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Free primary health care for vulnerable social groups in low income settings

Lessons from Malawi and Zambia

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Abstract

Due to the increased burden of poor health on poor and rural households, Malawi and Zambia waived user fees in health. Malawi introduced an Essential Health Package (EHP) in 2004 to address common causes of morbidity and mortality that disproportionately affect the poor. Zambia abolished user fees in health for rural households in 2006. Waving user fees was seen as an effective tool for bridging the socio-economic divide and improving health equity. These policies sought to reduce the national health burden, which falls more heavily on poor and rural households. Against this back drop, this study was formulated to review literature on the effects of the stated policies on access to health services by vulnerable social groups in both nations and investigate the challenges that constrain their implementation. The study focused on social protection in health for vulnerable groups using a social constructionist approach.

The review found that access and utilization of health services have significantly improved in both cases. However, coverage of services is still limited. Services are free in principle but poor households still have to bear indirect costs to health services. Health centers and personnel are still disproportionately distributed between urban and rural areas and structural factors still threaten household accessibility to services. The analysis also finds the targeting strategies used in delivering services inadequate. Thus, both countries have not effectively extending coverage of services. Overall, Malawi's EHP has produced better coverage than the Zambian waiver policy due to more coordinated implementation. However, the understanding of what the policies entail on the part of health managers at facility level is in both cases weak thus compromising implementation. Although intended to be supply-side both policies are in practice demand-side.

Both nations suffer human resource and essential medicine shortages, poor distribution of health facilities and poor funding and coordination. Hence, health systems should be strengthened and remote areas targeted more. Both governments should increase social protection budgets. Donors should pool support to reduce coordination problems in implementation and a quasi-internal market in health care with a system of purchasers and providers of services should be introduced. Further inquiry on social impacts of the policies and not only cost effectiveness is necessary.

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1.0 Introduction

1.1 Background

It is indubitably clear that there has been tremendous improvement in the global health situation in the past 50 years. The World Health Report (2003, 1-22) shows increased life expectancy as well as a reduction in child mortality among many other significant gains. However, these gains have been unevenly distributed. The World Health Report of 2008 highpoints vast disparities between low income countries and high income countries. On the one hand, high income countries boast of most of the substantial gains. On the other hand, low income countries are generally characterized by a large disease burden with poor health outcomes: relatively high mortality, lower life expectancy and sanitation problems, WHO (2008, 1-22). For most low income countries, Sub Saharan African countries to be specific, the said poor health outcomes are inextricably linked to poverty. This has tended to produce what scholars term the medical poverty trap (see Araoyimbo and Atagua 2008, 2).

While the medical poverty trap is a multifaceted phenomenon, it is undeniable that in settings with low resources and large disease burdens, medical expenses are a core precipitating factor. When households lack the capacity to meet medical expenses from their personal resources and yet they have to, consequences are usually dreadful for both patients and their families. In this respect, Iyer writes of the grim set of realities that follow such situations:

"…denial of treatment, incomplete treatment, or treatment at the cost of financial and social wellbeing. Households curtail spending on food, children are pulled out of school and/or forced to work, adults are pushed into labour, people are made to work longer and harder than usual, caregivers are stretched to breaking point... It is no wonder then that such payments are called 'catastrophic' or leading to impoverishment…" (Iyer 2005).

The proceeding has been the picture of many Sub-Saharan African countries more so with the introduction of user fees in health in the late 80s. As part of the World Bank induced cut backs in social sector spending under the Structural Adjustment Programs, user fees in health were seen as a means to raise revenue for the health sector and also to increase community participation in the

delivery of health services (see Gilson 1997, 273-285). The fees were also thought to create greater accountability on the part of health care providers. The reform was essentially market oriented in the hope of making state run social services more efficient and effective.

According to Duff (2004) in Araoyimbo and Atagua (2008, 2) user fees in health are defined as, "…amounts levied on consumers of government goods or services in relation to their consumption...also the amounts of money levied on individuals for the use of goods and services from which they receive 'special benefits'..." In practice, these fees entail two things: payment made at the point of service use and a lack of risk sharing (see Lagardea and Palmera 2008, Chee and Tien 2002). The fees may also mean any combination of drug costs, supply and medical material costs, entrance fees or consultation fees. Chee and Tien (2002, 5) are quick to point out that, "although user fees can be used to generate income for drug purchases or to help fund a health facility, it can be an additional barrier for the poorest population." They argue that fees can prevent people from seeking health care in a timely manner when they are unable to pay the price for care. In this respect, fees can also induce the dangerous practice of self-medication.

For Sub-Saharan Africa, effects of user fees in health are contentious. In some cases, as Litvach and Bodart (2002) found in Adamaoua province in Cameroon, service utilization increased due to improved service quality and shortened patient waiting hours. This has often been the basis for the argument that properly managed; user fees can improve quality and utilization of services. There however is also evidence that user fees have adverse effects on health care utilization for vulnerable groups. Among others, McPake (1993) shows a 34% decline in attendance of all health services among low income patients after the introduction of fees in Swaziland. Mbugua, Bloom and Segall, (1995) also report a similar experience in Kenya where massive declines in attendance rates in Kibwezi, a poor rural area were recorded after fee introduction.

The advent of the Millennium Development Goals (MDGs) and their 2015 targets thus brought a renewed focus on the health situation in low income countries. Over the years, MDG progress reports have heightened the emphasis on vulnerable social groups within low income settings and the acute need to improve their health outcomes vis-à-vis conditions of living. Taken here, vulnerable groups are those who are likely to have additional needs and experience poorer

outcomes if these needs are unmet. In general, these are poor people but more specifically, they are rural population, the aged, children, and people living with disabilities or HIV and women with dismal access to quality health care.[1]

Enmeshed in this new approach is the understanding that poverty and its related social determinants of health are the major causes of poor health among the said groups (i.e the medical poverty trap). In consequence, efforts to substantially improve health outcomes within these social groups have been intensified in the low income countries across the globe. These approaches integrate social protection concerns in health care provision. Many African countries thus adopted fee reduction and removal in health. Yates (2007) in Araoyimbo and Atagua (2008, 2) explains that similar countries such as Rwanda, Zambia, Burundi, Malawi, Democratic Republic of Congo and Niger implemented similar reforms though on selected facilities or services after the experience of Uganda in 2001.

It was against this backdrop that this study was formulated to evaluate the effects of the policy shift from fee paying to free primary health care at the point of use in Malawi and Zambia, two of many Sub-Saharan countries that have experienced both the user fee policy and the free health care/waiver policy. Using a social constructionist approach, this study collated and discussed literature on how the effects of the free primary health care policies adopted in Malawi and Zambia have affected coverage and utilization of health services for vulnerable social groups.

1.2 Overview of approaches to health care provision in Malawi and Zambia

The Structural Adjustment Programs (SAPs)[2] induced cut backs in social sector spending and the introduction of user fees in both Malawi and Zambia had devastating effects on health services.

