The Uneven Implementation of User Fee Policy in Ghana

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INTRODUCTION

In response to worsening economic conditions and reduced public finance for health services, most developing countries, over the past decade, have undertaken reforms of various aspects of their health systems. The approach to health care financing has been identified as one of the fundamental causes of problems in the health sector. According to the World Bank, efforts of governments to provide free health care for everyone from general public revenues has resulted in chronic underfunding of recurrent expenditure, thus reducing the effectiveness of health staff and creating internal inefficiency of public programs (World Bank, 1987). In its 1987 document entitled "The Agenda for Health Reform", the World Bank provided four policy recommendations for adoption by developing countries undertaking the International Monetary Fund's Structural Adjustment Program. Two specific types of strategies that have been introduced by governments are reform of financing strategies and reform of public sector organization and procedures. These reforms have shifted some of the burden of financing health care from the public sector to the beneficiaries (households) and shifted some decisionmaking from central planning agencies to those in closer touch with local conditions and client needs. The decentralization of health services and the charging of users for publicly provided health care are, probably, the most widely implemented reform strategies in sub-Saharan Africa.

Changing attitutes towards governance and international trends favour decentralization in support of primary health care. Decentralization, which has been proposed as a means to enhance efficiency and responsiveness to local health needs, is expected to bring major changes in institutional and managerial roles. There are different patterns and definition of

decentralization. The various forms of decentralization have been called different names like devolution, delegation and privatization (Rondinelli et al, 1983). Conyers and others have indicated that the "most important aspects of decentralization are to establish the level to which authority is to be decentralized, the precise authority being delegated, the policy instruments to be used to effect decentralization and the types of activity to be decentralized" (Conyers, Cassels and Janovsky, 1992). In sub-Saharan Africa the "prefered management level is usually the district, where the management of primary and secondary level services can be integrated and planned for a defined population" (Gilson and Mills, 1995). In Africa, district-based health care is practiced widely in countries like Ghana, Tanzania, Botswana and Zimbabawe, partially in Benin, Guinea, Mali and Nigeria, and on an experimental basis in Burundi and Senegal (World Bank , 1994). Experience indicates that successful decentralization requires definition of specific objectives, clear delineation of functions and decisionmaking authority at each level, mechanisms for communication and coordination among various levels, and sufficient training to enable full assumption of new responsibilities (Vaillancourt, Nassim and Brown, 1992). Within the framework of national policies and norms, district health managers can be authorised to make decisions on many issues.

In many African countries, user charges have become a reality, serving as a significant source of finance for health care. As governments reduce their per capita health expenditure, the need to mobilize and sustain additional resources for health becomes paramount. A recent survey of 37 Sub-Saharan African countries showed that 33 had cost recovery programs or planned to introduce one (Nolan and Turbat, 1993). About a third of African countries, implementing a user fee policy, view mobilization of revenue as a primary objective

(Shaw and Griffin, 1995). The importance of user charges in health care finance policies was endorsed by participants at a meeting of senior health officials from 12 African countries in Windhoek, Namibia, in 1993 (WHO, 1994). The importance of fees as a potential source of revenue in the developing country context can be assessed by actual cost recovery experiences in countries. Some studies from Africa show that revenue from user fees have traditionally covered only 6 - 8 percent of recurrent expenditure even without taking account of the administrative cost of fee collection process(Mwabu,1990). Aggregated at the national level, revenue from user charges may appear insignificant; however, at the health facility level, revenue from user charges as a percentage of total income is way beyond 6 to 8 percent, and positively affects the quality of health care being provided.

But user charges have other goals. Proponents claim that a user charge is a policy tool that seeks to generate revenue, promote efficiency, foster equity and enhance sustainability. Several theoretical arguments have been used to justify the feasibility of these goals. Price signals from user charges, it is argued, could help restore efficiency in the referral system; zero prices hinder a health system from efficiently directing users to places where unit costs for particular services are lowest. Demand for health care rises proportionately with income. Charging those who use expensive curative services most frequently and are able to pay could supplement public coffers and raise funds to subsidize those least able to pay, thereby fostering equity (Shaw and Griffin, 1995). It has also been argued that user charges and other types of cost recovery are important to ensure the sustainability of publicly provided health services as well as the improvement of quality.

