

User fees and drugs: what did the health reforms in Zambia achieve?

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The article reports on exploratory research into the effects and prospects of health reforms in Zambia. The research, which was qualitative, was carried out in two rural and two urban health centres and their surrounding catchment populations. The authors focus on four principles of health reform: community involvement (including cost sharing), prevention, equity and quality of care. One of their main conclusions is that many people criticize the introduction of cost sharing because it does not improve the quality of care, by which they first of all mean the availability of drugs. The authors plead for a humane implementation of user fees in public health care that is directly linked to a more efficient provision of essential medicines.

Introduction

The fortunes of a good economy, which Zambia enjoyed at the time of Independence, were short lived. A fall in the country's chief export prices and a rise in oil prices precipitated an economic contraction which was compounded by internal mismanagement. Since the provision of health services was largely contingent on continued resources from the government, the poor economy meant that health conditions deteriorated. Infant and under-five mortality rates rose, the percentage of population with access to safe water and sanitation declined, and immunization coverage decreased. In addition, a rise in malnutrition levels was noted (Saasa and Kamwanga 1994; World Bank 1994b).

To stop the downward spiral the new government, which came to power in 1991, set out on a package of measures to bring new life into primary health care. These 'health reforms' were very much influenced by the spirit of the day: structural adjustment, which was being 'sold' to policy-makers (and by policy-makers to health workers and their clients) as an exercise in making health care more sustainable (World Bank 1994a; cf. Chabot et al. 1995). With the Bamako Initiative of 1987, this new policy was made concrete, and in accordance African governments agreed to:

- put their resources squarely behind the proven elements of PHC;
- make more rational use of their slender health budgets; and
- examine creative approaches to community financing methods, which had already enabled communities in a number of African nations to take charge of local health needs.

The idea of charging communities for health services was based on the premise that people already paid high fees for

private health care provided it was of good quality. It was assumed that if people are willing to pay for private services, they will equally be willing to pay for government services, as long as quality is assured.

The health reforms package was adopted as a comprehensive approach to resolving the inequities inherent in health services. The health vision was stated as a commitment to 'the fundamental and human principle in the development of the health care system to provide Zambians with equity of access to cost-effective, quality health care as close to the family as possible.' This meant provision of better management to attain 'quality health care for the individual, the family and the community.'

The government selected six operational principles to guide the new strategy: self-reliance and participation of individuals, families and communities; equity; intersectoral collaboration; decentralization; appropriate technology; and emphasis on promotive and preventive health services. New was that community involvement came to include cost sharing and that more emphasis was placed on the development of basic health care in urban areas. The question we address in this article is how successful these health reforms have been.

Methodology

Research design

Exploratory research was carried out to investigate what effects the government's revitalization policy has had on the quality of health care (Macwan'gi et al. 1996). The study was conducted in two urban health centres in Lusaka (the capital) and two rural ones in the Western Province, about 800 km from Lusaka. The study focused on four of the six principles

which had guided the health reforms, namely decentralization, community involvement, promotive/preventive care and equity. Two overall questions were addressed: (1) to what extent have the objectives of the health reforms been reached; and (2) have they contributed to an improvement in the quality of health care?

The research was carried out by a team of five field researchers, with occasional support from three medical anthropologists from The Netherlands. The three main research tools were interviews, focus group discussions and observations regarding provider–patient interaction and physical conditions at the four health centres. Observations were carried out with the help of a checklist which had been pretested in a pilot study. In total, 35 open, loosely structured interviews were held with health workers and key informants from the community, and 25 focus group discussions were conducted with community leaders (9) and actual users of the health centre (16).

Special attention was given to the interaction between providers and users of health services, and to their divergent views on the functioning of health care. Deviating or conflicting interests between these two parties and their subsequent differences in experience and interpretation of what takes place in health care, are likely to have a great impact on the outcome of health reforms. The confusion about the meaning of key concepts in health care, due to different definitions and explanations at different levels of social organization, is insufficiently understood. It prevents policy-makers from getting a clear picture of developments and concerns ‘on the ground’.

Study sites

The two rural health centres selected for the research were Itufa and Kaanja, situated in Senanga District of the Western Province. The area is extremely sandy and marks the beginning of the Kalahari Desert. The predominant occupations are subsistence farming and fishing. Persistent droughts over the past years have taken their toll. Many people are unable to produce enough food for their own consumption and, as a result, are forced to obtain it from the market. Poverty is recounted as a major problem. People live in scattered villages over a wide area and transport is difficult. Malnutrition, malaria, diarrhoea, and eye and skin infections are the most commonly cited health problems.

