dispose of. Consequently, rubbish thrown into gutters along the streets or piled up at public latrines present serious health problems. Occasionally, however assembly men and voluntary organisations such as the Red Cross help organise clean-up exercises to improve sanitary conditions.

CHAPTER FOUR

DATA ANALYSIS

In this chapter, data collected from the field are analysed in the light of the objectives of the study. Consequently, a background knowledge of respondents' characteristics, awareness levels and the effects of the cash and carry policy on both the policy implementors and consumers are discussed.

The analysis begins with an examination of the socio-demographic background of respondents.

SOCIO-DEMOGRAPHIC CHARACTERISTICS

Socio-demographic variables have been observed to be among important factors affecting the utilization of health facilities. Habib and Vaugham (1986) note that the utilization of health services is related among others to variables such as age, sex, education, occupation and family size and type. They argue that all these factors influence the utilization behaviour and may be associated with different levels of health and sickness which results in different levels of health service utilization.

The socio-demographic characteristics to be examined are age, sex, occupation, education and religion.

AGE

Age is an important factor in considering people's perception on disease and illness and hence treatment. However, there appears to be no uniformity regarding the effect of people's age on the utilization of health facilities. Nchinda (1977) and Akin et al (1985) have noted that health services were used more by children and elderly people. These studies indicate that the relationship between age and the use of health facilities is 'U'-shaped. This means that at a tender age people use health facilities more and as they grow, the utilization declines and eventually rises again at an older age.

On the contrary, Belcher et al (1976) in a study of rural households in Ghana showed that the use of medical facilities declined with age. They found that parents felt their children would be most effectively treated with modern methods of health care. Also, Fosu (1981) observed that, in some Ghanaian households, the younger age groups used health facilities more than the older age groups (30 years or more) due to their perception of natural disease causation.

Age therefore, has become an important consideration when perception about disease, illness and treatment (utilization of health facilities) are discussed. As a result the need for this study to examine respondents' ages is crucial. The study reveals that, the age distribution of respondents varies extensively from 18 years (lowest) to 71 years (highest).

The age groupings indicated that the majority of respondents were in the 26-35 years group. This group is followed by the 36-45 years group which recorded 22.0 per cent. The least group recorded was the 0-18 years old (1.3)

The table below shows the details of age distribution of respondents.

TABLE 4.1: **AGE DISTRIBUTION OF RESPONDENTS**

AGE RANGE YEARS	FREQUENCY	PERCENTAGE
0 - 8	2	1.3
19 - 25	32	21.3
26 - 35	63	42.0
36 - 45	33	22.0
46 - 55	9	6.0
55+	11	7.3
TOTAL	**150**	**99.9**

From the table above, it becomes clear that the study is dealing with a fairly matured population. Thus, most respondents are concentrated in age groups that can be described as fairly matured.

SEX COMPOSITION

The sample size for the study included both males and females. This was to ensure gender balance in the shades of opinion among respondents.

Studies have shown that sex has influence on utilization of health facilities and this varies from one place to another. Akin et al (1985) note that, many cultures practice sexual discrimination against women. For example, female babies in Bangladesh were immunised less than male babies because of low perception of their value to the households and food and medical resources are kept away from female (Stanton and Clemeus, 1989). However, Belcher et al (1976) show no sex difference in the utilization of medical care facilities among some Ghanaian rural households.

The present study reveals a female population of 46.0 per cent and a male population of 54.0 per cent. The result thus, shows a male dominant group. This may be due to the fact that many women refused to be interviewed. Hence, the results show a slightly contrary picture to the national population structure which indicates a female dominance of about 52 per cent as against 48 per cent by males.

OCCUPATION OF RESPONDENTS

The ability to afford cost of health care depends among others on an individual's sources of income which also depends on one's occupation. Although income was not directly examined in this study due to difficulty in economic grading especially in developing countries (Bailey and Philips, 1990) it has been looked at indirectly since most authors describe it as an important factor in the utilization of health facilities. Consequently, occupation and educational levels have been used as an indirect criteria to judge the effect of income on one's ability to utilize or meet cost of health care.

Berman et al (1987) indicate that utilization of all types of health care facilities (except traditional care) increases with income level. Use of private care facilities or treatment by a private physician appears to be primarily restricted to the upper income category. Gish et al (1988) show

that in Indonesia, the insured population Civil Servants and their dependants used services almost four times more frequently than the rest of the population. Dutton (1986) has also observed that, the overall economic status of the clientele was the most significant obstacle to the utilization of health care facilities.

On the contrary, a study of household survey in southern Iraq indicates that the income of the household was not an obstacle to the use of local health centres and the general use of Government health care services (Habib and Vaughan, 1986).

As observed earlier, Bolgatanga is a typical subsistence farming community. However, the expansion of the formal sector and the rapid growth of the informal sector has made farming less lucrative. As a result, farming has become less attractive to the youth who migrate to the urban centres in search of jobs.

The study therefore shows that majority of respondents are in the formal sector. Together, these represent about a third of the targeted population (31%). About 21 per cent of respondents are also engaged in petty trading. Of this number, almost 70 per cent are women and they do this to supplement the domestic budget. As has been observed by Apt

TABLE 4.2 **OCCUPATION OF RESPONDENTS**

OCCUPATION	FREQUENCY	PERCENTAGE
Civil/Public Services	46	30.7
Petty Trading	32	21.3
Artisan	24	16.0
Farmer	21	14.0
Student	18	12.0
Unemployed	9	6.0
Total	**150**	**100**

As the table shows, the people are generally low income earners. Despite the expansion of the formal sector, a majority are in the informal sector where sources of income are generally low.

EDUCATIONAL BACKGROUND OF RESPONDENTS

Education is important not only to the individual but to nation building as well. Also one's level of consciousness is largely determined by one's educational level. Thus, one's educational status is a significant determinant of the level and direction of social perception as well as the understanding and analysis of issues.

Like age therefore, education is associated with change in attitude (Fosu, 1981). Consequently, it was important to investigate the educational level of respondents because studies have shown that there is a relationship between education levels and the use of health care facilities. For example Gosh and Mukherjee (1989) observe that in Bengal state, India, utilization of health facilities was lower among persons with low education levels.

Osei (1990) has also shown in Ghana that, the degree of utilization of maternal care services was high among educated than non-educated women. However, under-utilization of the antenatal care was frequent among women with higher education in Jerusalem (Ellencweig et al, 1990).