In many countries the introduction of user fees has been (???????highly politicised). In most instances, initiation of the policy has not been indigenous but has been at the behest of the World Bank. The adoption of a user fee policy has been viewed by governments as political,

something governments ought to be doing, whilst the implementation has been considered administrative (Walt, 1994). In Kenya, introduction was accompanied by announcements from the Minister of Health. And when the first introduction had to be called off, it took President Arap Moi himself to announce the decision (Collins et al, 1996). In Tanzania, formulation of legislation on user charges is a central government function (Newbrander and Sacca, 1996). When user charges were first introduced in Ghana, it was done through an act of parliament (Hospital Fees Act, 1971). Subsequent revisions of fee levels in 1983 and 1985 were also through central government decrees (Hospital Fee Regulations of 1983 and 1985). Cost recovery programs have been introduced through what Shaw and Griffin refer to as a "political process" (Shaw and Griffin, 1995).

The controversy that surrounded the introduction of user fees has rendered governments unable to revise fees to reflect reality. A World Bank study stated that, "there is considerable scope for expanding user fees and that households are willing to pay those fees, provided quality improvements accompany higher prices" (World Bank, 1994). Barnum and Kutzin have indicated that one of the important ways of maintaining the revenue potential of of user fees is to adjust the fee levels regularly to keep pace with inflation (Barnum and Kutzin, 1993). Shaw and Griffin have argued that maintaining the real level of prices does not negatively affect equity and recommended periodic adjustment be built into any system of user charges. They further advocated that these regular increases should be effected through an "administrative process rather than a political process"(Shaw and Griffin, 1995), that is, central level legislation. (Support with empirical evidence from Ghana, Kenya, Tanzania and Uganda). ??????????
This brief review indicates that the idea of a decentralized fee adjustment seems to be gaining popularity both in theory and practice.

Opponents of cost recovery programs focus on inequity as a major drawback to the policy of user charges. In most countries user fee legislations and programs have incorporated principles to deal with the problems of inequity and inefficiency. The design of most cost recovery programs have price structures and exemption mechanisms to bring about positive efficiency and equity impacts (Gilson and Mills, 1995). A graduated/hierarchical fee structure is intended to enhance the referral system, encouraging the first use of lower level facilities. Exemptions and waivers are used to ensure access to the poor and medically vulnerable. Thus exemptions and graduated price structures are seen as strategic design features of most cost recovery programs.

In sub-Saharan Africa the debate over user fee policy has evolved through three phases. During the first phase, the debate was whether to introduce user charges. As more countries adopted the policy, the debate shifted from “whether” to “how to” introduce cost recovery programs. Now that the policy is almost universal in sub-Saharan Africa, the focus of the debate is shifting to procedures for revising the policy. Whilst an official policy of decentralized adjustment of fee level has not been adopted, empirical evidence indicates that the process of decentralization has resulted in a defacto policy to revise user fee levels in some countries.

A major concern of this study is how the decentralized readjustment of fees affects the design features of the cost recovery program. Do these localized readjustments of user charge maintain the guiding principles of the cost recovery schemes, especially the graduated fee structure and the exemptions? This study examines the implementation of policy

decisionmaking in the health sector in Ghana. In particular, it examines the effect of decentralization on the implementation of user fees in Ghana, and determines whether the graduated fee structure and exemptions policies, key features of the cost recovery program, have been adhered to by district level decision makers. The paper first describes the user fee policy as stipulated in national legislation, then describes the current practice under decentralization in Ghana, and finally identifies variations between the stipulated policy and actual practice.

Two caveats are essential at this stage. First, the study does not examine the real value of fees but deals with absolute prices to enable a comparison between legislation and practice. Admittedly, there would be many arguments for using real value of prices; some may even want to see the prices in dollar terms. The study uses absolute prices because the main focus is on decisionmaking processes and implementation not the economics of user fees. Second, the study does not cover "illegal fees". "Illegal fees" are those collected by the service provider as a professional fee and go into the provider's personal account. In this study user fee was defined as a fee collected from patients for services rendered, for which an official receipt is issued and accounted for through institutional record keeping.