Itufa, with a catchment population of over 10 000, had a staff of four: a nurse, a clinical officer, a Classified Daily Employee (CDE) and an Environmental Health Technician (EHT). Kaanja, which serves about 3000 people, did not even have a nurse at the time of the research. Its staff consisted of one clinical officer and two CDEs.

The two health centres in Lusaka were Chilenje and Kabwata, both situated in the south-east of the city. Most people are employed as private sector workers, government employees, domestic servants and marketeers. The population may be characterized as ‘middle class’, meaning between poor and rich. Because of their employment profile, it was assumed that they would be able to pay health care fees.

The most common health problems in this area include respiratory infections, fevers, diarrhoea and other gastro-intestinal infections, malaria and skin infections. Other problems frequently mentioned were lack of money, water, inadequate food, poor sanitation and crime. Garbage is everywhere and the fear of burglars can be detected from the high walls surrounding many houses.

Community involvement

We asked policy-makers, health care providers and ‘ordinary’ people whether the community was involved in the planning and evaluation of basic health care. It is significant that people of Western Province (which is meant to have community involvement) denied that they played any role in the planning and evaluation of health services, while those not belonging to this community, the policy-makers, claimed that the people were involved. The health workers were divided; some said the community was involved through health committees, others denied it.

In fact, the Western Province does have a tradition of community involvement, and the research team witnessed a meeting of health workers and community members on issues of planning. Such traditions seem relatively rare in the urban setting of Lusaka, which is characterized by a conspicuous absence of community spirit.

What interested us most, however, was how people *perceived* their involvement. The fact that policy-makers said that the community was involved suggests that the paper world of plans, guidelines and rules constituted the real world for them. Believing in that world provided them with a means to legitimize their work. Answering in the affirmative to our question was at the same time an act of faith in the government policy of which they were a part.

Conversely, the denial of involvement by community members showed their lack of faith; they indicated that they had nothing to do with the organization of health care – it was not ‘theirs’. They went for treatment, but it was ‘foreign territory’. The fact that even people in the rural communities of the Western Province denied any involvement in planning and evaluation – although such involvement seems to exist in practice – suggests that those who participated in the health committees did not really represent their community. Their fellow community members were either not aware of what they were doing or did not feel it was their concern.

The only involvement that community members did acknowledge was occasional voluntary work. One person in Lusaka said: ‘We only come to know of a health project when they want free labour.’ One woman asked: ‘How can we become involved in health services when the services are planned and brought to us?’ Some did not even seem to know what the term ‘involvement’ meant.

Health workers too were sceptical of community involvement, even where voluntary labour was concerned. A health worker in the Western Province remarked: ‘I have never seen the community come to work voluntarily. They only work

when they are given something, for example maize from PAM (Programme Against Malnutrition). The people are willing to work when they know what they will be paid.'

Ironically, the most prominent form of community involvement and the most conspicuous element in the government's health reforms, user fees, was never mentioned when people were asked about community involvement.

Cost sharing

User fees

The topic of user fees engendered the liveliest discussions during our research, but people did not talk about them in the context of community involvement. In their eyes, user fees had nothing to do with it. How could they regard the fees as a form of involvement if they had not even been involved in the decision to introduce them? People complained that the fees had been forced upon them. Nearly all users of health care who took part in the research saw the fees as proof that health care was something that was planned and organized from outside, somewhere high-up in the Ministry.

The fees were always mentioned when we asked people if they knew of any recent changes in the health care system. The fees preoccupied them, and nearly always negatively. Only four people expressed some support for them. All other informants denounced the new measure which they had come to see as the sobering truth behind the attractive slogans of the health reforms. One teacher said: 'The pay of a teacher is the lowest in the country. How do we manage the escalating cost of living now that we have to pay for health services too? We do not get enough to pay user fees.' Some young men became angry as they tried to explain their predicament. One pointed out that he was unemployed and not even able to buy soap. How did they then expect him to find money to pay the fees in the health centre? Some said they may stop coming to the health centre and instead visit a traditional healer or just stay at home. A man in Lusaka, a member of the Health Neighbourhood Watch Team commented: 'The new government had very convincing slogans but their actions are terrible... How do we explain this to the people in the community?' A female member added: 'What will my friends say when they realize I am in the Health Neighbourhood Watch Team?'