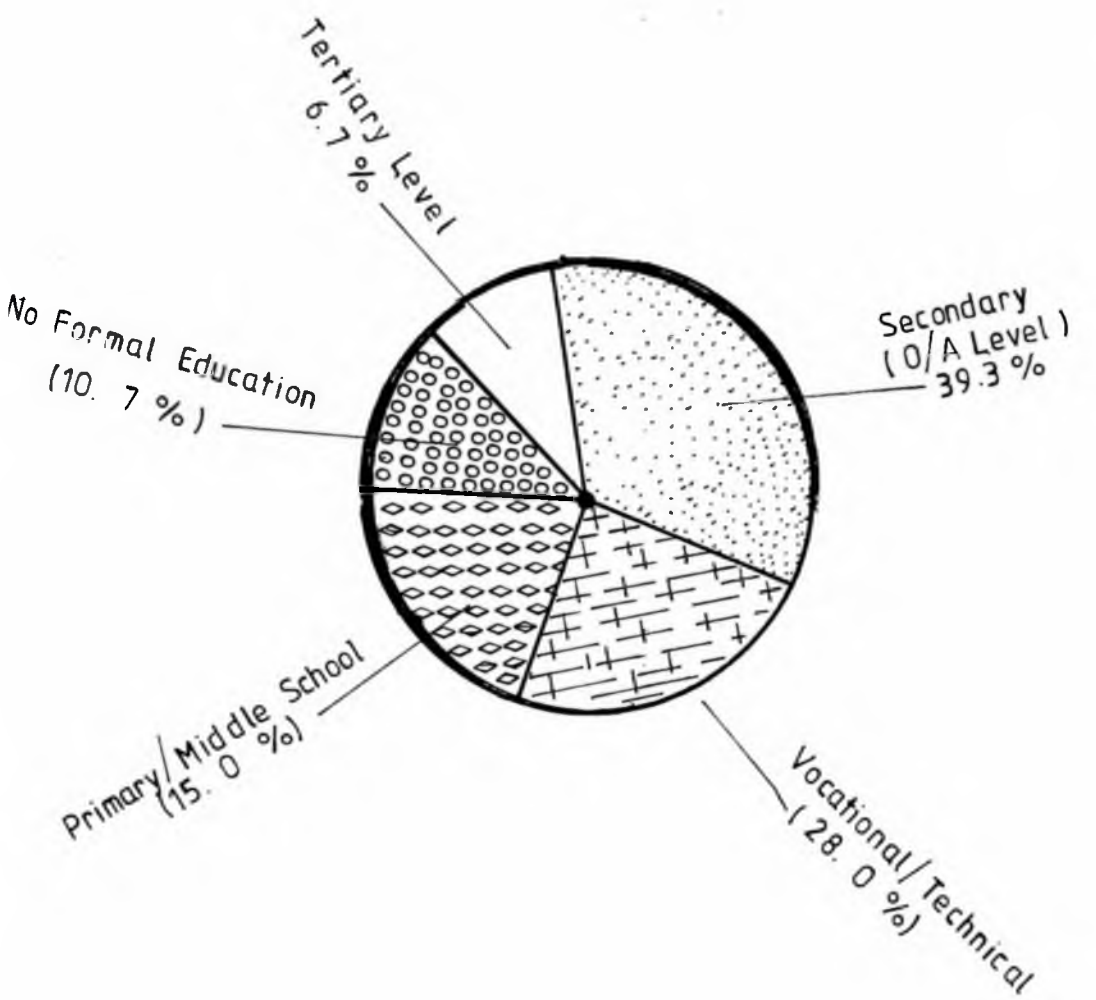
The study shows that about 10.7 per cent of respondents lacked formal education. About 15.3 per cent have the basic level education primary, middle or junior secondary schools. However, about 28.0 per cent continued to the vocational and technical levels.

The majority of respondents have had secondary education up to the Ordinary or Advanced levels. These represent about 39.0 per cent and only 6.7 per cent have gone through tertiary education.

The figure below shows the educational levels of respondents.

FIG.1

RESPONDENTS EDUCATIONAL BACKGROUND



From figure 1 above, it is clear that the study is dealing with a fairely educated population. Most respondents have had secondary education. However, quite a significant number (10.7%) lack formal

education whilst only a few (6.7%) attended higher educational institutions.

RELIGIOUS AFFILIATION

Religion is of significance to this study because the way people perceive and treat diseases depend largely on their religious affiliations. This attitude may probably be influenced by the desire from an individual to use a particular mode of treatment for illness due to individuals' religious beliefs (Senah et al, 1983).

Foso (1981) also argues that people's beliefs in the cause of illnesses affect their choice of health care: where people classify causes of illness as natural they most probably seek care at the health facilities but where the illnesses are classified as supernatural, perhaps they go to traditional healers.

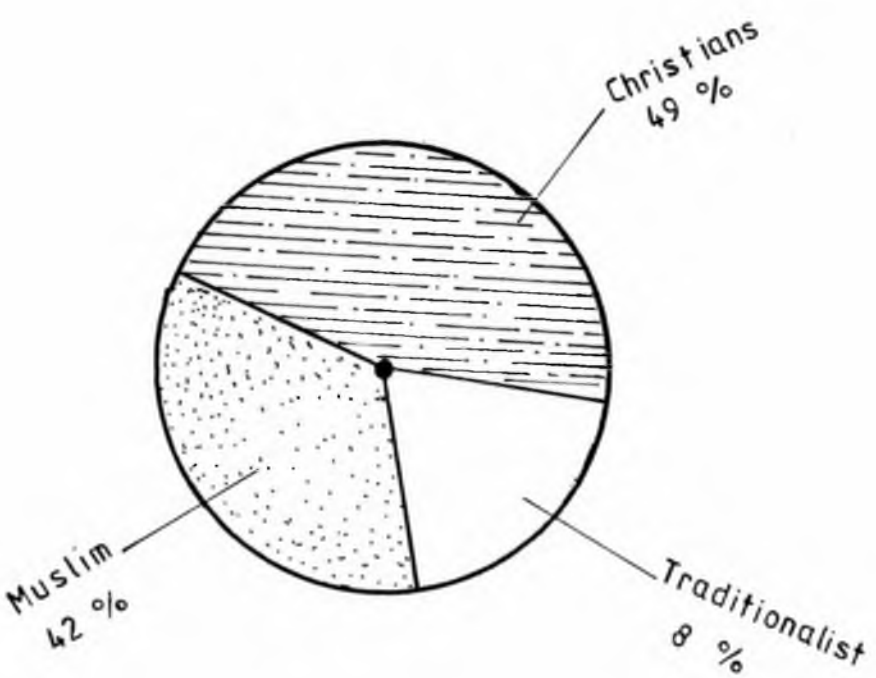
Boerma and Baya (1990) note that, in the coastal province of Kenya, christians use modern health care services more than muslims and traditional believers. However, it has been observed that both christians and muslims easily resort to traditional therapeutic systems in the event of illness whose etiology are perceived as metaphysical (Senah, 1997). As a result, Busia (1950:208) notes that, christianity remains a "thin-

veneer" as evidenced by the Ghanaian christian's readiness to employ traditional religious practices when the need arises.

The present study shows a dominant christian group amongst respondents. This is followed by muslims and the lowest group coming from the traditional believers. The chart below indicates the various religious groupings.

FIG. 2

RELIGIOUS BACKGROUND OF RESPONDENTS



CONCLUSION

The discussion so far has been on the socio-demographic variables (age, sex, religion, education and occupation) of respondents. Various observations have been made on how these variables are important and influence the utilization of health facilities and hence, the perception and treatment of diseases.

OPERATIONS OF THE POLICY

AWARENESS

One of the basic objectives of this study, is to know how cash and carry operates and its effects. As a result the awareness level of respondents about the policy was first ascertained. The study shows that about 98 per cent of respondents indicate their knowledge about the policy. Only 2 per cent show that they have no idea about the existence of the policy. It is therefore obvious that an overwhelming majority of respondents know that pre-payments are required for the use of health facilities at the government hospitals.

As to how local implementors understand the policy, various responses were given during focus group discussions (FGD) with nurses.

Some discussants observed thus: "It involves paying and taking drugs". Others also held that, "It is the payment of cash before drugs are given to a patient". Without payment a patient cannot be treated they emphasised. The general impression is that the system involves pre-payment of cash before medical attention can be given to people.

From the responses obtained, it was clear that emphasis is placed on "payment of cash" before treatment. By these indications money becomes an important prerequisite to the utilization of health services. This implies that money is core in the operations of cash and carry. It is central and the absence of it can hinder the possibility of rendering health service to patients.

Based on this emphasis of "cash" prior to treatment the discussants were asked how they handled emergencies or patients who are unable to pay. Basically, some expressed ignorance about any exemptions though a majority indicated their awareness. However, they expressed practical difficulties in providing services to such patients. As to how situations are then handled, they indicated that nurses will need to report to their immediate superior who will contact the social welfare officer whose duty it is to authorise the treatment of such patients. However, it was observed that the high administrative cost in verification and processing

of paupers and indigent in the face of limited resources sometimes make the officer practically inactive.