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[1] Slightly adapted from Social protection and Social inclusion Glossary. DG Employment, Social Affairs and Inclusion.http://www.eqavet.eu/qa/gns/glossary/v/vulnerable-group.aspx

[2] The World Bank and IMF lead adjustment programmes were primarily intended to improve economic management and thereby raise the standard of living of the population. Exacting maximum economic efficiency from the macro economy was the implicit goal of the reforms in African countries. The reforms included packages to stabilise the host economies and structural reform aimed altering the way systems operated so as to generate efficiency. Reductions in social sector spending and introduction of user fees in health were part of this array of reforms (see Donkor 2002, Bøås and McNeill 2003).

In Zambia, Civil Society Health Forum, CSHF (2011,1) points out that during this period, about one quarter of patients were turned away from health facilities as they could not afford even modest fees while almost one in every four patients were given prescriptions to buy medicines that they could not afford. The poor suffered and the rural poor suffered more. The rural poor whose main income generating activity is subsistence farming had a particularly difficult time given that their only meaningful income is weather dependent and comes only once a year (Daura et al.,1998) in CSHF (2011, 2). Like Zambia, Malawi experienced diminishing health outcomes during this period. Kalipeni (2004, 23-30) for example cites declining maternal health, raising infant mortality as well as the proliferation of HIV/AIDS and infectious diseases among the salient results of the effects of SAPs on health care in Malawi. The recognition that most of the disease burden in these countries arises from poverty related causes led to a health policy shift that sought to prioritize health needs of income disadvantaged groups. As a result, both Malawi and Zambia introduced reforms in health that waived user fees.

1.2.1 Malawi

According to NORAD (2008, 25), a conscious decision was taken by the Malawi Government and its collaborating partners to adopt the delivery of an Essential Health Package (EHP) as the main vehicle for achieving the mission and goal of the Ministry of Health (MoH) in respect to severe challenges that characterised the health situation in Malawi. In the context of low income countries, the World Health Organisation, (WHO 2008b, 2) defines an EHP as consisting of a limited list of public health and clinical services which are provided at primary and/or secondary care level. They suggest that in high income countries, essential health packages are known by what they exclude instead of include. As a policy practice, EHPs vary from country to country.

In Malawi, the effective delivery of this prioritized and limited package was to be the core business of the MOH over a 6-year plan period covering 2004 to 2010. Major causes of morbidity and mortality were defined. Conditions and diseases that contribute most to the burden of ill health and premature death were selected for priority attention. Prioritization was also undertaken through the selection of a limited set of core interventions for each of the 11 selected conditions which constitute EHP. Six pillars that would support the effective delivery of the EHP, including

a comprehensive Sector Wide Approach (SWAp) monitoring framework to track progress on a biannual basis, with a midterm review and an end evaluation were also elaborated. The EHP covers acute respiratory tract infections, diarrhoea including cholera; adverse maternal and new born outcomes (Family Planning), malaria, tuberculosis, HIV/AIDS and STI, schistosomiasis; malnutrition, (micronutrients), Eye, Ear and Skin infections and common injuries, accidents and trauma. Zere et al. (2007, 3) emphasize that the EHP is delivered at community, primary and secondary levels of the healthcare delivery system and is provided free of charge. It addresses the most common causes of morbidity and mortality that disproportionately affect the poor.

1.2.2 Zambia

The Zambian government waived user fees in health in 2006. The African Health Workforce Observatory (AWHO) reports:

"To protect the vulnerable, government formulated an exemption policy based on demographic, age and disease-based characteristics as criteria in providing exemptions. Children under the age of five and adults over the age of 65 were to be treated free of charge. Patients with chronic illnesses such as TB, STDs and those affected by epidemics such as cholera were to be exempted from paying user-fees. In addition, those in need of obstetrics and family planning services were equally exempted from paying fees (MOH 2006)" (AWHO 2010, 25).

Masiye et al (2008, 5) explain that although the president declared free primary health care for rural areas from April 1st 2006 for the 56 rural districts (out of the 72 districts of Zambia), this official classification can sometimes become unclear as several districts do contain both urban and rural sections. Masiye et al. (2008) stress that because rural dwellers bear a disproportionate share of poverty; the removal of user fees was seen as a potentially effective and pragmatic tool for bridging the socio-economic divide across the country and improving health equity. This approach was also thought to lead to a reduction in the national health burden, which also falls more heavily on rural households (ibid, 5). The assumption was that the price of health care kept many poor households away; hence, the removal of fees was thought to increase demand for and increased utilization of services. Masiye et al (2008, 6) further add, "there was also a public health motive, which suggests that increasing access to primary health care would lead to appropriate health-care seeking behaviour and reduce the country's health burden." Oxfam

reported that the move to scrap user fees in health was made possible using money from the debt cancellation and aid increases agreed at the G8 in Gleneagles in July of 2005 when Zambia received four billion dollars of debt relief (Oxfam 2006).

As can be seen, both these approaches embodied the classical welfare argument that exemptions and waivers can facilitate people's access to health care by eliminating financial barriers for those who are most vulnerable. The ultimate goal of such financing reforms is to improve people's health by ensuring that those unable to pay have access to services. However, it goes without saying that good intentions do not necessarily save lives. The key question is not what the naive or pious hopes of the people who advocated or drafted these policies were but rather what their actual effects have been; are they working well, are they a success and do they warrant any sort of regional diffusion for instance (see Kymlicka 2007, 135). In this space, this study was formulated. It sought to understand what the effects of the policies have been on coverage and utilization of primary/basic health care services for vulnerable groups. Since the two nations are neighbours with similar policy climates it was thought that this study would provide a viable opportunity for contextual lessons and informed policy transfer. The researcher also had a fairly adequate understanding of the policy climate in these two nations to warrant a detailed analysis of the particular situations.

2.0. Aims

This study purposed to explore the effects of the free primary health care policies on access to health services by vulnerable social groups in Malawi and Zambia. It also sought to investigate the challenges that have constrained their successful implementation.

2.0.1 Study rationale

Despite the seemingly self-evident gains to be made from the free primary health care, preliminary evidence pointed to the fact that health improvement has been scanty and that implementation of the policies has been fraught with difficulties from the outset. Since the two

nations have a similar policy climate, it was thought that a comparison of their experiences would provide a bed rock for recommendations on alternative policy practices.

2.1. Research focus and questions

The main focus of this study was to understand how the described policies have affected coverage of, and utilization/access to health services by vulnerable social groups as well to understand the challenges that have made successful implementation of these policies difficult. The investigation was guided by the specific research questions presented below.

2.1.1. Research question 1

Has the policy extended coverage of services to vulnerable social groups?

The focus was on whether or not health services had now reached previously unreached areas through this policy.

2.1.2. Research question 2

How has the policy affected access and utilization of services by vulnerable social groups?