User fees are the focus of a report by a team of Zambian and British researchers who studied their implementation and people's reactions to them in five locations in Zambia (Booth et al. 1994). They highlight two main objectives in the government's cost-sharing policy: to raise additional resources which can be used to improve the quality of services and to break the passivity of service users and change their 'dependency syndrome' into active involvement and a greater sense of 'ownership' of public health care. The objective of increasing a sense of ownership proved a 'red herring', however:

'People are affronted by the proposal that they must now pay for the services of the clinical staff because they feel they have already contributed a great deal to the establishment

and maintenance of the clinics. In fact, they already have a strong sense that the clinics... are 'theirs', on the grounds that most of the labour and materials that have gone into their construction and upgrading since the 1960s have been provided free by community members.'(p.46)

People felt 'cheated' by the government's decision to make them pay for the services. One person in our own research expressed the same irritation, asking: 'If it is our clinic, why are we told to pay?'

The introduction of user fees was not seen as a way to involve the users in the service, but rather as a sign that they were 'dis-owned' and excluded from having a say in the running of the centre. They simply viewed the government's decision as a trick to get more money and to help it to pay staff salaries. In their cynical comments on the user-fees scheme, people revealed their own concerns. They too were short of money and for that very reason rejected any measure which cost them money. The denouncement of any increase in costs reflected their own precarious financial condition. They acted as critical consumers who, quite naturally, wanted to pay as little as possible.

Interestingly, people in Zambia do not always object to paying for health care. Missionary and church-related hospitals have a long tradition of raising fees and they are well attended by people who are willing to pay for their services. The understanding is that they get their money's worth. These non-profit private institutions have the reputation of providing relatively good services and being well stocked with medicines (cf. Soeters 1997).

People are also prepared to pay traditional practitioners and faith healers. The latter abound in the independent spiritual churches in urban areas. In fact, the costs of traditional healers may well be substantially higher than those of biomedical institutions. Forsberg (1990: 10) reports that in the Western Province, 82% of health care expenses involved traditional healers (cited in Booth et al. 1994: 1-5). Indeed, paying for health care is nothing new in Zambia, nor in Africa as a whole (cf. van der Geest 1992).

So why did people object to paying for public health services? Firstly, they have always been 'free' and no one likes to start paying for what used to be free (cf. Waddington and Enyimayew 1989). We say 'free', in quotes, because it is well known that in the past people often paid informally for scarce medicines or paid at a commercial pharmacy or drug store for medicines unavailable in the government health centre. Secondly, as is shown in the examples above, people felt betrayed because, they said, they had paid already in the form of voluntary labour. They demanded free services in reward. Politically conscious citizens in Lusaka added that they had paid taxes, so they were entitled to free care. User fees amounted to double paying.

However, the strongest reason was probably that people had little confidence that they would get better quality of care after paying. If they thought they would get proper treatment, in particular good medicines, most of them would probably

be happy to pay the fees. Their scepticism about possible improvements after the introduction of fees was expressed in many comments. Some said they were cheated because, after paying the fees, they discovered that the medicines they needed were not available. They had paid for ‘nothing’ and were given only a prescription, which meant they would have to pay again at a pharmacy.

The insurance scheme

An insurance scheme was introduced a few years after user fees had been implemented, but only on a very limited scale – mainly in some urban areas. The scheme seemed in many ways more attractive to health care users than the user fees. The required payment was 500 kwacha per month per person. For those who had joined the scheme by paying its membership, all services were free. Those who were not members of the scheme had to pay 2500 kwacha each time they visited a health centre.

During the research little insight could be gained into people’s views on insurance compared to fees for services. Community members in rural areas were not familiar with the phenomenon, since the prepayment scheme had not yet been introduced there. Most urban respondents who were familiar with insurance preferred it to user fees, clearly for financial reasons. In the end, the insurance would be more economical for them. People were very ‘rational’, they wanted more medicine for less money. Health workers were the same. They would rather pay nothing to get their medicines. One of them agreed that the prepayment scheme should continue, but ‘members of staff should be excluded from paying for health services and be attended free of charge’. Research a few years later showed that those who were familiar with prepayment – those in the towns – preferred it in overwhelming numbers (75% of the health workers and 85% of the community members). In order to better understand the logic of this, we consider two other recent studies on cost sharing in Zambia.