They indicated also that, depending on the time of patients' arrival at the hospital, the social welfare officer may or may not be at post. Where he is, the patients could be attended to shortly. Where he is not the consequence could be serious. Patients may remain unattended to for an unnecessarily long period of time. Occasionally, nurses could guarantee for patients on humanitarian grounds. However, some regard this as risky since they may be called upon to pay should the patient abscond or declare his inability to pay. It is also possible for doctors responsible for emergency cases to recommend the release of drugs for treatment to start.

It was noted however that nurses have difficulties in procuring prescription from the pharmacy staff who will want to insist on payment of cash before the supply of drugs. Generally, my observation was that, when confronted with emergencies the procedures involved are not well communicated. Not only was co-ordination poor but commitment to work was low. Indeed these largely explain the undue delays that often occur at service delivery points.

It may thus be inferred from above that knowledge and understanding of the policy implementation is quite limited on the ground. As the MOH (1996) observed, knowledge of the objective of the cash and carry program was limited to a few management staff. Consequently, not only do the implementors lack sufficient knowledge about the policy directives but also, there is lack of effective co-ordination between the various units to enhance efficient delivery of services.

To ascertain if any in-service training was offered at their level before the introduction and operations of the policy, the response was negative. Indications were that a non-compulsory durbar was held and it was at that forum that the hospital management announced the commencement of the new system. As to the detail of its operations much remains unclear. No official document has ever been made available to facilitate their understanding of the policy. Obviously therefore, this kind of situation confirms the wide spread ignorance about the policy directives.

EFFECTS OF CASH AND CARRY

The effects of user charges have been a subject of wide and varied analyses. On one hand, proponents of user charges claim that charges

deter frivolous usage and generate revenue which can be used to improve the scope and efficiency of services (IMF/WORLD BANK 1988; UNICEF 1990; Creese 1991 and Mills and Lee 1993). Opponents on the other hand claim that charges are inequitable and cause a decline in health service utilization, particularly amongst the most vulnerable groups (Attah, 1986; Yoder, 1989; Vogel, 1988 and Waddington and Enyimayew 1990). Indeed "much of the debate seems to stem from ideologically based prejudices, with a certain lack of concern for the facts" (Ryan and Birch, 1988:3).

Also, Creese (1991) notes that fees serve two principal functions: they generate revenue from those patient who judge the service to be worthwhile at the going price; and they discourage or deter patients who either cannot pay or who judge the services less desirable than some other alternative sources of care.

In terms of revenue generation, it is argued that the practical life situation shows that people everywhere are accustomed to paying for some components of their health care. Consequently, paying fees for health services is no new phenomenon. It is thus expected that charges will help recoup cost and offer quality services. Ghana for example, has made significant mark in cost-recovery. Thus, in 1988 the MOH

recouped 15 per cent of recurrent expenditure on health (Vogel, 1989). However, recent experience of several African countries show that cost-recovery system yields gross averages of about 5 per cent of operating costs. While this can be an important sum, it is simply a contributory rather than a determining force in financing public health (Creese, 1991).

In furtherance of its basic objectives, the present study sought to know respondents view about the effects of the policy on both the consumer (patients) and the policy implementors.

As a result, about 34 per cent of respondents indicate that people may resort to other alternatives such as traditional medication if they cannot afford the cost of services at the hospital. They argue that traditional medication is comparatively cheaper and quite reliable. Indeed some refer to history and indicate that prior to the white man's arrival, earlier generations depended on traditional medicines and they were as healthy as the present generation. Hence, it is their opinion that, where the use of hospital facilities is beyond the reach of the poor, the tendency to seek other alternatives cannot be completely ruled out.

About 29 per cent indicate the tendency of complete avoidance of hospital and abuse or misuse of drugs. In their opinion this is real when

people cannot meet cost of health services. Hence, they will often at their own discretion or without expert advice buy drugs from open shops based on what they can afford. This may or may not be in right quantities. Consequently, the possibility of adequate treatment cannot be guaranteed. Indeed, Waddington and Enyimayew (1990) have noted that many people went to a drug store before visiting government facility because they could obtain drugs in smaller quantities (incomplete course). They would therefore have lower absolute amount of money to pay. In a town such as Bolgatanga therefore, the prevalence of drug peddlers and numerous pharmacy shops is conducive to drug abuse.

Purchasing drugs from these shops without prescription is as easy as buying a bottle of Coca-Cola. Certainly the desire of the shop owners to make profits without a fair consideration of the consequences of selling and the abuse of drugs makes them readily prepared to sell. Sometimes they do so irrespective of the age of the buyer.

Other studies have also indicated under-utilization of government hospitals due to increased charges. Thus, where people avoid hospital due to cost indications are that facilities will be under-utilized. As Mbugua et al (1995) observed in Kenya, there were lower levels of utilization of public hospitals and health centres when full fees were in

force. Attah (1986) has also identified high cost, lack of supplies and equipment among other reasons for the severe under-utilization of public health facilities in Imo State, Nigeria. It is in this respect that Biritwum (1994) recommends a review of the mechanism for pricing of prescription to patients since this could influence management of disease and the use of hospital facilities.

Indeed, Yoder (1989) has indicated that when health services fees rise, at least three types of patients can be expected to drop out, or reduce their use of health services: low income patients for whom the fee is no longer affordable, patients who decide their ailment is not serious enough to justify the costs and patients making multiple visits.

About 20 per cent of the respondents mentioned the problem of delays in attending to patients. In their opinion this is partly due to the emphasis on payment of money prior to treatment. When patients are unable to pay therefore, delays result. Meanwhile it has been established that such a practice is contrary to Legislative Instrument (L.I.) 1313 which provides exemptions for eight categories of patients such as paupers and patients suffering from diseases such as leprosy. In practice, patients hardly enjoy these provisions due to financial constraints or bureaucratic procedures. This point was confirmed during focus group

discussion with nurses as they indicated that this is one problem area confronting them. Indeed, they expressed difficulties in providing services to exempted cases. Consequently, delays arise and quality of service is affected. Meanwhile, studies have shown that, the time involved for treatment is among important considerations for quality services (Bennett, 1987). Time is therefore among attractive factors to utilization of health facilities.

Further, it is the opinion of about 12 per cent of respondents that patients are denied full treatment. This they think is the result of inability to purchase all prescribed drugs or meet full cost of treatment. This point was further confirmed by nurses during discussions when they reported the case of a child on admission at the children's ward. The said patient was unconscious for 5 days and while his condition was improving the parents asked for early discharge because they could not bear the cost of treatment any more. Though such a practice is against medical norms, nurses indicated that there was little they could do. Indeed it was remarked that such practices are common in the hospital.

It was also reported that drugs are comparatively cheaper at the hospital than in pharmacy shops in the town. As a result when it becomes necessary for patients to buy drugs from outside, they buy what they can

and leave what they cannot. Eventually treatment is half met. This position confirms Waddington and Enyimayew's (1990) observation that people sometimes did not have money to pay for prescribed drugs. In such situation the patient would usually be given a quantity of drugs according to the amount of cash they have.

About 5 per cent of respondents think that the policy makes patients to abscond. Persons who cannot afford cost of services during admission abscond shortly after discharge. This was confirmed during focus group discussions with nurses. Such situations, according to them, explains the rationale for occasional seizure of patients' belongings. The hospital pharmacist also indicated that between January August 1997 an amount of over ¢2 million was unpaid for (absconded). The table before depicts the various responses of respondents.

TABLE 4.3:

WHAT DO YOU THINK ARE THE EFFECTS ON PATIENTS

RESPONSES	FREQUENCY	PERCENTAGE
Resort to traditional Medicines	112	34.4
Patients avoid hospital	96	29.4
Delays in receiving attention	64	19.4
Patients are denied full treatment	38	11.2
Patients abscond	16	4.9
TOTAL	326	99.0

From the above table, it is clear that most respondents have expressed the possibility of people finding other alternative sources of care or avoiding hospitals when they consider the cost of services deterrent enough. This obviously undermines the quality of care needed for the people and nation-building.