The study also sought to find out whether and in what ways utilization has been affected by the policy. Focus was thus on such socioeconomic sensitive aspects as maternal and child health and HIV and AIDS.

2.1.3. Research question 3

What specific challenges have constrained the implementation of the policies and what alternative policy practices can be pursued to make implementation of these policies smoother?

3.0. Methods, Data and Theory

This study was based on an extensive review of literature in research articles, books and country reports from World Bank, UNICEF, and UNDP, WHO, ILO and national governments on provision of free primary health care in general and on social protection and health practices in the two countries in particular. This provided the most scientifically reliable inferences. Pub Med, Academic Search Premier, The Lancet, and Google scholar were used in the collation of literature for review. The International Social Security Association (ISSA) website and the poverty action lab were also used. Combinations of key words and phrases were used for the literature search. These included primary health care, social protection for health in low and middle income countries and constraints of free health care.

3.1. Search and Inclusion criteria

Only studies conducted on the two countries and other World Bank[3] defined low and lower middle income countries between 2005 and 2012 were included. This was because Malawi introduced the EHP in 2004 and Zambia's waiver policy started in 2006. This time frame provided sufficient literature to assess what the policies effects have been over time. Attention was given to outcome and impact evaluation studies. This criterion was added to limit the biases that would arise from analyzing a limited dataset since most studies conducted on the area focus on economic cost-effectiveness. Though many studies were found, a large number were using Demographic Health Survey (DHS) data from before 2006. These were only used for baseline data as they could not provide any evaluation of how the policies have evolved over the years.

3.2. Theoretical Framework

The approach taken in this study was social constructionist. It focused not only on micro level analysis but also on understanding the wider social-political factors that condition the delivery of

[3] The World Bank classifies as lower-middle income those countries with GNP per capita income of between $756 and $2,995 in 2000.OECD/IMF (2003, 267). External Debt Statistics Guide for Compilers and Users.

free primary health care services in Malawi and Zambia. In view of Moran (2005,236), such an approach problematized both sides of the story i.e., "the mechanisms by which social-political contexts affect the production of social scientific knowledge and the ways in which this knowledge is simultaneously appropriated and interpreted in social political contexts." In Houston's (2001, 846) view:

"…constructionists argue that our understanding of the social world is historically and culturally specific. Put more simply, our way of understanding the world is more or less contingent upon time and setting or, as Garfinkel (1984) observed, events are dependent on the context in which they occur for their meaning."

This ability to look outward into the realm of interaction, discourse and ideology as is provided by the social constructionist approach was particularly insightful for this study. Given that this study was comparative, constructionism enabled a cross-national comparison while preventing the kind of simplistic judgements that are based on national assumptions. Attention was paid to the impact on policy of regional and global processes to understand how common solutions could be applied to common problems through identified processes of policy transfer.

In using this approach, the focus was not to uncover deep truths per se, but rather to understand both the complexity and the multiplicity of factors affecting the delivery of free primary health care to vulnerable households in the stated countries and in this manner highlight the contestedness and fluidity of the mechanisms involved. This positioned the study to identify and suggest scientifically informed ways of making implementation of such policies less problematic. While 'meaning' is the prime focus to inquiry in this orientation, the study also assumed a critical approach; asking why situations in the two nations were as they were observed. It however is noteworthy that although this approach was most suitable and thus preferred for the comparison of experiences of Malawi and Zambia, it's mainly explorative and context biased orientation means that findings and subsequent study conclusions cannot be overly generalized.

3.3. Conceptual framework

Given that any evaluation of public services needs to be informed by the understanding of what constitutes a good public service, the conceptualisation of public service delivery offered by Julio

Le Grand in the other invisible hand proved very insightful in this study. Le Grand discusses various views on the provision of public services in a way that maximises gain for both users and the provider. This framework was used to give an understanding of the background against which the results of this project were assessed since it is the most recent and arguably one of the most comprehensive practice based conceptual discussions on public service delivery. Discussions by Daniels (1985) and Gulliford et al. (2002) on what constitutes equitable access to health care were also used to analyse the nature of the findings. These authors present philosophical considerations that shape discourse on equitable access to health care today.

3.3.1 Constituents of a good public service

Le Grand (2011, 7) argues that there are at least five attributes of a good public service. He cites high quality, management and operational efficiency, responsiveness to needs and wants of users and simultaneous accountability to tax payers as well as equitable delivery as the fundamental aspects of a good public service. The quality of the service as he proposes can in view of this discussion be seen in terms of inputs to the service that is, for example the number and type of staff that work in a hospital, or the process of the service delivery such as amount of time patients have to wait for a service or the consideration with which they are treated. Quality could also be seen in terms of outputs or outcomes of the service for example improvements in patients' health over time.

In Le Grand's (2011, 9) view, an efficient service is that which, "delivers the highest possible quality and quantity of that service from a given level of resources." Inherently, this definition considers the opportunity we for go to use our resources on another service instead of this one; the opportunity cost of providing this service. We should thus ask ourselves if by providing free health care to vulnerable populations we are doing it in a way that maximises the benefits we could obtain from such a policy and minimising adverse effects, or are we better off investing these resources in another set of policy choices. Responsiveness and accountability in this context refer to the extent to which a particular service is able to respond to specific needs of users (the voice of users) while also taking into consideration those of tax payers who are the funders of public projects. In the case of the policies under discussion, there is a general societal consensus

to use resources to provide care to the marginalised (a sort of citizenship based solidarity). The question however is whether or not the users have a voice in the service provision.

The last of these considerations is equity. Equity is enmeshed in philosophical underpinnings and is more difficult to exhaustively conceptualise in this space. However, Le Grand views it as close relation of social justice and fairness. It arguably was the reason why the free health care policies where formulated: to promote 'equitable' access to health care among disadvantaged groups. In this view, a service is inequitable if access to it is not subject to conditions and circumstances that are irrelevant to it. More aptly, inequities in access to health are those that are changeable through a sort of social action (Daniels 1995, Kawachi 2002). It is important to note at this point that these aims as presented here are not always compatible with each other in their totality and compromises and trade-off have to be struck in certain situations. Means of delivering public services which bring these ends within reach in the best possible sense should always be sought.

3.3.2. Provision of a good public service

Le Grand presented four models of service delivery that best suit the provision of a public service as health care given the attributes discussed above. The first is the trust model where professionals and other public service workers are simply trusted to deliver a good public service without interference from the government. The second model is the command and control also referred to as 'hierarchy' where the state or its agencies are involved in service delivery through a managerial chain where top managers give orders to subordinates. Considine and Lewis present this as the procedural governance model and argue that its defining characteristics include, "the following of rules and protocols, high reliance on supervision and expectation that tasks and decisions will be well scripted…"(2003, 133). On this basis Le Grand (2011, 15) argues that the target and performance management (as was widely use in Britain) is a branch of this model.