STUDY AREA

The study was conducted in Brong Ahafo, one of the 10 administrative regions of Ghana. Decentralization and cost recovery of hospital fees have been widely implemented in Ghana, with PNDC Law 207, (1988)

providing the framework for decentralization. The law transferred wide ranging functions, powers and responsibilities to District Assemblies, including legislation, budgeting revenue collection, political and social development, etc. According to Ahwoi, the Minister for Local Government in 1988, "the policy of decentralization is designed to install monolithic institutions at district, town and unit community levels to which some functions/responsibilities of government should be transferred, and through which access to state power can be created for the entire population of the country to exercise their democratic rights to take part in administration and decision making ..."(Nkrumah, 1992). The goal of creating a monolithic structure with all ministries and departments coming under the District Assembly is yet to be realised. Civil Service reform, a prelude to creating monolithic structures, is currently ongoing. The process of decentralization is most advanced in the Ministry of Health, which has been restructured with the establishment of District Health Services in all 110 districts. The Ministry of Health is the torch bearer in decentralization and in Civil Service reform.

Several attempts were made to introduce user fees in Ghana prior to the World Bank's recommendation for charging users of publicly provided health care. Free medical services were introduced by the socialist government of the Convention People's Party (CPP) in 1960 in the face of stiff opposition from health care providers. The Busia regime re-introduced user charges in 1971 by Act 387 - Hospital Fees Act of 1971. However, the law was never implemented before the government was overthrown in January, 1972. In the middle of December 1981, the PNP government, which had promised the nation free medical care as stated in their manifesto, passed a law introducing user charges. However, again, the bill had not become law before the PNP government was toppled on December 31 1981. The coup brought Rawlings to power. The Rawlings

government later adopted the Structural Adjustment Program of the World Bank and International Monetary Fund, with its conditionalities.

In 1983, in the face of very difficult economic circumstances, the PNDC government very reluctantly agreed to introduce nominal fees. The government argued that it was “impolitic” to introduce full scale user charges at the time. By 1985, the economic situation had reached rock bottom. Government had very serious liquidity problems, because revenues were not flowing. As a result, the Ministry of Health’s import program could not go through by the close of the financial year, because the Accountant General could not provide the local currency cover for the import licence. According to Dr. Moses Adibo (former Director of Medical Services), to overcome this difficulty, the ministry argued that if a “cost recovery scheme was designed properly and efficiently implemented, enough revenue could be generated to support at least, in part, the most important drugs and supplies”. Thus the main objective was to collect enough money to make importation of drugs much easier, hence the need to recover the full cost of drugs (Adibo, 1996).

The Hospital Fees Act of 1971 conferred on the Minister/Secretary for Health the authority to regulate user charges, with the approval of government. In 1985, with the approval of the PNDC government, the Hospital Fees Regulation was promulgated to stipulate the fees to be collected at government health facilities. The regulation set fees for outpatient attendance, laboratory and other investigations, medical, dental and surgical treatment, medical examinations, drugs, and hospital accomodation and catering.The regulation provided for a graduated fee structure with fees for outpatient consultation and delivery, increasing from rural health center and posts through district and regional hospitals to teaching hospitals. The regulation also differentiated general outpatient consultation from specialist outpatient consultation. It had price disparity for Ghanaians and non-Ghanaians, adults and children, as well as rural and urban areas. Another key feature of the program was its exemptions policies. It exempted patients suffering from tuberculosis and leprosy from all fees; charged only the cost of drugs for patients with specific communicable diseases like meningitis, tetanus, schistosomiasis,

typhoid, viral hepatitis, etc. It also supported care for children and mothers, by waiving all fees for antenatal and postnatal services and treatment at child welfare clinics other than those for hospital accomodation and catering services. ????conclusion

Between 1983 and 1990 the administration of user fees evolved to allow individual institutions retain all revenue generated. At the beginning of the cost recovery program, all revenue generated by individual health facilities went into a central account controlled from national level. Subsequently, health institutions have been allowed to keep increasing percentages of revenue generated. Today, health institutions retain all revenue generated. The revenue is kept in two separate bank accounts: one for drugs, and a second for other revenue. The rationale is to use money from the drugs account solely for the purchase of drugs to ensure that there is always money for drugs. Funds from the other accounts can be used at the discretion of the local facility's manager to improve the quality of care provided.