A study by Atkinson et al. (1995) in Lusaka showed that many people had a positive appreciation of the insurance scheme, although some complained that they paid for nothing in the months when they did not use the medical services. Health workers, however, pointed out that people had already discovered various ways to abuse the scheme: some people did not join the scheme until they fell sick, some used other people’s cards, some visited several health centres with the same card in an attempt to obtain more medicines. They believed that in general the scheme would lead to the over-utilization of services as people want maximum benefit from their membership. It seems likely, therefore, that the scheme will not bring much financial relief to the government.

In a recent study of the effects and options of the health reforms in the Western Province, Soeters (1997) found that an overwhelming majority of the local population preferred health insurance to user fees. From a consumer’s point of view, this preference makes sense. It does not mean, however, that health insurance, at this stage, is the best policy option. The self-interest of the consumer in a market situation is

mostly a matter of ‘negative reciprocity’: getting the maximum of health care for the minimum price (cf. Criel 1998: 65–67). People calculate that an insurance system will allow them more room to pursue their interests than paying user fees. Insurance, after all, is a public fund which can be (mis)appropriated by individuals in the same way as public health facilities in the pre-health reforms era. An insurance system will yield attractive short-term benefits to consumers, but it is doubtful that it will serve them best in the long run. Positive experiences with church-related private/non-profit medical services suggest that a system of user fees, although disliked by the community, is a better guarantee for sustainable health care in Zambia.

Preventive and promotive health services

To what extent have the health reforms led to a greater interest in preventive and promotive health care among users of health services? This question was not addressed directly during discussions with staff and health-care users, but indirectly much was said.

Whatever we asked, members of the community brought up the issue of drug availability at the health centre. Whether we talked about decentralization, user fees or quality of care, people linked it immediately to drugs. To them medicines were the *raison d’être* of the health centre and health care in general. A competent and kind nurse or doctor who does not have drugs to dispense becomes useless. The health worker, wrote Alland (1970) many years ago with some exaggeration, is the adjunct to medicines. You have to see him because it is through him that you will acquire the desired medicines. The doctor’s value lies in the drugs he gives. After all, the people believe, it is the drugs that make medicine work, not the doctor or the nurse.

This way of reasoning has its consequences for user fees and insurance. The fees and the insurance only make sense if they are instrumental in obtaining drugs. The greatest dissatisfaction with the user fees lied in the fact that they did not guarantee receipt of medicines. If they did, most people would probably be much more inclined to accept them, as they did at missionary health institutions. A teacher in Lusaka criticized the fees by saying: ‘After all there is no real improvement to the services. Medicines are still out of stock and nurses are still rude. So what are we paying for?’ And another teacher said: ‘You pay money but get no medication.’

Conversely, those who were more positive about the health reforms based their appreciation upon the fact that they did now get the medicines they wanted. Soeters (1997: 92), in his research in the Western Province, reaches the same conclusion: ‘Availability of drugs is probably *the* most important indicator to assess the performance of health institutions.’

If drugs are still regarded as the acid test for judging the quality of health care, we do not have to look much further for an answer to the question about preventive and promotive care. People’s outlook on health and health care is still overwhelmingly curative. The health reforms have been unable to change that attitude.

Equity

The PHC policy of the 1980s is said to have been too exclusively focused on rural areas, at the expense of the urban poor. The health reforms were to redress that imbalance. Comparing the two urban and two rural health centres that took part in the research, there is no impression that the rural centres have been favoured above the urban ones. The physical conditions in the urban centres are generally better than in the rural ones. Most equipment in the rural centres was not functioning well and was less adequate than in urban centres. However, there was no apparent significant difference in drugs supply between rural and urban centres.

The most conspicuous difference between the rural and urban centres was the staffing, both in terms of qualifications and number. Kabwata health centre counted one resident doctor and 38 nurses of various qualifications. Chilenje did not have a resident doctor at the time of the research but had 45 nurses of various qualifications. The two rural centres stood in stark contrast to these figures. Itufa had a staff of four, only one of whom was a nurse. Kaanja had no qualified nurse at all at the time of the research; the total staff consisted of one clinical officer and two untrained labourers.

The much larger catchment population of the Lusaka clinics does not warrant such enormous differences. The urban centres had more than twice as many staff as the rural ones, taking catchment into account, albeit at an estimate. The most likely explanation for this inequity is the government's appointment policy. Women, who constitute the overwhelming majority of health centre nurses, are entitled to employment in the same place (area) as their husbands. Moreover, there is always a strong pressure exercised upon those deciding on appointments to place the employees in urban institutions. Most nurses – and doctors – with families do what they can to secure a place in an urban environment where life is more comfortable and there are education facilities for their children. They will use both social and material resources to realize their preference. This means that there will also be an 'unplanned' bias in staffing urban health centres, to the disadvantage of rural ones.