In the third (voice) model, users get a good service by communicating concerns directly to service providers in one of several ways (i.e. petitions, face to face talks, through elected representatives etc.). The fourth approach is mainly dependant on choice, within the context of competition and the quality of service is in this case determined by the ability of users to choose

among providers. This approach is more suitable since service users are utilizing not their own resources but those given by the state. So, these are markets in that service providers are the ones who compete for users and are not monopolies. However, critics argue that choice and competition privatises the public services and is driven more by ideology than by well-considered policy programmes. In response, Le Grand asserts that 'public' should not be conceived as only in the means of delivery of services but as standing for the goals of such services. Hence, the state is not always the best if it is a monopoly to deliver services especially given that people that work in the public services do not always represent interests of the public (knaves not knights[4]).

However, Giddens on the times higher education website asserts that the major weakness of this approach is cream skimming. If as Le Grand argues, choice is extended through competition hence increasing the likelihood of needs being met, then we ought to realize also that chances that the affluent will scoop the best opportunities exist. Le Grand's responds to this critique by introducing 'a disadvantage premium' to encourage facilities to accept disadvantaged populations. This response still faces administration difficulties as well as the fact that such a grant would have to be high to cover the needs adequately. There is no sufficient ground to worry about this difficulty in this discussion because in the service provider in question (government) may play the role of financier by providing both financial and operational incentives for health care providers that partner with it and produce the best package of designated services for the population in question. In practice, it is very difficult to delineate these models even though they may appear so clear here since most programs use them as combinations. In his discussion of merits and demerits, Le Grand thus cautions that debates about these models should be more about how and which ones can be combined to produce the best results than on how to replace one model with another.

[4] In view of Le Grand (2011,18) knaves are individuals whose concern is only their private self-interest while a knight is one whose principle concern is the welfare of others; in this case, a gallant defender of the public interest. Metaphor used in relation to the trust model and its principle argument that the public services operate better if those tasked with the responsibility of managing them are left to do so by relying on their dedication and expertise.

4.0. Results: Coverage, Utilization and Constraints

This chapter presents evidence collated on the effect of the policies on access to health services for vulnerable populations. Two variables, coverage and utilization of services are considered. Using these two variables enabled an in-depth analysis of the issues under review. This would have been impossible to do had more variables been considered given the space limitation of this paper. Although the cardinal issue of quality of services was not given separate attention, it was assessed alongside utilization. Further, it was thought that if effects on these areas could be determined, then to a reasonable extent, the effect of waiver policies on access to health services by vulnerable populations would have been sufficiently determined. Also presented in this section is a review of the factors constraining successful implementation of the said policies.

4.1. Coverage

According to the International Labour Organisation (ILO), "health care coverage provides an indication of how the benefits of health care expenditure are distributed across the population" (2008, 125). Coverage is thus related to the distribution of facilities, services, and interventions across and among the population. It is in this respect that this study sought to assess the impact of free health care policy on coverage and to assess the extents to which it has been extended coverage.

4.1.1 Malawi

Despite the services being free at the point of use in principle, literature reviewed shows that affordability is still a major problem. Lawson et al.'s 2008 Oxfam review of the Essential Health Services in Malawi records that only 9% of government and mission facilities (54 out of 585) provide the full EHP despite government announcing that essential health care needs are free (2008, 15). They point out that only one or two health facilities had adequate EHP capacity in each district. This leaves the poorest households to still finance their health services with out of

pocket payments. [5] At the time of Larson's study, about 26% of the total health spending in Malawi was out of pocket and poor households spent up to 10% of their annual expenditure on health care. As a result, Larson et al. state:

"…Interviews with community members clearly revealed that user fees were a barrier for the poorest people when accessing health services. Focus-group respondents, particularly women, were clear that often they would not go to Churches Health Association of Malawi (CHAM) facilities because of cost, despite their proximity compared with the district hospital. Respondents also stated that they would not go to mission hospitals for chronic conditions requiring repeated visits, meaning that they only go to CHAM for one-off health incidents. However, it was clear that the quality of care at CHAM facilities is higher than at government ones. This is partly due to the lower utilisation rates because of cost, meaning more facilities and more staff time being available…." (2008, 15-16).

The percentage of annual consumption that households spend on health is still the same as that reported by the Malawi Health SWAp (2004, 7) which argues that, "the poorest of all households spend between 7.4% and 10% of their annual consumption income on health care." However, a review of the EHP by Makoka (2009, 237) argues differently. Makoka measured socio-economic inequity in maternal health after enactment of the EHP using the indicators deliveries attended by skilled personnel and access to prenatal services to examine if there are any systematic differences in inequities in maternal health amongst the three regions of Malawi (South, Central and North). He found that the poorest wealth quintile in the sample spent 4.2% of their non-food expenditure on health care while the richest group spent 3.6%. Clearly, this is an improvement from the proportion of out of pocket spending given by Larson et al. (2008). He further argues that these figures are very low and that in general, the findings of his study indicate that there is no systematic trend as one moves from the poorest to the richest socioeconomic group. He thus contends that the result did not seem to support the notion that the poor spend a higher proportion of their income on health than the non-poor and that the results are similar when the sample is classified into regions (Makoka 2009, 237).

[5] Out-of-pocket household expenditure on health here comprises costs of medical care related to an illness, such as the cost of prescription medicines and non-prescription medicines, as well as expenditures on preventive health care (Makoka 2009, 237).

On deliveries by a skilled worker, ("skilled worker" used as per WHO definition)[6], Makoka reports an income related inequality in access to delivery assistance from a health professional in favour of the non-poor. He argues that a similar result was found earlier by using the Malawi Demographic and Health Survey (MDHS) data of 2004, (2009, 238). The centre region of Malawi is according to this study the worst affected while the South region is least affected but his assessment of access shows that the proportion of women with access to prenatal services is very high across all the wealth groups in Malawi. He reports that around 94% of pregnant women from the poorest socioeconomic group had access to prenatal services with the proportion fairly uniform across the different wealth groups. He also argues that a similar picture emerges at regional level, although there is a small upward trend across the wealth groups. He states:

"…in particular, access and utilization of prenatal services is highest in the south followed by the north and then the centre. Further, the concentration index for access to prenatal services is very close to equity for the central region and it is 0 in the north and the south indicating that there are no income-related inequities in the access to prenatal care services in the two regions" (Makoka 2009, 240).

Makoka (2009) points out that the proportions as reported are highest in the central region partly because there are more private clinics and CHAM health facilities where user fees are levied for services outside the EHP. What Makoka's study certainly shows is that Malawi's central region has the highest disparity in medically attended deliveries in favour of the non-poor. Among other things, it cites low levels of women literacy, cultural traditions and the important roles of traditional healers in the communities in the central region as some of the reasons for the observed regional disparities.