A decade has elapsed since the 1985 legislation for user fees was revised. Over this period, the high rate of inflation in Ghana has eroded the value of fees stipulated by the 1985 law. The current legislation stipulates fee levels that are ridiculously low. A Ministry of Health circular dated January 30, 1997, stated, "this policy of providing free medical consumables to the health institutions appears not only outdated but economically unbearable to the system since it is a fact that almost all the institutions have been charging patients for these same items" (MOH, 1997). To improve revenue flows, local health authorities and health care institutions have, on their own initiative and in collaboration with local interest groups and other actors, revised user charges to reflect reality. As a result, actual user charges at government health facilities are higher than the fees stipulated by LI 1313, 1985. In addition, certain services and supplies which did not attract any charges under LI 1313 are now part of the cost recovery scheme. In short, the process of fee revision has been decentralized

de facto, in ways that may erode the exemption scheme and increase inequity. These concerns are particularly important in view of the earlier finding by Waddington and Enyimayew that the 1985 increase in user fees resulted in a sharp and significant reduction in the utilization of ambulatory care (Waddington and Enyimayew, 1989).

METHODS

The study covers 55 health facilities owned by government or by religious missions in the Brong Ahafo region. It excludes private and traditional health care providers. All levels of the health care system are covered, including regional hospital, district hospitals, health centers, and clinics.

In each institution, data were collected in five areas: 1) prices of selected services and procedures provided at the health facility (including outpatient consultation, laboratory, x-ray, inpatient care, major surgery, minor surgery, and deliveries); 2) charges for selected medical consumables and supplies that were not covered by the cost recovery legislation of 1985; 3) prices of selected essential drugs; 4) charges for selected exempted illnesses; and 5)how prices were determined. Data were collected through an interviewer administered-questionnnaire to the administrator of the health facility and the review of institutional records. The interviews were conducted by three public health nurses who were trained as research assistants. Table 1 shows a breakdown of the selected institutions by type and owner.

Table 1: Sample of Institutions in the Study

PROVIDER	Regional Hospital	District Hospital	Health Center	Rural clinics	Tota
Government	1/1	4/5	23/27	17/63	45/9
Catholic	0/0	5/7	1/1	0/0	6/8

Presbyterian	0/0	1/1	0/0	1/1	2/2
Methodist	0/0	1/1	0/0	0/0	1/1
Islam	0/0	0/0	1/1	0/0	1/1
TOTAL	1/1	11/4	25/29	18/64	55

RESULTS

i. Fee Structure

It is clear that government institutions are no longer complying with the Hospital Fees regulation of 1985. Indeed the study found total disregard for the fee levels stipulated the legislation. At all levels of facilities, fees charged are way above stipulated levels. Tables 2 to 6 show the differences between the stipulated fee levels and those being charged by district and regional hospitals owned by missions and government.

Table 2: Stipulated prices compared with mean prices charged in government district hospitals (n=4)

Price category	Stipulated price	Mean price	% increase in price	Min price	Max price
OPD	50	350	600	200	500
INPAT.	100	325	225	200	500
DELIV.	100	2000	1900	1000	3000
XRAY	200	2000	900	2000	2000
H'GLOBIN	10	475	4650	400	500
URINE R/E	40	575	1338	500	800
STOOLR/E	20	475	2275	400	500
CAESAR.	1000	55000	5400	5000	100000
APPENDI.	1000	55000	5400	5000	110000
HERNIA	500	28333	5567	5000	50000
E.O.U.	500	5500	1000	1500	10000

Table 3: Stipulated prices compared with mean prices charged in catholic district hospital (n=5)

Price category	Stipulated price	Mean price	Min. price	Max price
OPD	500	500	500	500
INPAT.	700	700	700	700
DELIV.	5000	5000	5000	5000
XRAY	4000	4750	4000	7000
H'GLOBIN	700	700	700	700
URINER/E	700	760	700	1000
STOOLR/E	700	700	700	700