EFFECTS ON IMPLEMENTORS

The impact of cash and carry (user charges) represents a change in the method of health financing. This impact, it is believed, affects not only consumers but the policy implementors and the general service

delivery. Consequently, about 30 per cent of respondents indicate that the policy implementation creates difficulties at the service delivery points. They argue that delays arise and hence prompt attention is not provided to patients. In the opinion of these respondents, the procedure of looking for supplies in order to render services during emergency was rather cruel. They contend that human life appears to be sacrificed in favour of bureaucratic procedures as far as time is concerned.

Indeed, respondents also indicate that the pre-payment of various sums of money for treatment was rather over emphasised. In their view this affects the quality of services. Pre-payment of fees was confirmed during discussions with nurses. For example, it was reported that whereas ¢15,000 deposit is usually requested before admission at the children's ward, the deposit could be up to ¢100,000 at the male/female surgical wards depending on the reported case. In this respect, it was noted that many are the cases where people find it extremely difficult to meet such deposits immediately. The result is that prompt attention is delayed. Respondents therefore think that such an arrangement is seriously inappropriate. Waddington and Enyimayew (1990:309) have also noted that, "one important concern raised by patients is the issue of ability to pay at the appropriate time".

Asked how situations are handled when patients are unable to pay, it was reported that, the nurse on duty will have to report to the immediate superior who will also report to the social welfare officer. It then becomes the responsibility of the officer to determine whether or not the patient is a pauper. In practice, the officer's role as has been noted is very limited due to resource constraints. It has been observed also that, the role of the social welfare officer has not been spelt out in both Act 387 of 1971 and LI 1313 of 1985. But the situation where decision on paupers and indigent are made on the recommendation of the officer is quite acceptable and helpful to health managers despite the various difficulties and problems.

Logistics has been observed to be the most prominent constraint. Thus the MOH (1996:4) notes that, "though budgetary provision has been made at the Department of Social Welfare under Hospital Welfare for the indigent, hospitals are made to absorb fully the cost of these services" The report observed that the department's involvement is virtually non-existent as they found that allocation made for paupers was very low compared to the number of cases and amounts involved. For example, in 1996 budgetary allocation was only ¢8 million countrywide. Indeed, in the present study, nurses expressed practical difficulties in treating patients under emergency and that the bureaucratic bottlenecks pose

serious constraints. It therefore remains a fact that despite exemptions outlined in the policy and the presence of social welfare officer, delays in treatment remains a serious problem.

It was further indicated that where patients meet the cash deposits required, cost of treatment could rise and by the time the patient is discharged, the difference may not be settled. As to how this situation is also handled, nurses indicated that they sometimes collected patients' belongings as a guarantee for payments. While some are able to settle the outstanding bill after sometime, others abscond.

It is the view of about 27 per cent of respondents that nurses experience unpleasant situations. This in their opinion is the result of helpless situations nurses find themselves in when a patient is unable to afford cost of treatment or make prompt payment. Such occurrences, to many nurses are sources of discomfort. Whilst occasionally they guaranteed payments for patients on humanitarian grounds, the consequence of being called to pay when a patient defaults or declares his/her inability to pay is deterrent enough. Indeed, some remarked that this is an extra burden.

It is also the view of about 20 per cent of respondents that the policy serves as sources of revenue to the MOH. In their opinion, revenues collected can help meet cost of drugs, administrative services and new equipment. Generally their contention is that, instead of relying fully on government funding 'reasonable' cost-sharing could bring or sustain significant improvement and better services. As Hsiao (1995) observed in China, little public spending can produce significant benefits. Other studies have also indicated that cost-sharing or cost-recovery can produce a net social gain. (Akin et al 1990; Vogel, 1991).

About 16 per cent of respondents think that the constraints associated with the implementation of the policy affect workers' morale negatively. The best of nurses' output is therefore not realized as job satisfaction is low. This was a problem generally expressed during focus group discussions. Workers morale was reported to be low and hence a source of concern to most nurses. Consequently the issue of motivation becomes crucial. Respondents argued that for efficient and adequate service delivery, workers must be well-motivated. As Griffin (1989) notes, the need for incentives among health workers is necessary to improve efficiency.

Another area of concern to nurses was the fact that they are sometimes insulted. Patients see them as causes of bad or poor services. They accuse them of hoarding drugs and of not being sympathetic with the plight of patients. Patients accuse them of being rude and disrespectful. This kind of patient-nurse relationship in the opinion of the nurses is as a result of inadequate knowledge about the policy and the fact that various sums of money are often requested before any services or drugs can be supplied. Where an individual patient is unable to make the pre-payment he/she out of stress or pain would want to find fault with the nurse concerned instead of the policy. Meanwhile, most nurses felt that they should not be held responsible. This problem of patient-nurse relationship was noted by Waddington and Enyimayew (1990) when they observed that one area of concern to patients was the general rudeness and disrespectful behaviour of health workers. Asibuo and Odoi (1993) also note that an area of worry to people is the harsh attitude of some health workers towards patients.

Finally about 6 per cent indicated they cannot tell or do not know of any effects on implementors of the policy.

Below is the table showing the reported effects of the policy on health services providers or the implementors.

TABLE 4.4: WHAT DO YOU THINK ARE THE EFFECTS OF THE POLICY ON IMPLEMENTORS/THE SERVICE PROVIDERS

EFFECTS	FREQUENCY	PERCENTAGE
Delays in providing attention	98	30.3
Nurses experience unpleasant situations	86	26.4
Source of revenue to MOH	66	20.4
Low worker morale	53	16.4
Cannot tell/Do not know	20	6.2
Total	323	99.9

From the table above, it is obvious that quite a significant proportion of respondents (30.3%), expressed serious concern about time delay. Though some respondents view the policy as an appropriate means of revenue to the MOH, the unpleasant experiences that arise sometimes due to the patient's inability to pay, was also expressed.

WILLINGNESS TO PAY

The controversy surrounding the whole idea of hospital user fees can be centred around the question of ability or willingness to pay. Were it possible for every individual to afford the cost of health services,

probably the whole exercise of examining the pros and cons of the concept (user fees) would have been worthless. On the contrary, in real life situation many people cannot meet cost of health services.

Meanwhile, the discussions so far shows that the effects of cash and carry is a multiple one. The most significant issue of concern to many respondents is the ability to pay or payment prior to services. As a result the crucial question is the ability and willingness to pay. Do people oppose payments for health care services or that they do not have the purchasing power? In other words, is it the unwillingness of people to afford cost of health services or that poverty levels present serious constraints? As has been noted, "the inability to pay is an issue of concern for some people" (Waddington and Enyimayew, 1990:309).

Indeed, research has linked willingness and ability to pay to various factors such as economy, demography and the people's perception. Thus Wouters (1991) has shown that willingness to pay depends on the perceived quality and other socio-economic and demographic variables. This implies that people's economic status (purchasing power) and perception influence their willingness and ability to pay for health care. As Hepake et al (1992) also noted, perceived

quality of services is one of the most important determinants of patients' choice of provider and willingness to pay.

In the present study, observations are that poverty levels are quite high. For example, it has been shown earlier that respondents generally engage in various small scale businesses such as petty trading, artisanship and subsistence farming. Quite a number of respondents are in the civil and public services where wages and incomes are generally low. People can hardly meet the cost of basic needs including health. Meanwhile studies have shown that at low income levels, the demand for health care (of constant quality) is more elastic with respect to price among the poor than in the higher income group. Consequently, Creese (1991) notes that low household income is a barrier to the use of modern primary medical services even where they are publicly provided. Berman et al (1987) have also noted that utilization of all types of care (except traditional) increases with income levels. Hence the use of health services by the poor is more affected by price increase than use by the rich. But, Ghosh and Mukherjee (1989) note among Indians (West Bengal) that higher income groups utilize primary health centres the least.