A comparison of Makoka's (2009) and Lawson et al.'s (2008) review reveals a discrepancy in the picture of financial barriers to coverage. It however is difficult to see how the barriers reported by Lawson were resolved by the time of Makoka's 2009 review since no intervention to offset them was recorded between the two time periods. It is in this respect that this paper argues that

[6] Deliveries attended by an accredited health professional such as a doctor, midwife or nurse, who has been educated and trained to proficiency in the skills required to manage uncomplicated pregnancies, childbirth and the immediate postnatal period, and in the identification, management and referral of complications in women and new-borns.

Makoka's review could have been blind to the non-use of EHP services by the poor in the other regions of Malawi hence its inability to recognise the inequity exhibited by the process.

The Malawi Health SWAp (2004, 7) had argued that access to health services in Malawi was modest with only 54% of the rural population having formal access to services within a 5 km radius. This proportion was increasing to 84% if urban populations were included. The report also showed that there were significant geographical variations by district. The Malawi Health Sector Plan (2011) however suggests that there has been a substantial increase in health facility coverage between 2003 and 2010 owing to the Program of Work for the Health Sector (PoW 2004-2006). This report posits, "between 2003 and 2010 the number of health facilities in Malawi increased overall from 575 to 606, largely due to an increase in the number of health centres (from 219 to 258)" (2011, 34). Despite this increase in health facility coverage, this report shows that coverage problems still remain. It argues that an analysis of the proportion of Malawi's population within an 8 km radius of a health facility shows that there are some districts that are better served than others:

"On Likoma Island, where there is no government facility, none of the population is served, and this district is followed by Chitipa where 51% of the population live more than 8 km from a health facility, Kasungu (38%), Balaka (32%), Chikwawa and Mangochi (27%). On the other hand, in Chiradzulu, Blantyre, Mulanje and Zomba Districts less than 5% of the population reside more than 8 km from a health facility. In some rural places, the health infrastructure is absent or dysfunctional. In others, the challenge is to provide health support to widely dispersed populations. In high density urban areas, health services can be physically within reach of the poor and other vulnerable populations, but provided by unregulated private providers who do not deliver EHP services" Malawi Health Sector Strategic Plan 2011 – 2016 (2011, 34).

Pearson (2010, 7) adds voice to arguments that coverage has improved after the EHP. He asserts that the SWAp has enabled two broad systems- the delivery of a prioritised essential health package and human resources- to be addressed in ways which would almost certainly not have been possible under earlier vertical approaches. He argues that this approach has had effects although questions about long term sustainability still remain. The results are in his view fragile and reversible and he argues that if for example drug and health supply procurement systems are not addressed adequately, then gains in the Expanded Programme of Immunisation (EPI), malaria prevention, HIV testing, counselling and treatment and prevention of Mother to child

Transmission (PMTCT) may be lost and even reversed. He suggests, "Health sector outputs have generally increased in both absolute and per capita terms throughout the SWAp period. Again, though, the picture is mixed" (2010, 24). Bowie and Mwase (2011, 3) also point out that services like health facility based deliveries, treatments of Acute Respiratory Infection (ARI) in children aged under five years as well as abortion related complications and cases of acute malnutrition and supplementary feeding as needing to be doubled. Also reported are limited services in dealing with complications of pregnancy and the new born, treatment of diarrhoea and Prevention of Mother to Child Transmission (PMTCT).

4.1.2 Zambia

Cheelo et al. (2010, 18-19) highlight that the exemption policy was applicable based on age, medical condition and socio-economic status and was in practice found to be so. This study shows that some criteria were reportedly easier to apply in practice than others, for example in emergency cases. Age related exemptions were also found to be relatively easy to grant to under-5 children as these usually had an under-five record. It was hard to exempt those over 65 years old given the difficulties in establishing the ages of the elderly who often did not have birth records (and whose ages were often not recorded on their National Registration Cards (NRCs). The study also reports that health condition related exemptions were sometimes complicated to apply because user fee payments were generally paid at point of registration, before the patients had received their consultation services, which establish their condition. It argues:

"If the consultation determined that a client met a given condition-based criterion and meanwhile the patient had already paid the user charge, it was very difficult to claim a refund. Indeed, none of the facilities in the sample reported ever have made a refund payment against erroneous user fee charges" (Cheelo et al. 2010, 18)

In relation to socio-economic (poverty) based exemptions, this study argues that implementation was problematic since the mandate to determine the socio-economic status of patients rested with the district level structures of the Ministry of Community Development and Social Services (MCDSS). It points out that the relations between the Ministry of Health (MOH) and MCDSS local level structures were generally weak. The MCDSS was also widely poorly resourced to

carry out its mandate. Hence, health care providers used their own assessment to determine eligibility under the various criteria, more often granting exemptions (Cheelo et al. 2010, 18).

Hadley in her (2011) evaluation found similar inconsistencies in the exemptions from payment in Zambia as those identified by Cheelo et al (2010). She writes:

"Findings of this study suggest that those exempt from payment on grounds of age and some chronic conditions as well as pregnant women were excused from payment. The category 'those who cannot afford to pay', however, appeared to be less well understood by health providers and patients alike and therefore not consistently adhered to. Indeed, a system to identify those unable to afford and to cover the costs incurred by the waiver of user fee by these patients did not appear to be well-functioning and led to both confusion and inconsistent application of exemptions in this category" (Hadley 2011, 247).

Hadley identifies additional costs that still restrict coverage despite the services being free. These include registration costs (having to buy a registration book for medical records), and charges related to referral to hospital. She explains that such costs as those related to registration were sanctioned by the District Health Management Team (DHMT) due to inadequate funding from government for stationary for medical records. In this way, patients have to bear the costs of any referral made to the hospital (Hadley 2011).

Unlike the above studies that found mainly financial related barriers to coverage, ILO (2008, 125) contends that poor physical coverage remains one of the main impediments to the achievements of health targets in Zambia. It argues that data from alternative sources collaboratively shows that vulnerable groups and citizens residing in hard-to-reach and under-served areas do have difficulties getting access to services (2008, 125). ILO further points out that benefits of national health expenditure are disproportionately captured by relatively wealthy urban citizens. It argues that although health is determined by a complex interplay of many factors such as poverty, education, sanitation and water of which health care is only one, there is evidence that inadequate coverage of health interventions has played a central role in defining Zambia's health profile and cites the impact of extended coverage of simple-technology interventions such as measles immunization on child mortality as a case of how extending coverage can improve health outcomes.

Similarly, the Ministry of Health 2011 Action Plan Zambia argues that health infrastructure in both rural and urban areas is inadequate. It posits:

"In rural areas 46% of families live outside a radius of 5 km from a health facility (compared to 99% in urban areas) making it difficult for many people to access the needed services. While the distribution of health facilities in urban areas is better, long waiting time before a patient sees a health provider demonstrates the need to increase the number of facilities or expand the existing ones. The main drivers of physical accessibility bottlenecks include insufficient or inappropriate infrastructure, poor scheduling of services leading to missed opportunities; inaccessibility due to geography and seasonal variation; and inadequate outreach posts and resources (fuel, vehicle, bicycle, motor-bike, boats) for outreach services, scattered population in rural areas; unreachable terrains – mountains, valleys, plains, rivers; and inadequate resources for infrastructure development" Ministry of health 2011 action plan (2011, 7).