CAESAR.	20000	22000	20000	30000
APPENDI.	20000	22000	20000	30000
HERNIA	20000	22000	20000	30000
E.O.U.	_	7500	5500	9000

Table 4: Comparison prices of district hospitals with regional hospital

Price category	Government	Catholic	Presbyterian	Methodist	Regional Hospital
OPD	350	500	400	400	200
INPAT.	325	700	500	500	500
DELIV.	2000	5000	6000	3500	3000
XRAY	2000	4750	4500	3000	4000
H'GLOBIN	475	700	500	500	400
URINE R/E	575	760	500	500	500
STOOLR/E	475	700	500	500	500
CAESER.	55000	22000	30000	35000	1000
APPEND.	55000	22000	40000	40000	1000
HERNIA	28333	22000	20000	30000	1000
E.O.U.	5500	7500	8000	10000	1000

Table 5: Stipulated prices compared with mean prices charged in government regional hospital

Price category	Stipulated prices	Reg. Hospital	% increase in price
OPD	75	200	167
INPAT.	100	500	400
DELIVERY	100	3000	2900

XRAY	200	4000	1900
H'GLOBIN	10	400	3900
URINER/E	40	500	1150
STOOLR/E	20	500	2400
CAESER.	1000	1000	0
APPENDIX	1000	1000	0
HERNIA	500	1000	100
E.O.U.	500	1000	100

Table 6: Comparison of levels of govt. facilities

Price category	Reg. Hosp'tal	Dist. hosp'tal	Health center	Rural clinic
OPD	200	350	110	77
DELIVERY	3000	2000	1011	988
HEM'GLOBIN	400	475	200	N.A.
URINE	500	575	200	N.A.
STOOL	500	475	200	N.A.

Tables 2 and 5 show that the pricing of health care is not systematic????????. The mean price for ambulatory care charged by government district hospitals was higher than that of the regional hospital; the mean government district hospital price was 600% above the stipulated fee level, higher than what was charged by the regional hospital; and the maximum price charged by a district hospital was 150% above that of regional hospital. Mean prices for inpatient care and delivery were lower in the government district hospitals compared to the regional hospital, but even here some district hospitals charge as high as the regional hospital. District hospitals had a uniform price for x-ray, which was half the price charged by the

regional hospital. Generally, government district hospitals charged higher prices for laboratory investigations with the exception of stool R/E. All government district hospitals set fees way above what the regional hospital charges for surgery. Whereas the regional hospital did not raise prices for major surgery, district hospitals raised prices by over 5000%. The price range for surgery epitomizes the price disparities that have arisen, reflecting the de facto autonomy of health facilities.?????

The Catholic health system in the region, in contrast to the public health system, has revised fees regularly. Current fee levels for Catholic health facilities were revised in 1995. On the whole, most Catholic institutions comply with fee levels set by the Diocesan Health Committee, a regional level body. Table 3 illustrates the level of compliance of Catholic hospitals with fees stipulate by the Diocesan Health committee, showing that Catholic hospitals have a higher degree of with their regulations than do government facilities. In a few instances some Catholic institutions have set different fee levels. The other religious institutions, that is Presbyterian Islam, and Methodist, set fees at the health facility level.

Table 6 shows the price structure for basic service components within the government sector. A graduated price structure seems to exist at the district level. The graduated price structure breaks down at the regional level; apparently, as a result of greater effort by the regional hospital to adhere to stipulated fees for some services components, particularly surgery, district hospitals charge higher fees than the regional hospital for most service components.

ii. Drugs

Generally, there was no marked differences in the prices of drugs sold by different providers and at different levels of the health care system. However, like the charges for specific services, the prices of drugs were higher in district hospitals than in the regional hospital, irrespective of ownership.

Table 7: Comparison of price of specific drugs by provider ??????????