The 'overstaffing' was also noticed by the users of the urban centres. One pregnant woman said: 'We are attended by a handful of nurses at the antenatal. What are the others doing?' And another woman remarked: 'What are they doing? They are supposed to find something to do instead of drinking tea!' Several people indicated that there would be no queues if all the staff would do their work.

At the rural health centres the staff are likely to be busier as they have to perform many different tasks simultaneously. Taking other factors into account, such as transport difficulties and long distances, there is no doubt that the rural communities of the Western Province are at a disadvantage with regard to good health care. Interestingly, however, the people themselves do not seem to see it that way. Patients at the urban clinics are less content about the medical services than those at the rural centres. This brings us to 'quality of care'.

Quality of care

Quality of care is a complex issue. The question of whether the health reforms have led to an improvement of that quality is difficult to answer. What does quality of care entail? In our research we distinguished five clusters of criteria which we put to people when discussing quality of care:

- (1) the interaction between health worker and patient, which includes not only the attitude of the health worker (kind or rude, attentive or negligent, etc.) but also the way he/she took trouble to make a proper diagnosis and to communicate that information to the patient;
- (2) availability of drugs;
- (3) the physical condition of the clinic – equipment including benches for waiting patients, maintenance, cleanliness;
- (4) the accessibility of the services – distance to the centre, presence of staff, opening hours, etc.; and
- (5) the perceived outcome of the treatment.

We were not so much interested in the 'objective' conditions that made up the quality of health care but in people's perceptions. This led to some interesting observations. Although those in Lusaka seemed to be quite a lot better off in 'objective' terms, they were considerably more critical of the quality of services.

People of Itufa and Kaanja spoke well of the health workers in their centre: 'They are okay, they don't insult us.' Someone else said: 'They have good attitudes towards us. They welcome everyone and treat each one. They are respectful and friendly towards us. The only problem I notice is that the clinic runs out of drugs.' And a third one: 'They really take care of us.' Some teachers, however, held negative views about health workers. As 'colleagues' of the health workers, they thought they should be given preferential treatment. As a result they criticized the health workers. The other people, however, held the medical staff in high esteem, even when they were unfriendly. They excused their behaviour by putting it down to the staff's frustration about their poor work conditions and lack of medical equipment. The health workers were regarded as members of the community; most of them, in fact, originated from the Western Province and shared the same culture.

People in the city, however, frequently criticized health workers for their rudeness and overbearing attitudes: 'Nurses think they are bosses, yet we are the ones who are served by them, so they should not be rude.' A woman complained that some nurses shouted at women with a venereal disease. One woman showed some understanding for nurses' rudeness: 'Nurses are supposed to be compassionate people but few have any compassion. They have lost the human element that makes them compassionate due to too many people passing through their hands.'

Conversely, some health workers in Lusaka also complained about the rudeness of patients, whereas others excused them because, as they said, their sickness and anxiety made them behave like that. One linked the tense relationship to the user fees: 'Ever since the user fees were introduced we have

become servants, as everyone wants to be attended to at once, all because they pay for services.' Unpleasant interactions are particularly frequent in connection with STDs. Pregnant women with STDs felt very uncomfortable and sometimes reacted sharply to questions posed by health staff.

Social differences between Lusaka and rural areas of Western Province probably account for much of the reported variations. Life in Lusaka is hard; the social environment is almost hostile. People do not only barricade their houses out of fear of burglars; they also barricade themselves against the interference of others. This is reflected in the irritations between health workers and patients.

In the rural communities near Senanga, life is more relaxed in spite of the dire existence and poverty. There is also more mutual respect between people. Moreover, health workers constitute some kind of local elite and enjoy special esteem. The more negative reactions of rural teachers towards health workers seem to confirm this. They regarded health workers as their equals and did not have this special respect on the basis of perceived hierarchy.

Most of the other aspects of quality of care (drugs, physical conditions and staffing) have already been touched upon. Information on perceived outcome of treatment was not collected. Although the drug situation in health centres has improved somewhat with the implementation of user fees, people still complain bitterly about lack of medicines. As we spelled out above, drugs are the overriding criterion by which patients judge the quality of health services. As long as people continue to be sent away without drugs, there will be only one conclusion in their minds: the health reforms (i.e. the introduction of user fees) have not improved the quality of care (i.e. the availability of drugs).

