Available online at www.sciencedirect.com
SCIENCE DIRECT®
Health Policy 75 (2005) 1–8
HEALTH policy
www.elsevier.com/locate/healthpol

Healthcare reform involving the introduction of user fees and drug revolving funds: influence on health workers' behavior in southeast Nigeria

Benjamin Uzochukwu [a,*], Obinna Onwujekwe [b,c]

[a] *Department of Community Medicine, College of Medicine, University of Nigeria, P.O. Box 3295, Enugu, Nigeria*
[b] *Health Policy Research Unit, Department of Pharmacology and Therapeutics, College of Medicine, University of Nigeria, Enugu, Nigeria*
[c] *Gates Malaria Partnership, London School of Hygiene and Tropical Medicine, London, UK*

Abstract

Objectives: To assess the perceptions of health workers towards the drug revolving fund (DRF) scheme and the perceptions of the community members about health workers since the introduction of the DRF.
Methods: The study was conducted in four purposively selected local government areas (LGAs) in southeast Nigeria where the Bamako initiative DRF was operational. Data was collected using in-depth interviews with randomly selected health workers and exit interviews with patients who attended the health centers.
Results: There were differences between the ways the DRF affected health workers in the different LGAs. In general, the motivation of the health workers to deliver health services improved significantly largely because they had basic drugs to work with and they benefited from the drug gains accruing through the operations of the DRF. However, as time went on, some got de-motivated and their attentions became more focused on revenue generation and profit making through sale of own drugs at the expense of health of the people as no incentives were paid and salaries were delayed. Curative services were provided more than promotive and preventive services and drugs are prescribed irrationally. Patients showed wide spread dissatisfaction with fees charged, waiting time before being seen, and treatment instructions given to them.
Conclusion: Governments need to focus not only on the provision of drugs and revenue generation but also on providing strong support for in-service training, monitoring and supervisory activities to improve health workers' attitude to work. The governments also need to explore incentives such as working condition and monetary incentives to motivate health workers to improve their performance so as to serve the consumers better.

Keywords: Health workers; Bamako initiative; User fees; Drug revolving funds; Nigeria

1. Introduction

In 1988, following a resolution at Bamako in 1987 by African Health Ministers' to reform the health sector through the acceleration and strengthening of PHC

* Corresponding author. Tel.: +234 42 259609; fax: +234 42 259569.
E-mail address: bscuzochukwu@yahoo.com (B. Uzochukwu).

0168-8510/$ – see front matter © 2005 Elsevier Ireland Ltd. All rights reserved.
doi:10.1016/j.healthpol.2005.01.019

in Africa and the subsequent WHO guidelines that laid down the principles and measures to operationalize the initiative, the Nigerian Government announced the restructuring of its Primary health care system through a healthcare reform called the Bamako initiative (BI) programme [1]. This was accompanied with the establishment of the drug revolving fund (DRF) scheme. By this time, the economic crisis and efforts in response to it through the structural adjustment programme (SAP) had curtailed the availability of essential drugs, causing an increase in drug prices and fake drugs. The "out-of-stock syndrome" became a norm in the country. The main focus of the initiative in Nigeria is to ensure a steady supply of the most basic essential drugs prescribed under generic names at affordable prices and at the same time improve prescribing practices [2].

The DRF mechanism within the BI framework was adopted as the initial approach for sustainable financing of drugs supply at the local government level in Nigeria. Through it, local government areas (LGAs) were expected to use a percentage of their subventions from the federal government as 'seed' money to purchase an initial supply of drugs and send them to primary healthcare centers. The various LGAs were given a local currency of $ 10,000 (using 1989 exchange rate) to buy these drugs in early 1989 at the inception of the DRF scheme. The health centers were expected to sell these drugs to patients at more than the cost price to provide funds to replenish stocks; to pay for some related expenditure and provide surpluses at the district development committee level as a contribution to community development activities, including covering deferments and exemptions [3]. Drugs are replenished with the money received from sales and the fund therefore revolves. The cycle can then be repeated indefinitely without further government allocation as long as the funds recovered from sales are sufficient to purchase replacement stock [4]. A total of 80% of the receipts from drugs sales are used to purchase replacement stocks while 20% is used for local health activities [5]. In the first 5 years of the initiative in Nigeria the objectives of the DRF were achieved and many health centers covered a large proportion of their local operating costs from user-fees and DRF and utilization of services increased [5–7]. However, most recently, the user fees and DRF has led to irrational drug prescription and inequity in access and utilization of health services [8,9].

There has been a lot of research on the effect of user fees and DRF on consumers' behaviors [10–14], but there is paucity of information about the effects that the DRF have had on the behavior of healthcare providers, apart from irrational drug prescribing. The knowledge is vital for improving the provision of healthcare and decreasing healthcare costs at the primary healthcare level because health care providers are powerful determinants of health care costs for consumers, because they make decisions on their behalf. This could lead to cases of supplier-induced demand, which can increase revenue of providers but escalate healthcare costs to consumers and to the society. A common complaint in many countries about public sector health workers focuses on their rudeness and arrogance in relation with patients [15,16]. Patients tend to choose health care facilities where they are treated well [17].

It is important to know whether the introduction of user fees under the DRF scheme has resulted in any change in behavior of the health workers, either for the better or for the worse, The available evidence suggests that the existence of user fees does not encourage greater restraint in the provision of services but rather the reverse and fees encourage inefficiency through supply-induced demand and poly-pharmacy, particularly when the revenue is retained by the collecting health facility [18,19]. Many studies have found that increased drug availability in a health facility leads to greater demand for services in that facility [19–22]. Thus people tend to equate the availability of drugs with a higher probability that they will receive better treatment. But this perception of quality may be deceptive. With a good supply of drugs, health workers prescribe excessively [8,23]. It has also been reported that physicians' prescribing practices seemed to be more related to agreement with social expectations and caretakers' perception of the physicians' role than to standard biomedical rules for disease treatment [24].

This study assessed the perceptions of health workers and consumers towards the DRF scheme, because the information is important for improving the performance of DRF in Nigeria so that the implementation of user fees would be more efficient and responsive to the demand of the people. The perceptions of the health workers were assessed in terms of staff motivation influence of user fees, salaries, sale of drugs, supervision and general working conditions such as equipment and drugs, their prescription practices and patients' demand