Observation in this study reveals that people are not opposed to or are unprepared to pay for health services. Respondents indicate

willingness and preparedness to pay once expected results can be obtained. In this respect the quality of care has been very much emphasised. Quality to many respondents include, among others, availability of drugs, its affordability and promptness of service provision. As Wouters (1991) noted, quality is an important utilization pattern to the patient.

Indeed, the study found that about 75 per cent of respondents are favourably disposed to payment for user fees while about 25 per cent do not. This disposition might have accordingly reflected the perception respondents held for the policy. Thus, about 70 per cent were positive about the policy. In their opinion the whole idea is a noble one. Cost recovery is necessary in order to create stronger incentives for efficiencies. Not only did they indicate the difficulty associated with free medical care but also expressed hope for net social gains. However, 30 per cent perceive the policy to be bad. In their opinion the policy is alien and inappropriate for our development. Hence, the state should consider it vital and provide free care for the poor.

The general impression therefore is that many people think it appropriate to pay for health care services once the services are of quality and are reliable. As Akin et al (1987) have shown that, citizens would be

willing and able to pay for services especially if the services were of high quality.

In furtherance of this point, respondents indicated various reasons why cost recovery is appropriate. Whilst about 29 per cent accept payment in order that drugs could be purchased and supplied constantly, about 24 per cent recognise the meagre government health budget. Hence, they want payment as a way of supplement.

About 20 per cent also accept payment of user fees in order to enhance quality services. And, 12 per cent think that free medical care is not feasible. However, whereas about 10 per cent disagree with payment of user fees on grounds that health is an essential part of nation-building and should be provided by the state, about 5 per cent think that the poor performance of the Ghanaian economy makes the policy inappropriate. Wages and salaries are generally low and jobs very scarce. Hence, people do not earn enough to enjoy the basic human needs.

The table below shows the reasons respondents assigned to the idea of paying user fees.

TABLE 4.5: **WHY DO YOU THINK PEOPLE MUST PAY AT GOVERNMENT HOSPITAL**

RESPONSES	**FREQUENCY**	**PERCENTAGE**
Purchase/Replacement of drugs	94	29.2
To Supplement Government Budget	78	24.2
For better/quality services	63	19.7
Free Medical care not feasible	39	12.1
Gov't/State should provide	32	10.0
High unemployment/poverty level	15	4.5
TOTAL	**321**	**99.9**

In view of the above responses (table 4.5) the impression gathered is that most respondents appreciate the need to share cost of health care. Indeed, the belief is that free services cannot be financially sustained by the state in the face of other competing national needs. Modest user fees to most respondents can make an impact. As Ellis (1987) notes, modest user charges have made significant contribution to public health cost. Also, the issue of drugs supply was very much emphasised by respondents. It is one area that gives high satisfaction to patients. Thus

Waddington and Enyimayew (1989), Dovlo et al (1989) have all indicated that an important source of satisfaction to people when sick is the supply of drugs. When drugs are available and supplied to patients at some reasonable cost, satisfaction is high but, where they are not available, patients often complain.

The issues that probably appears to be in dispute are: what people can or cannot afford and who are able or unable to pay. As mentioned earlier (chapter two), the policy identified eight categories of exempted patients in section 2 of Act 387. However, the operations of the directives appear to need further clarifications (MOH 1996). For example, in section 3 of Act 387 exemption for emergency cases have been clearly spelt out. But financial constraints make it virtually impossible for the hospital to abide by the policy directives. It is also unclear whether psychiatric or tuberculosis patients who have been exempted from fee-payment should be offered free treatment if they report with other condition such as malaria and fever.

For the sake of enhancing better services and smooth operations of the policy therefore, a clearer understanding of the policy need to be given to local implementors. Constraints on the ground should be closely addressed. As much as possible, it is desirable to determine what people

can or cannot afford. In this respect, the difference and difficulties can be analysed for the appropriate solution to be taken.

RESPONDENTS' SUGGESTIONS

In view of the series of difficulties enumerated, respondents were asked to suggest solutions that can address the problems.

About 32 per cent thus suggest the introduction of subsidies. In this respect, respondents generally submit to payments for user fees. However, they argue that the cost should be affordable and reflect the realities of our socio-economic situation. They emphasise that the state should determine what people can or cannot afford and assist (subsidize) where necessary. As Vogel (1991) observed, it would be more administratively efficient to differentiate the poor from the non-poor possibly by geographic areas. Though this might pose some difficulties in our situation (Ghana), other criteria such as income levels and whether employed or not can be useful. However, these criteria call for proper records keeping countrywide.

Also, about 24 per cent of respondents call for the constant provision of drugs. The general impression is that drugs are less costly at the hospital dispensary compared to prices on the open market. Some

respondents therefore indicated that, the core of being satisfied with treatment is the availability of drugs. This position has been confirmed by Waddington and Enyimayew (1990) when they noted that much more important (to patient) than fees per se is the issue of the availability of drugs. People generally feel unfairly treated when necessary drugs are not obtained at the hospital. It is therefore the view of these respondents that a constant supply of needed drugs will largely enhance the quality of care. Dovlo et al (1992) and Haren et al (1994) have all noted the importance patients attach to drugs.

It is also the view of about 21 per cent of respondents that a review of the policy should be considered. In their opinion, the policy per se is good, but there are implementational difficulties. They suggest therefore a comprehensive review to address the difficulties. By this, many of the inherent bottlenecks, be they administrative or otherwise shall be addressed. For example, on the issue of exemptions the MOH (1996) reports that there is the need to define more specifically what "Exemption" and "No payment of fees" mean. This is more so when refund mechanisms are in place for some categories of persons who are required to pay and collect refunds later. For these exempted categories the act states "fees shall not be paid". But the report notes that this has a potential of creating problems for management. It was noted also that

this was a possible area for free services for hospital staff. Thus, where as the act states "fees shall not be paid" the provision for staff to pay at the service delivery point and collect refund seems to give a different interpretation.

About, 11 per cent think that worker morale is low. They see this as contributing to poor services. Hence, efforts be put in place to ensure or provide better service conditions in terms of equipment and rewards. Improved service conditions in their opinion is necessary to enhance efficiency. As Griffin (1989) observes in Chile, the state had to restructure its health care delivery system to increase incentives for greater internal efficiency.

The table below shows the various suggestions offered.

TABLE 4.6: WHAT SUGGESTIONS CAN YOU MAKE ABOUT THE DIFFICULTIES ASSOCIATED WITH THE POLICY

RESPONSES	**FREQUENCY**	**PERCENTAGE**
Introduce Subsidies	83	31.6
Provide Needed drugs	63	41.3
Review of the Policy	54	20.5
Motivate health Workers	28	10.6
Public education.	21	7.9
Free Care/Policy withdrawal	15	5.7
TOTAL	**264**	**99.9**

CONCLUSION

The task in this chapter has been to analyse the main objectives of the study. In furtherance of this, discussions have sought to examine the operations of the cash and carry, its effects on patients and providers of health services as well. Respondents' opinion about the policy and the whole idea of paying user fees at government health institutions was analysed.

The outcome of these analyses thus shows some of the difficulties asociated with the implementation of the policy. These difficulties

among others, include insufficient knowledge about the policy to local implementors, poor supervision and co-ordination among the various units at the hospital. Other findings that also featured in the analyses are, the short supply of needed drugs, inability of patients to make prompt payments or deposits when required and the patients worry about delays in attention or promptness of services.