Another report from WEMOS and CHESSORE (2008, 34) adds that the average number of and density of health workers in urban parts of the country is considerably higher than in rural parts of the country. It shows that on average, there are 5 times more health workers in urban areas in Zambia than there are in rural areas, 20 times more doctors and over 5 times more nurses/midwives. While citing reports from the Ministry of Health (MoH and HFSD 2007), this report argues:

"…despite the majority of people living in parts of the country considered rural (i.e. 71.38%), only slightly more than half of all health workers (i.e. 52.6 %) work in rural areas…the picture is largely repeated when taking into account population numbers, with an average roughly 2.2 times more health workers, 8 times more doctors, and two times more nurses per 1000 population found in urban over rural areas" (WEMOS and CHESSORE 2008, 34).

4.2. Utilization

4.2.1 Malawi

Mueller et al. (2011, 4) explain that there is a slight increase in attendance rates as compared to previous years. They report:

"the availability of staff has to be considered in the light of workload and attendance rates. The number of patients per staff per day is within the range of similar settings in Sub-Saharan Africa or (in terms of hospital staff) even lower. While one could speculate that the low attendance rates identified (of 1.4 visits per person per year) could be related to limited staff availability and

perceived quality of service, our finding is higher than previously reported country-wide utilisation rates" (Mueller et al. 2011, 4) .

In their estimation of the utilization of the EHP interventions in Malawi, Bowie and Mwase (2011, 3) conclude that for most of the services such as reproductive health, child services, immunisations and HIV/AIDS, utilization has increased since the introduction of SWAp. Bowie and Mwase argue:

"the rate of outpatient attendances and inpatient days per 1000 population had both increased from 929 attendances in 2002/03 to 1135 in 2007/08 and from 124 inpatient days in 2002/03 to 179 in 2007/08. The treatment of acute respiratory infection in children less than 5 years of age increased from 265/1000 to 348/1000 between 2004/05 and 2007/08" (Bowie and Mwase 2011, 3).

This study also argues that only a narrow gap existed between what was required and what was provided (0.68 mean gap of estimated need) by 2007/08. However, it also points out that a few services such as the treatment of malaria were over-provided, citing over-diagnosis of malaria in out-patients as a probable cause.

Pearson (2010) suggests that there has been improvement in utilization of health services in Malawi by the poor after the EHP but that the results have been mixed. For example, he argues that whilst the proportion of pregnant women receiving antenatal care visits remained broadly constant and family planning activity declined sharply until a recent up- turn, caesarean rates increased. He points out:

"ART roll-out has been particularly rapid and well above target….there is an increase in clinic attendance, treatment of malaria and diarrhoea. Children presenting with malnutrition has fluctuated over the same period (which may explain, in part, the high prevalence of underweight children). The health portfolio review concluded that "the data available suggest an increase in health sector activity over the last 6 years, despite staff shortages, particularly in early years" (Pearson 2010, 24).

There was an absence of specific documented evidence on access and utilization of general EHP services in Malawi and most documents used information on physical access (by distance to health facility) to general health services as a proxy. Most literature found was relating to MDG 4 on child health and is thus presented in a later segment in this review.

4.2.2 Zambia

Masiye et al (2010) performed a comparative analysis of trends in utilisation before and after the removal of fees at rural health centres by age group, and geographical area in order to evaluate the experience of rural Zambia after the abolition of user fees. Utilization was here defined as, "the number of visits to a health facility by individuals seeking a health service," (Masiye et al 2010, 744). Quarterly district data was drawn from the Health Management Information System (HMIS) a national database for the period January 2004 to June 2007. The study reports:

"On average utilization in public health facilities across all rural districts among the population aged five years or older has increased by 55% over the 12 months following the removal of user fees. The increase in utilisation in individual rural districts ranged from 2% to 95%" (Masiye et al 2010, 746).

The study shows that utilisation increased sharply from Quarter1 of 2006 for the rural population aged at least five years and that per capita utilization increased so rapidly among the rural poor to the extent that it surpassed the urban utilization rate. It notes, "…this level of utilisation has been sustained for at least the 15 months after user fee removal shown in our data" (Masiye et al 2010, 746). There was no change in the utilisation trends for the urban population aged five years or more (p-value ¼ 0.257) but the study records a slight decline in utilisation levels among the under-five population in urban areas. It states:

"…it is not clear exactly why utilisation per capita among children aged below five years in urban areas declined by nearly 10% during this period. One possible factor is that population surveys have shown that there has been progress in malaria control prevention with bed-nets and residual spraying" (Masiye et al 2010, 746).

It thus concludes that there were significant increases in the utilization of primary health care services in the rural areas where fees were removed and that increases were greatest in those areas where levels of material deprivation were higher. By the above findings, the study supposes that the removal of fees is more effective in providing protection against financial barriers to health care services than other mechanisms such as targeted exemptions (Masiye et al 2010, 749).

Hadley (2011, 248) also argues that abolishment of user fees increased utilization. She advances, "after removal of user fees health workers reported seeing sick people who were not previously attending and others consulted at health facilities at earlier stages of illness. A clinician practicing in a hospital where user fees had been removed summed up the difference in his own practice… 'we used to treat complications now we treat diseases'…" one clinician in this study highlights how when user fees were charged, patients would only go to the hospital with 'old' infected wounds that required both systemic and longer term local treatment while, following user fee removal, he attended to minor injuries that had been sustained in the recent past.

Despite the above observations, Hadley (2011, 244) questions whether increased utilization rates indicate success of free health services and adopts a local context of attendance rather statistical trends in her analysis of the impact of free health care in Zambia. This way, she found that people were denied health care due to known barriers of distance, staff attitudes, waiting times and additional costs despite free services. Visits to the community health volunteers and traditional healers, home remedies, self-medication from kiosks locally known as 'Ntembas' and wait and see approaches were used often as alternatives by patients. Hadley's study also revealed that 'frivolous use' and 'sharing of medicines' in the community further compromised the ability of the free services to achieve success (2011, 253). In this regard, Hadley argues that context of local practices contributes to determining the degree of success of a user fee policy beyond calculations of utilization rates. She thus concludes:

"Utilization rates as a statistical indicator are not sufficient to assess the success or failure of user fee policies in improving health outcomes. Qualitative insight into local health care practices is required to understand how (removal of) user fees affect both individuals and communities. Further research in remaining barriers to access, frivolous use, treatment and adherence to medical advice is required" Hadley (2011, 244).