Drugs	Govt. dist.	Catholic dist	Presby dist.	Met'dist dist	Reg. Hos'tal
ChloroQ tab.	22	22	25	25	20
ChloroQ inj.	200	171	200	200	160
ChloroQ syr.	413	340	240	450	240
ORS	200	144	200	170	150
Para. tab.	11	7	8	10	7
Para. syr.	413	340	240	450	240

The price of chloroquine tablet ranged from 20 to 25 cedis for all institutions,with a range of 20 to 22cedis for government facilities and a range 22 to 25 cedis for mission facilities. The range for the price of chloroquine injection was 160 to 200 cedis, with the regional hospital having the lowest price.

Table 8: Comparison of price of specific drugs of govt. facilities by level

Drugs	Reg. Hosp'tal	Dist. hosp'tal	Health center	Rural clinic

ChloroQ tab.	20	22	20	20
ChloroQ inj.	160	200	199	190
ChloroQ syr.	240	413	314	287
ORS	150	200	148	160
P/cetamol tab.	7	11	9	11
P/cetamol syr.	240	413	283	247

Chloroquine syrup had a range of 240 to 450 cedis, with Methodist facilities having the highest price. The price of ORS ranged between 144 to 200 cedis, with government and Presbyterian facilities having the highest price within the range. The price of paracetamol tablet was highest in the government institution, with a range of 7 to 11 cedis for all instituttions. Again, within the government sector, with the exception of ORS, prices of drugs at the regional hospital were lowest (Table 8).

iii. Exempted Illnesses

Both governemnt and mission institutions disregarded the official policy on exemptions and waivers. At both district and regional hospitals, patients were charged for laboratory sevices and for consultation for illnesses like typhoid, tetanus, hepatitis, sickle cell, and measles.

Table 9: Proportion of facilities charging for consultations and laboratory for specific exempted illnesses

Disease	Type of fee	Regional Hospital	District Hospital
Measles	Consultation Laboratory	0/1 1/1	10/11 6/11
Typhoid	Consultation Laboratory	0/1 1/1	11/11 11/11
Hepatitis	Consultation Laboratory	0/1 1/1	11/11 11/11
Tetanus	Consultation Laboratory	0/1 1/1	11/11 11/11
Sickle cell	Consultation Laboratory	0/1 1/1	11/11 11/11

Although the regional hospital did not charge for consultation, it charged fees for laboratory services in all cases. All 11 district hospitals charged for both consultation and laboratory services for hepatitis, tetanus, typhoid, and sickle cell disease. Measles was the only exception where some (6 out of 11) facilities did not charge for laboratory services and consultation.

iv. medical consumables and supplies

The waiver policy on medical consumables and supplies was generally disregarded.

Most institutions, irrespective of ownership, charged for consumables (Tables 10 and 11).

Table 10: Percentage of government facilities charging for exempted supplies by level ???

Item	Reg. Hosp'tal	Dist. hosp'tal	Health center	Rural clinic
Gauze	100	81.8	78.3	90.0
Plaster	100	63.6	75.0	80.0
Gloves	100	90.9	70.0	77.8
Antiseptic	100	33.3	52.4	44.4
Needles	100	90.9	87.0	90.9
Syringe	100	81.8	78.3	90.9
Bandage	100	81.8	70.0	60.0

Table 11: Percentage of institutions charging for exempted supplies by provider ?????

Item	Govt.	Catholic	Presby	Methodist
Gauze	80.6	83.3	100	100
Plaster	75.7	66.7	100	0
Gloves	72.7	100	100	100
Antiseptic	51.5	25	50	0
Needles	86.5	100	100	100
Syringe	78.4	100	100	100
Bandage	69.4	83.3	50	100

The regional hospital charged for all medical consumables and supplies. Within the government sector, antiseptic and plaster, particularly, were exempted by several institutions. There was no item that attracted fees from all institutions. More than 70% of all institutions at all levels charged for gauze, gloves, needles, and syringes. In the mission sector, again plaster and antiseptic were exempted by several institutions. The Methodist facilities provided plaster and

antiseptic for free but charged for every other item; only 25% of the Catholic facilities charged for antiseptic. All mission institutions charged for gloves, needles and syringes.

v. Decisionmaking Processes

In this study, prices of services provided by the different organizations were set at regional (9%), district (45%) and health facility (45%) levels.