CHAPTER FIVE

DISCUSSION AND CONCLUSION

Ever since the 'Cash and Carry' programme became operational in 1992, several concerns and reservations have been raised among health workers and the public at large. Issues about the policy have indeed made headline news on some occasions, especially in cases relating to emergencies and paupers

In the opinion of the researcher, free medical care is not feasible considering the several constraints facing our government. The difficulties of the 1970s and 1980s are enough manifestations of the high cost associated with free health care. Not only was it impossible to ensure the supply of basic drugs, but also some equipment to operate efficiently at most health centres were absent. As Vogel (1991) observed, Ghana suffered a decline in its physician stock from 1700 physicians in 1981 to 800 in 1994. Many of these traveled to Nigeria to seek greener pastures. Thus Ewusi (undated) notes that the medical supplies situation deteriorated over the period 1970-1983, with drugs such as cotton wool, gauze, bandages, needles and syringes in short supply.

Though it is not being suggested that all is well now, there has been some improvement and there is room for much more. However, the fact is that providing free medical care even among the wealthiest nations is an arduous task. Indeed, it has been established that very few countries can accommodate free health care programmes. Consequently, what appears necessary in our situation is to address problems on their own merits. For us in Ghana, the confronting problems are not limited to the health sector only, but to others as well. The situation therefore calls for a concerted effort to revamp the entire economy. When the macro-economic environment is more favourable, access to jobs and reasonable wages/salaries can be earned. Hence, providing for or meeting the cost of basic needs, including health, will be easy.

Essentially, Cash and Carry is about cost -recovery and the aim is to set up a revolving drug fund for purposes of making health institutions more efficient in the management of drugs and pharmaceuticals. The policy, though claimed to have made some impact in terms of improvement in drugs supply, has also created awareness in the area of cost management at health facility level. Sometimes, this awareness partly explains health workers disregard for the policy's provisions on exemptions or free services.

Undoubtedly, user fees (charges) may be a legitimate or appropriate means of cost recovery, general enhancement and increased access to health care services. The crucial issue to many people is the extent to which people can and are willing to pay for health services. Much as fees can generate revenue and improve efficiency, the extent of people's ability to utilize health facilities in view of cost is very important. For, studies have shown that declines or under-utilization of health facilities are real when cost matters are discussed (Attah, 1986; Yoder 1989; and Mbugua et al 1995).

It is in this line of thought that Asenso-Okyere (1993:13) notes that "in searching for these non-traditional sources of funds, care must be taken not to over burden the poor who may react by refusing to seek health care if the need arises". Consequently, a careful discrimination of fees system is necessary to ensure that revenue is provided only by those who can afford to pay, and that resulting income improves the quality and accessibility of health care targeted at the poor (Crease 1991). User fee policy may therefore be successful only when it is able to provide improved and efficient services and restore public confidence in the health delivery system.

As an alternative financing mechanism, the present study observed that adequate knowledge about the objective of Cash and Carry was quite limited at the local level. Thus, ignorance was wide spread at the service delivery points especially among nurses.

The study discovered also that patient's perception about the policy rather looks more favourable than that of nurses. Whilst about 75 per cent of respondents appreciate the need to pay something little for health care in order to enhance revenue generation especially cost-recovery on drugs, nurses hold the contrary. They prefer the old system where everything was free. However, it was noted that patients attach great importance to the supply and availability of drugs at the service delivery points. It is indeed a source of satisfaction to patients.

The study noted further the existence of the Essential Drugs list. However some essential drugs are inadequately supplied. This often makes people buy drugs from outside pharmacy shops where prices are generally exorbitant. Many respondents therefore call for the need to ensure constant supply of drugs at the hospital.

Reasons for this inadequate supply according to the hospital Pharmacist were sometimes the result of changing prices from the

Regional stores without corresponding price changes at the hospital dispensary. The MOH (1996) also reports the effects of delays in refund from exempted categories as another area of delays in obtaining the needed cash to procure new supplies.

It was observed also that monitoring and co-ordination among the various units of the hospital was poor. Thus, it is quite difficult to establish who is responsible for what when emergency cases arise. Service delivery appears poorly supervised, uncoordinated and very slow. In addition, the exemption mechanism can hardly be seen operating. As a result, there were several cases when patients suffered from undue delays resulting from their inability to pay.

Indeed, one other effect of the idea of fees as observed is that it discourages or deters people from attending hospital in time. Consequently, it was common to find situations where people chose to visit drug stores first or attempt self-medication. Whilst this may be part of the Primary Health Care (PHC), the dangers associated with the misuse and abuse of drugs is the issue being emphasised. The abuse of drugs indeed threatens human health. As a result nurses interviewed indicated that some of the attempts at self-medication have sometimes resulted into

serious complications and eventually patients report at the hospital when conditions get out of hand.

Another important observation is the low commitment and morale among nurses. Attitude to work was lukewarm. This to a large extent is attributable to the numerous unpleasant situations they experience especially with paupers. They argue also that, the fact that pre-payments are required of them when sick affects their morale negatively. Though it is on paper that they are entitled to refund, this is not so in practice. An added fact is the inadequate supply of basic equipment such as gloves and detergents. Consequently, some nurses question the effectiveness of the cost-recovery or its revenue generation ability.

As regards nurse-patient relationship, patients interviewed expressed general dislike for the behaviour of nurses. They consider their attitude to be rude and inhuman. Most patients think that nurses do not appreciate or sympathise with the plight of the sick as they often insult and mock at them. They argued that nurses place undue emphasis on pre-payments as against the survival of human life. They therefore question the behaviour of nurses and not the policy.

The study found also that private participation in health services is generally low. Thus private health facilities are rather skeletal. Hence, their impact is yet to be felt. As a result, over 80 per cent of health care services are provided by the Regional hospital. This obviously accounts for the usual over crowding in some wards at the hospital.

RECOMMENDATIONS

In view of the facts available from the study, the following recommendations are made towards improving the operations of the policy and hence general health care services.

1. Health education on the operations of 'Cash and Carry' should be promoted among health workers and the public at large. This will not only enhance the understanding of the policy directives but also facilitate its implementation.

2. Adequate monitoring of and co-ordination among the various units should be ensured. This will check the undue delays and provide quality services.

3. Since fees are important determinants of health service utilization, these could be well graduated to cater for all categories of persons.

Income levels and geographical location can serve as useful criteria in this regard.

4. Supply of basic drugs should be given closer attention. As much as possible, problems associated with shortages and delays should be well checked. Where necessary the needed resource support should be readily made available.

5. Since time is an important factor in the quality of health care, service delivery at the OPD and in the wards should be improved. As much as possible minimum time should be entertained in attending to patients.

6. The services of nurses have also been found to be indispensable hence the need to give much more attention to worker morale is crucial. This will largely enhance general service delivery. Thus, fringe benefits, bonuses and other forms of rewards could be instituted.

7. Traditional medicines were found to be common among the local people. These are widely used. Hence, effort could be made to get these medicines well prepared under hygienic conditions. This will thus make

the medicines better for human consumption. It will also, to a large extent offer much more improved health services to the people.

8. The policy itself should be reviewed to provide some flexibility. This is necessary especially for fee-exempt cases that often pose implementation difficulties. Areas that need further clarification should be identified.

9. Since inadequate funds have been observed to be the major constraint facing the Social Welfare Department in catering for paupers and indigents, budgetary allocations should be increased. This will help meet most of the cases that usually make social welfare officers inactive at the hospital.

10. Periodic workshops could be organised for nurses and health workers in general. This will largely help health authorities or policy makers keep abreast with the problems at the implementation level.

REFERENCES

1. Abel-Smith, B. (1992) "Funding Health for All" Is Insurance the answer? World Forum Vol.7(1) : 3-11

2. Addo, J.S. (1996) A technical proposal for a feasibility study into the establishment of National Health Insurance Scheme. J.S. Addo Consultant Ltd., Accra

3. Adjei, S.A. (1995) " Comparison of the effects of User-Charges on attendance in low income and medium income Polyclinics in Accra" MOH, Accra

4. Akin, J.S., Guilkey, D.K., Griffin, C.c. and Popkin, B.M. (1985) The Demand for primary health care services in the third World Rowman and Allanheld, Totowa, N.J. U.S.A.