4.3. Case comparison: Maternal and Child Health in relation to HIV and AIDS

In the segment below, a case comparison on maternal and child health in relation to HIV and AIDS is presented. Maternal and Child health are good indicators of health status in so far as the

social determinants of health are concerned since these indicators are sensitive to social conditions, (Karlsen et al. 2011**,** Hunt and De Mesquita 2012). These indicators thus proved to be suitable comparison points for a policy that seeks to better the health outcomes of socially marginalised groups.

4.3.1 Malawi

Two studies in Malawi (Mwase and Bowie 2011 and Malawi ALMA Quarterly Report of 2011) had consistent maternal and child health trace indicators. Both reports show unsatisfactory coverage of PMTC in 2010. In the ALMA Quarterly Report for example, only 39% of HIV positive pregnant women received ARVs and delivery assisted by a skilled birth attendant was at 54% of births in spite of the free services. On the contrary, the "MDGs Progress- Status at a Glance" 2011 snapshot report from the Ministry of Development Planning and Cooperation of the Malawian government and the Ministry of Health Sector strategic plan 2011-2016 indicate that delivery assisted by skilled birth attendant is 73%. This is a significant improvement from 57.2% in 2004 (see Ministry of Health Sector strategic plan 2011-2016 and the MDGs progress-status at a glance 2011).

It was however difficult to understand the cause for this disparity as the arguments presented for the 54% score and the 73% were the same. The Ministry of Health Sector strategic plan 2011-2016 (2011, 22) also shows that only 37% of HIV positive mothers received appropriate drugs and counselling as opposed to the 39% reported in the ALMA Quarterly report. However, a look at the child mortality through the UNICEF country profile (by far the most updated statistic on child mortality in Malawi) shows that the Malawi under five mortality rates as of 2010 is reported at 92/1000 and the infant mortality (under 1) is 58/1000. This is some improvement from the indicators presented in the Malawi joint programme of work for a health sector wide approach (Malawi Health SWAp 2004b, 6). This report scores infant mortality and child mortality at 104 and 189 per 1,000 live births respectively. Maternal mortality was 1,120 per 100,000 live births.

The Malawi MDG report 2010 (2010, 36) highlights regional inequities in skilled attended births. It shows that on average 86% of women in urban areas have skilled health personnel attended

births unlike rural women with an average of 63%. It argues however that that the proportion of births that are attended by skilled health personnel in rural areas increased from 2008 to 2009. It suggests that the increase is a result of government's policy of changing the role of Traditional Birth Attendants (TBAs) from delivering children to promoting institutional deliveries at community level.

An investigation into barriers to maternal health service use in Chikhwawa, Southern Malawi by Kambala et al. (2011, 1-5) found that patients were mistreated by health personnel when they go to the hospital. The study reports:

"For example one participant said: "The doctor is rude, he doesn't want to help us, he insults us every time we go there, and he says he cannot treat two people from the same family, saying that two people from the same family cannot fall sick at once". Another participant added that: "These health personnel, apart from not attending to two people from one family, they also refuse to treat for multiple problems. They will normally say that, one person cannot suffer from two diseases e.g. headache and stomachache". Therefore, if one has two complaints she/he will only be allowed to be treated for one and will be told to come next time for the other problem" Kambala et al. (2011, 1-5) .

This study also found that that Traditional Birth Attendants (TBAs) were favored by most participants not only because they are within reach but also because the women will not stay away from home for a long time. Also, the TBAs do not demand more items required for delivery than at the hospital. The length of stay and demand for materials needed for delivery at the hospital was a barrier to the use of health facilities during delivery. This study shows that fees are not the only barrier to utilization by the poor but the opportunity cost of care which in this case arose in view of longs stays in hospital and as well as staff attitudes can deter people from utilizing even free services.

In view of child health and immunizations, Pearson (2010, 24) argues that coverage in Malawi remains high. This assertion is also supported by the Malawi WHO and UNICEF estimates of immunization coverage (2011 revision). The Malawi Ministry of Health 2011 action plan also reports that Malawi has had a robust and enviable immunization programme for many years and that most recent high coverage is confirmed in the 2010 Demographic Health Survey (DHS) report which shows that 81% of children aged 12-23 months were fully immunized. The plan

argues that there has been an increase in coverage of 26% since the 2004 DHS though the country experienced an outbreak of measles with an estimated 43,000 children requiring treatment in 2010. In spite of the mentioned successes, this report argues that there is still more to be done. It asserts, "high coverage, particularly of measles is required to maintain herd immunity and additional resources will therefore be required to sustain a vaccine coverage of 90 per cent and above for all antigens" (Malawi Health Sector Strategic Plan 2011 – 2016: 2011, 18). Taking as an example the DPT3, the Malawi ALMA Quarterly Report (2011, 2) shows that Malawi has made tremendous achievement among 12-23 month where it stands at 93% (Malawi ALMA Quarterly Report).

Chirwa also argues:

"Child health services are part of the EHP and are offered at all levels (primary, secondary and tertiary) to ensure access and equity to the services (MoHP 1999). Health workers trained in child health related areas such as IMCI, PMTCT and many others are deployed in nearly all health facilities in Malawi. Various data sources indicate an improving trend in access and utilization of some aspects of child health services. For example, data from the HMIS of the Malawian public health sector indicates improved access and utilization of immunization services. It indicates that 62% of the estimated target population was fully immunized in the period 2006/07 registering an improvement from 59% and 55% reported in 2005/06 and 2004/05 respectively (MOH 2007)" (2011, 15).

4.3.2 Zambia

The UNICEF country profile provided the most updated statistics for Zambia as well in so far as Child and Maternal health are concerned. The under-five mortality rate as of 2010 in Zambia is reported at 111/1000 and the infant mortality (under 1) is 69/1000 (see UNICEF Zambia country profile). According to the UNICEF Zambia fact sheet, only 47% of women in Zambia had a skilled attendant birth and there were pronounced disparities in utilization between the rich and poor women with utilization by 91% of the richest women and 83% of urban women, compared to 27% of the poorest women and 31% of rural women. Antiretroviral treatment of HIV-positive pregnant women in Zambia reached 69% in 2009 and is according to this report almost twice as that of Malawi which stands at 37%/39%. However, even in Zambia, only 39% of the HIV-exposed infants received antiretroviral (ARVs) to prevent mother to child transmission of HIV.

Hazemba and Siziya (2009) investigated factors responsible for utilization of maternal services among rural households in one district in Zambia. They found that having had last childbirth at home was negatively associated with current delivery at a health facility. When the last delivery at home was complication-free, mothers would have a follow-up delivery at home as well. This study found a rate of utilization of health facility for childbirth in Chongwe (a rural district) in Zambia of 42.8%, a rate higher than the national figure of 27.9% for rural areas in Zambia. They argue that this indicates the large magnitude of variation of health care utilization rate for childbirth between rural districts in Zambia despite services being free. This study also found that the availability of delivery assistance by Traditional Birth Attendants (TBAs) was reported to be associated with non-utilization of a health facility. Also, place of last childbirth, and knowledge that traditional birth attendants were given none food items (excluding money) were significantly associated with delivering at a health facility. This was because usually the health center demands so many necessities from the expectant mother. So, in situations where the expectant mother deems a TBA to be cheaper help, they usually go for the TBA. These barriers to utilization as identified here are similar to those highlighted by Hadley (2011) above.