Table 12: Decision making processes

Level	Body	% of facilities
Region	Diocesan Health Committee	9%
	Institutional Management Committee	
District	District Health Management Team	45%
Health Facility		45%
	1. Institutional Management Committee (27%)	
	2. Provider in charge (18%)	

Two bodies were responsible for setting prices of services and medical supplies at the regional level. The Catholic health system in the region, fee levels set by the Diocesan Health Committee, a regional level body. The Institutional Management Committee of the Regional Hospital set the prices for the hospital. In the District Health Service of government sector, prices were set by the District Health Management Team (50%) and at the facility levels (50%). Decisions at the facility level were made either by the Institutional Management

Committee (?????%) or by the service provider single-handedly (???? %). In a few instances some Catholic institutions have set different fee levels. The other religious institutions, that is Presbyterian, Islam, and Methodist, set fees at the health facility level through their hospital boards or similar bodies.

DISCUSSION

This study illustrates how the reform of public sector organization can influence other reform strategies (user fees, in this case) being implemented at the same time. Decentralization affects implementation of specific health policies as well as the procedures of the policy making process more broadly. Decentralization in Ghana has led to local decision making for all aspects of the health system, including decisions that might be deemed political or reserved for higher levels. In the case of user fees, the adjustment of charges has not been officially designated as a district level function, but this has been assumed by various sub-national levels in the health system. Moreover, the function has been adopted in ways that show a disturbing disregard for the strategic design features of the cost recovery program; these features were specifically intended to mitigate potentially inequitable or undesireable consequences of user fees. The results indicate a breakdown of the graduated price structure as well as non-adherance to the waiver and exemption regulations under the government policy of 1985.

The results of the study raise two categories of issues for discussion. The first is specific to the user fee policy. Why did district-level authorities disregard the guiding principles of the design

of the cost recovery program? Four factors could explain this failure to comply with the waiver and exemption principles of the cost recovery program in Ghana. First is a lack of knowledge by service providers and facility managers. How well informed are district-level decision makers about policy strategies? Whilst being aware of the existence of a cost recovery program, most district level decision makers were unaware of key features of the program design which could have been maintained even when prices were raised. Apparently, as in Tanzania and Kenya, no staff training was provided to explain policy and procedures for waivers and exemptions as well as other strategic features of the cost recovery program (Newbrander, 1995; Newbrander and Sacca, 1996) Second, the policy of fee retention serves as an incentive for local managers to maximize revenue. Revenue generation, which is a key objective of user charges, has overshadowed all other goals of the cost recovery program. Third is the lack of general public awareness about the exemption and waiver guidelines. Again, as observed in Kenya and Tanzania, there was no active communication by health facilities to communities and individual patients on the exemption system and the process of obtaining waivers and exemptions. The administration of most health facilities emphasized revenue generation rather than ensuring access to the poor and vulnerable.

Fourth, there were no sanctions or penalties for disregarding national policy on exemptions and waivers; they know that no one at the headquarters cared.

Regional hospital

Health financing policy

The second set of issues are more general and concern the definition of health policy and the policy making process under a decentralized health system. The total disregard for central government regulations raises questions about the definition and implementation of health policy in Ghana. Central government documents indicate that ministry officials were aware of the readjustment of prices by district-level facilities; yet the center took no action. Could this laissez-faire attitude itself be an unwritten policy that was being implemented? Afterall, a defacto policy of non-interference could reflect a defacto policy of institutional autonomy for all health facilities, similar to the official policy that was advocated for tertiary institutions. In short, is health policy what is written in documents or what occurs in practice?

The study provided evidence of huge differences between the stipulated fees and the actual prices demonstrating the obsolescence of the government's official policy. These differences reflect problems in policy review processes which were not clearly defined or implemented. Repeatedly, the Ministry of Health headquarters acknowledged the obsolescence of certain policies and the fact that administrators of health facilities were not complying with those policies. Yet nobody seemed to know how to declare the policies obsolete or how to revise the policies to conform with reality. This question is particularly pertinent, given the highly dynamic environment of the health sector in developing countries. In short, some policies remain frozen in time, while roles and functions are rapidly changing with decentralization and other reforms in public sector organization.

<u>conclusion</u>

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