5. Akin J.S., Birdsall, N., de Ferranti, D. (1987) Financing Health Services in Developing Countries: An agenda for Reform. Washington D.C., World Bank.

6. Akin, J.S., Denton, H., Guilkey, Vogel, R.J., Wouters, A.M. (1990) Nigerian : Health Care Costs, Financing and Utilization. Washington, D.C. World Bank

7. Asamoa Ansa (1996) Socio-Economic Development of Independent African Countries: The Ghanaian Experiences Ghana Univ. Press, Accra.

8. Asenso-Okyere, W. (1993.) Health financing and Social Security in Ghana. Monograph Series NO.2 ISSER, Legon, Accra.

9. Asibuo, S.K. and Odoi, P (1993) Problems affecting community participation in health related programmes in Ghana. University of Ghana, Legon, Accra

10. Atta, E.B. (1986) Under utilization of public sector health facilities in IMO State, Nigeria - A study with focus groups. World Bank. Washington D.C.

11. Bailey, W. and Phillips, D.R. (1990) Spatial pattern of use of health services in the Kingsten Metropolitan areas, Jamaica Social Science and Medicine, 30(1) : 1-2

12. Belcher, D.W., Wurapa, F.K., Neuman, A.K. and Courie, I.M. (1976) A household morbidity servey in rural Africa. International Journal of Epidemiology 5 : 113-120.

13. Benneh, G. (1990) Population Growth and Development Ghana Publishing Co. Tema.

14. Bennet, F.J. (1987) Community diagnosis and health action: use of health services. A manual for tropical and rural areas. Macmillan Publications London : 65-70

15. Berman. P., Ormond, A.B., and Gani, A. (1987) Treatment use and expenditure of curative centres in rural Indonesia. Health Policy and Planning 2(4) : 289-300

16. Bhattacharya, R.D. and Tandoh, J. (1991) Managerial gaps in the delivery of antenatal care services in rural area of Varanasia. India Journal of Public Health 35(4) : 113-116

17. Birmingham, W., Neustadt, II and Omaboe, E.N.A. (1966) A Study of Contemporary Ghana. Vol.1 The Economy of Ghana. London George Allen and Union Ltd.

18. Biritwum, R.B. (1994) The cost of sustaining Ghana's "Cash and Carry" system health care financing at a rural health central. West Africa journal of Medicine. 13(2) : 124-127

19. Boerma, J.T. and Baya, M.S. (1990) Maternal and Child Health in an ethnomedical perspective: Traditional and Modern Medicine in coastal Kenya. Health Policy and Planning 5(4) : 347-357

20. Busia, K.A. (1954) "The Ashanti of the Gold Coast" in D. Forde (Ed), African Worlds, London International African Institute.

21. Chernichovsky, D. and Meesok, O.A. (1986) Utilization of health service in Indonesia. Social Science and Medicine, 23 : 611-620

22. Cornia, G.A., and Stewart, F. (1987) "Country experience with adjustment" In Cornia G.A. Jolly, R. Stewart (Eds) Adjustment in human face. Oxford; UNICEF/Clarendon Press, London

23. Creese, A.L. (1991) "User charges for health care: A Review of Recent Experience Health Policy and Planning 6(4) : 304-319

24. Creese, A.L. (1992) An Introduction to health Management in Developing Countries. Oxford Medical Publications, London

25. Dakpallah, F.C. (1988) Financing health services: effects of cost recovery mechanism on health services in developing countries -

a case study of Ghana. Unpublished dissertation. Univ. of Wales.

26. David Ofori-Adjei and Agnes B. Amoah (1990) Base Line Survey for the Implementation of Bamako Initiative in Ghana. MOH/UNICEF, Accra

27. Dickson. K.B., and Benneh, G. (1990) A new Geography of Ghana. Longman Group Ltd. London

28. Donebedian, A. (1980) Exploration in quantity Assessment and Monitoring, Vol.1:The Definition and approaches to its assessment. Health Administration Press. Washington D.C.

29. Dovlo. D., Boahene, A., Ntow, S., Matemera, B., Attipoe, D. and Ankrah, V (1992) What does the public want from us? : A study of user satisfaction with services in government health facilities in the Eastern Region, Ghana. MOH, Accra

30. Dulton, D. (1986) Financial, organisational professional factors affecting health care utilization Social Science and Medicine; 23(7) : 721-735

31. Durkheim Emile The Division of Labour in Society Collier, N.Y. Book II Chap II

32. Ellencweig, A.V., Ritter, M., Peleg-Olavsky, E. and Tamir, D. (1990) Utilization of preventive services by pregnant women in Jerusalem : A cross sectional study. European journal of epidemiology. 6(3) : 279-286

33. Ellis, R.P. (1987) The Revenue Generating Potential of User-fees in Kenya Government facilities. Social Science and Medicine, 25(9) : 995-1002

34. Ewusi, K. (undated) The challenges of health care in a Declining Economy. Mimeograph. ISSER, Legon, Accra.

35. Fassin, D., Jeannee, E., Cebe, D. and Reveillon, M. (1988) Who consults and when? : Socio-cultural differential in access to health care in Urban Africa. International journal of epidemiology 17(14 : 858-868.

36. Foests, M., Berghmans, F., and Janssens, L. (1985) The primary health care in Belgium. A survey on the utilization of health services. Social Science and Medicine, 20(3) : 181-190

37. Forster, S.D., (1988) Cost savings from Essential Drug Policies : The Evidence so far. Geneva : WHO.

38. Fosu, G.B. (1981) Disease classification in rural Ghana; Framework and implications for health behaviour. Social Science and Medicine 15 B : 471-481.

39. Gentler, P. and Van der Gaag, J (1988) "Measuring the Willingness to Pay for Social Services in developing Countries" World Bank No.45 Washington D.C.

40. Ghosh, B.N. and Mukherjee, A.B. (1989) An analysis of health service coverage of a primary health centre in Wet Bengal. India journal of public health, 33(1) : 26-30

41. Gilson, L. (1988) Governmental health care charges: Is equity being abandoned, an overview. Staff working paper No.721 Washington D.C. World Bank.

42. Gish, O., Malik, R. and Sudharto, P. (1988) Who gets What? : Utilization of health services in Indonesia International journal of health planning and Management.3(3) : 185-196

43. Goodman, H. and Waddington, C. (1993) "Financing Health Care". Oxford Practical Health Guide No.8. Oxford Press. London

44. Griffic, C.C. (1989) "Strengthening Health Service in Developing Countries through private sector" world Bank, Washington D.C.

45. Habib, O.S. and Vaugham, J.P. (1986) The determinants of health services utilization in Southern Iraq : A household interview survey. International journal of epidemiology 15(3) : 395-403

46. Hsiao, W.C. (1995) The Chinese health care system: Lessons for other nations. Social Science and Medicine 41(8) : 1047-1055

47. International Development Agency. Annual Report, 1995

48. Kidson, C. (1993) Investment health and development. Southeast Asia journal of Tropical Medicine and Public Health 24(3) : 407-409

49. Krause, J. (1991) The Political Economy of Stabilization and Structural Adjustment in Ghana. In : Rothchild and Donald (Eds) Ghana: The Political Economy of Recovery Boulder and Co. London.