Concluding comments

Discussing the effects of the health reforms from the users' point of view forced us to speak mainly about user fees and drugs. People are preoccupied with these two issues. For them, the former is only justified by the latter. Clearly, in the perspective of the community that justification does not obtain. The drug supply is unreliable; therefore, the fees are unjust.

The injustice of the situation also takes a prominent place in the report by Booth et al. (1994), in which the authors hold a passionate plea for more humaneness to the very poor. What can one advise to a beleaguered government which finds itself between the rightful claims of its citizens and the restrictions of a failing economy? Should it abolish the fees and return to the equally depressive situation before the health reforms? Should it replace the fees by an insurance scheme? Obviously, the problem of lack of drugs will similarly affect an insurance scheme.

Interestingly, although reporting much critique and misuse of cost sharing, Booth and colleagues do not conclude that the practice should be abolished, and we agree with them. The history of 'free' health care in Africa has been almost

everywhere a testimony of failure (e.g. Hours 1985; van der Geest 1988; Abel-Smith and Rawal 1992), exacerbated by the simultaneous presence of a relatively well-functioning system of non-profit private health institutions, usually managed by religious organizations. All who objectively study this unplanned experiment of two managerial systems will conclude that much can be learned from the way the churches were able to deliver reasonable health care, even without government support. Their health care was affordable for most citizens, and they tended to be merciful to those who could not afford it. History shows that people who had the means were willing to pay because they got their money's worth. Recent studies of the implementation of user fees confirm this (cf. Waddington and Enyimayew 1989/1990).

The Bamako Initiative was an implicit recognition that African governments have indeed learnt their lesson from this public/private mix in health care. 'Implicit' because the churches are never mentioned in the Bamako document. We believe, until further notice, that governments are right to pursue the route of moderate payment for health services and that this route will enhance the chances of sustainability. However, there are at least three conditions on this.

Firstly, and as also suggested by Booth et al. (1994: 106), the burden of charges should be transferred from registration or consultation to the provision of drugs and other forms of concrete treatment. People should pay for what they feel is worth the payment; not for being allowed to see a doctor or a nurse, but for receiving something palpable, something that cures or aids them, such as a drug, a dressing or an operation. This may seem to be giving in to the curative bias of patients and their preoccupation with medicines, a move which progressive health workers may resent. However, it can also be regarded as a temporary recognition that we take the patient's perspective seriously. When in due time consumers in Zambia become more critical of the blessings of medicines, the policy will change by itself. For now it will take away the main complaint of patients: that they must pay and still do not get drugs. In fact, that is exactly what the church hospitals and clinics have always understood; they let people pay for what they thought deserved payment, namely drugs and operations.

A second condition, which we also share with Booth et al. (1994), is that no patient should be sent away because of their inability to pay without having been seen by a health worker able to judge their condition.

Our third suggestion is mainly an elaboration of the first. If in the eyes of the public drugs are the test of good health care, why not allow health institutions greater independence in buying and selling drugs instead of forcing them to depend on the often irregular and inadequate drug supplies from the Ministry? If patients are to pay for medicines, health workers should make sure that they always have a good stock of essential medicines. The proceeds of sales should enable them to replenish their stocks before they are exhausted. Health workers render a poor service to people if they send them away to buy medicines in expensive pharmacies (which in rural areas may also entail a long journey). It would be in everyone's interest – pharmacists excepted – if health

workers were allowed to supply medicines themselves, for a much lower price. This would indeed be a sensible form of decentralization, which was one of the principles of the health reforms.

What did the health reforms in Zambia achieve? Our exploratory study suggests that up to now the government's health reforms have been unable to rekindle the old PHC ideal. Reviving PHC as it was once dreamt of looks indeed a highly unlikely undertaking. The chances for community involvement – in its old, somewhat romantic form – are now slimmer than 20 years ago. But a new style of involvement – unromantically called 'fee for service' – has a chance, provided that the promise of a good quality product is kept and applied in a humane way.

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Acknowledgements

We thank the Danish Ministry of Foreign Affairs for its financial support to the project, Cor Jonker, AnneLoes van Staa and Esther Ngoi for their help in the research, Rob Soeters, Anita Hardon and Pieter Streefland for their comments on an earlier version of this article and Gertrude Liyanda for helping with the production of the text. This study is part of the joint research project 'Revitalisation of Primary Health Care in Uganda and Zambia' of the Makerere University, the University of Zambia, the Royal Tropical Institute (Amsterdam) and the University of Amsterdam. The results of the Uganda study have been published in Munene et al. (1997).

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