50. Lewis, M.A. (1989("User fees in Public Hospitals: Comparison of three country case studies". Economic Development and Cultural Change. Washington D.C. 41(3) : 513-532

51. Malinowski, B. (1944) The Scientific Theory of Culture University of Cardina Press. Carolina, U.S.A.

52. Mbugua, J.K., Bloom, G.H., Segall, M.M. (1995) Impact of User charges on Vulnerable groups : the case of Kibwezi in rural Kenya. Social Science and Medicine, 41(6) : 829-835

53. Ministry of Health, Government of Ghana Hospital Fees Regulations, Ghana Publishing Co. 1985

54. Ministry of Health, Annual Reports 1985 (a and b); 1994 and 1995. MOH, Accra

55. Ministry of Health "Cash and Carry Programme" 1996 MOH, Accra

56. Nchinder, T.C. (1977) A household survey of illness prevalence and health care preference in a rural district of Cameroun. International journal of epidemiology 66(9) : 865-871

57. Ninsin, K.A. (1989) "Thirty-Seven years of Development Experience" In : Emmanuel Hanson and Kwame Ninsin (Eds). The State Development and Politics in Ghana. Corsdesria Book Series. London P1-12

58. Ofori Adjei, D and Amoa, A.B. (1990) Baseline Survey for the Implementation of Bamako Initiative in Ghana

59. Osei, C. (1990) A study of maternal health practices and utilization of maternal care facilities among women of child bearing age in Suhum, Ghana. Unpublished. Department of Community Health. University of Ghana Medical School

60. Parson, T. (1951) The Social System The Free Press. New York. U.S.A.

61. Rumney, J. (1966) Herbert Spencer's Sociology. Alherton. New York. Chp. ix and x

62. Ryan, M., and Birch, S. (1988) Estimating the effects of health service charges: Evidence of the utilization of prescription. Centre for Health Economics, Univ. of York, York. England.

63. Sam-Adjei, David Ofori-Adjei and Divine Asiama (1990) "Guidelines for the Implementation of the Bamako Initiative" MOH, Accra.

64. Senah, K.A. (1989) "Problems of the Health Care Delivery System" In Emmanuel Hanson and Kwame Ninson (Eds) The State Development and Politics in Ghana. Codersia Book Series, London. P 243-267

65. Senah, K.A. (1997) Money be man. The Popularity of Medicines in a rural Ghanaian Community Het Spinhuis. Amsterdam

66. Stanton, B. and Clemeus, J. (1989) User fees for health care in developing countries: A case study of Bangladesh. Social Science and Medicine 29(10) : 1199-1205

67. The Easmon committee Report (1969) P.81

68. The Konotey-Ahulu Committee Report, 1970.

69. Twumasi, P.A. (1975) Medical Systems in Ghana. Ghana Publishing Co. Tema. Ghana

70. UNICEF (1987) Programme of Actions to Mitigate the Social Cost of Adjustments. UNICEF, Accra. P.2

71. UNICEF (1995) The Bamako Initiative: Rebuilding Health System. World Marketing Services. Washington D.C.

72. UNICEF (1990) Economic Crises, Adjustment and Bamako Initiative: Health Care Financing in the Economic context of Sub-Saharan Africa. UNICEF, Accra

73. Vogel, R.J. (1988) "Cost Recovery in Health Care Sector: Selected country studies in West Africa. World Bank No.82. Washington D.C.

74. Vogel, R.J. (1989) " Cost Recovery in Health care Sector: selected country studies in West Africa. World Bank No.82. Washington D.C.

75. Vogel, R.J. (1990) An analysis of three National Health Insurance proposals in Sub-Saharan Africa. International journal of Health Planning and Management, 5 : 271-278.

76. Waddington, C. and Anyimayew, K.A. (1989) "A price to pay: The impact of user charges in Ashanti-Akim District, Ghana. International journal of Health Planning and Management, 4 : 17-47

77. Waddington, C. and Anyimayew, K.A. (1990) "A price to pay part II". The impact of user charges in the Volta Region of Ghana. International journal of Health Planning and Management, 5(4) 287-331

78. World Bank (1988) "Population, health and nutrition, sector mission". Aide Memoire. Washington D.C.

79. World Bank, Annual Report, 1989 and 1990. Washington D.C.

80. Wouter, A.U. (1991) "Essential National Health Research in developing countries: Health Care Financing and the Quality of Care". International journal of Health Planning and Management, 6 : 253-273

81. Wyles, S. (1989) Bamako Initiative : A report on the JINJA workshop on Health financing. WHO. Geneva.

82. Yoder, R.A. (1989) "Are People Willing to Pay for Health Services" Social Science and Medicine 29(1) : 35-42

83. Zanden, Vande J.W. (1990) Sociology : The Core,McGraw-Hill Publishing co. London.

APPENDIX 'B'

MEDICAL UNITS - BOLGATANGA HOSTITAL

A	Six Consulting rooms
B	A dressing room
C	An injection room
D	An O. R. S. Coner
E	Eye Clinic
F	Community Psychiatric unit

MOH: 1996

APENDIX 'C'

STAFF STRENGTH OF BOLGATANGA HOSPITAL (DECEMBER 1996)

1	Medical Officer and Dental Surgeon	11
2	Medical Assistant	6
3	Nurse Anaesthetic	2
4	Psychiatric Nurse	4
5	Ophthalmic Nurses	7
6	Nursing Staff	107
7	Laboratory and Blood Bank Unit	12
8	Pharmacist Unit	15
TOTAL		164

Source: MOH 1996

APPENDIX 'D'

TOP TEN (10) CAUSES OF OUTPATIENT MORBIDITY

NO.	DIAGNOSIS	MALE	FEMALE	TOTAL
1	Malaria	3,414	2,432	5,846
2	Gynecological Diseases	-	992	992
3	Diarrhoea Diseases	527	116	643
4	Intestinal Works	190	312	502
5	Diseases of the skin	244	198	442
6	Pregnancies	-	382	382
7	Upper Respiratory Infections	148	216	364
8	Pneumonia	111	231	342
9	Tuberculosis	216	102	318
10	Hypertension and other	214	59	273
11	ALL OTHER CASES	11,311	6,704	18,015
TOTAL		16,373	11,744	28,119

SOURCE: MOH 1996

DEPARTMENT OF SOCIOLOGY
UNIVERSITY OF GHANA - LEGON

FOCUS GROUP DISCUSSION ON THE TOPIC: "CASH AND CARRY ON THE GROUND" THE CASE STUDY AT THE BOLGATANGA CENTRAL HOSPITAL.

QUESTIONS:

1. What is the cash and carry all about?
2. When did it officially commence?
3. What necessitated the introduction of the policy?
4. What kind of preparations were made before the policy took off?
5. What was the immediate response from patients?
6. What is the situation presently?
7. What kind of difficulties do you encounter in the implementation of the policy?
8. How do you normally solve them?
9. Do you think the policy had any effect on you the implementors (of the policy)?
10. What kind of effect can you mention.
11. Were there any effect on the patients?
12. What is the nature of the effects (if there are)?
13. By way of summary what would you want t say about cash and carry?

DEPARTMENT OF SOCIOLOGY
UNIVERSITY OF GHANA - LEGON

TOPIC: "CASH AND CARRY ON THE GROUND"
A CASE STUDY AT THE BOLGATANGA CENTRAL HOSPITAL

QUESTIONNAIRE

1. Sex:..... .. 2. Age:..... 3. Religion:..... ... ..

4. Occupation:..... 5. Marital Status:.....

6. No. of Children:..... 7. Educational Level:.....

8. Are you aware of this policy of pay for services (cash and carry) in government hospital? Yes/No

9. When was the last time you visited the central hospital?...

10. What was the problem?.....

11. Were you satisfied with the treatment? Yes/No

12. How much did you pay for treatment?.....

13. Did you find this expensive? Yes/No

14. Do you think people must pay for services at government hospitals, Why?:.....
.....
.....

15. Did you have any difficulty when you visited the hospital? Yes/No

16. If yes, what were some of the difficulties .....
.....
.....
.....
.....
.....

17. What do you think are the effects of cash and carry on providers (of health services)?
.....
.....
.....

18. What do you think are the effects on patients?:.....
.....
.....
.....
.....

19. What suggestions can you make about the difficulties associated with the policy?
.....
.....
.....
.....

20. By way of summary, how do you perceive the whole policy?
.....
.....
.....
.....