Hazemba and Siziya (2009, 56) thus conclude that it is important to reach these mothers when they seek postnatal care services or during clinic outreach sessions and talked to about the importance of delivering children at a health facility despite that they had a previous safe delivery at home. Having a safe previous delivery is not a guarantee that the follow-up delivery would also be complication-free. Clearly, this is a barrier to utilization that requires urgent attention.

In view of child health and immunisations, ILO argues that, "overall, it is shown that immunization coverage has been high in Zambia. International support through the Global Alliance for Vaccines and Immunization has been crucial to this success" (2008, 125). ILO however contends that despite many children getting immunized, access to effective treatments for leading causes of disease among young children such as respiratory infections, diarrhoea and malaria is still low. Barriers to care related to distance to health centre means that they usually get to the centre when it is too late. Given that the said are acute mortalities, this is arguably one of

the major reasons why child mortality remains high in Zambia despite major strides in immunization coverage.

For HIV/AIDS, ILO argues that there has been dramatic improvement since inception of free services that were scaled up to include ART. However, it points out, "it is estimated that these figures represent less than half of the target group. The distribution of coverage by province also shows that coverage is unequally distributed". Although crude estimates of coverage of adults in need of ART shows that 36% are covered, this report argues that coverage across the country is modest and is still very low in some places with Luapula province as an example (2008, 127). In the case of the example of DPT immunisation provided on Malawi, Zambia is lagging behind at 82% of DPT3 vaccinations in 12-23 month olds (see UNICEF country profile). This pattern is consistent for all other immunisations. For example, the EPI from government funding stands at 39% in Malawi and a marginal 19% in Zambia.

4.3. Constraints

Many challenges were found to constrain implementation of the policies in both countries. They include shortages and unbalanced distribution of health workers at all levels of the public health system, inadequate and poor state of essential infrastructure, equipment and transport, the shortage and erratic supply of essential drugs and medical supplies as well as procurement and logistics management problems (WHO 2009a, 2009b). Below is a detailed overview.

4.3.1 Malawi

Evidence from WHO shows that Malawi is struggling with a persistently inadequate availability of health workers and health facilities (WHO 2009a, WHO 2009b). The situation of Malawi regarding health workers is even more critical and is arguably the major barrier to universal access to equitable, quality health services. According to WHO (2006) in WHO (2009a, 7), Malawi has the lowest staffing levels in the region with two physicians per 100 000 population and 59 nurses per 100 000 population and outputs at training institutions are reported as too low to fill existing vacant posts.

Another pronounced challenge identified in Malawi was non availability of health workers due to frequent and numerous training days of the already insufficient work force. According to Mueller et al. (2011, 6), "facilities fell short of even half of the expected staff allocations and staff, which was available, was often absent, especially on meetings and training. This is in line with findings of previous studies and reports." They report that their respondents agree that fewer training, focussed on need, would be helpful, but that no stakeholder offered any comprehensive solution to the problem. It was mentioned that current government rules prevent restructuring of training to reduce monetary incentives. Suggestions to improve the current ways of knowledge transfer include harmonisation of training activities between different actors; provision of onsite training; pre service training, but also increased supervision; rotation of staff; and improved emergency communication. The study records that stakeholder's report a lack of stewardship on the part of government to reform the situation. A stakeholder stated in the study, ''Government is aware of the problem, but nobody has stood up to it so far'' (Mueller et al. 2011, 6). Indeed, this has made physical access to functional health centres poor in rural areas.

Functional health centres exist in urban areas but their capacity is limited leading to congestion in the facilities. Larson et al. (2008, 12) state that there are only approximately a total of 252 doctors for a population of about 13 million people, and that the nurse to population ratio is approximately 1:3500 with about 64% of nursing posts in Malawi unfilled. They argue, "Even in African terms, Malawi does not come out well, with fewer health workers per person than Sudan" (2008, 12).

Health Worker retention is another challenge as the public sector continues to lose skilled health workers to the private sector and the international market due mainly to low remuneration and poor working conditions.[7] "The HIV epidemic is also taking its toll on caregivers and administrators alike, exacerbating an already chronic shortage of appropriately trained personnel.

[7] Nurses interviewed in Larson et al. (2008, 12) report long working hours with erratic pay schedules of salary's that cannot last them the whole month. They seek work/workshops outside both during and after work hours to cover for the salary a shortfall which further compromises their ability to deliver quality and timely care. The government trains more nurses at nurse technician level, a low paying and not so skilled position, a reform that is not sustainable in the long run if quality and performance outcomes are considered. A nurse stated that she can in no way recommend the profession for her daughter.

The few available health workers are also not evenly distributed across the country (see WHO 2009b, Pearson 2010). Although rural retention schemes were introduced in 2007, health centres still operate below the 50% of the recommended staff establishment with acute deficiencies in some departments since health workers still migrate to urban areas or the private sector.

According to Larson et al. (2008, 15), Malawi has unevenly and inadequately distributed health care resources which has continued to make access for poor people difficult. They argue that the Malawi Poverty Reduction Strategy Paper (MPRSP) shows that physical distance to health centres is poor with only 3% of the population living in a village with a health centre. Only 46% of the population has access to a health facility with a 5 km radius and only 20% within a 25 km of a hospital. One public health facility has to carter for approximately 17,000 people with the situation worsening as one moves from urban to rural areas. People have to travel close to 30 km and about 33% of the population has to travel by foot to the hospital. For example, 53% of the people interviewed in Larson et al. (2008), reported having taken on average two hours to get to a health centre.

A substantial number of health services in Malawi are provided by the Christian Health Association of Malawi and these facilities are often nearer to the people. Most of these hospitals are owned and operated by the Roman Catholic Church, the Presbyterian Church and the Seventh Day Adventist Church. They are mostly located in rural areas where government health facilities are lacking. For communities that are served by CHAM hospitals, equity of access is compromised, as the poor do not always afford to pay for their medical treatment that falls outside the EHP although the quality of care in these hospitals is better than that in the government run facilities (Larson et al 2008). These factors have often led to the poor people waiting until they are very ill to seek formal medical attention. Otherwise, they resort to traditional healers and medicine men.

One of the major tasks of the EHP was to deal with the drug shortages in Malawi (see Malawi Health SWAp 2004). Malawi also revised its National Medicine Policy in 2007 in order to ensure equitable access to quality, safe medicines and ensure rational use. Lawson et al. (2008) however showed that there were still significant shortages of vital medicines. Among others, stock-outs

throughout the country of basic antibiotics, insecticide treated nets (ITNs) and HIV-test kits with stocks of vaccines have run dangerously low at times, (Lawson et al. 2008, Pearson 2010). These studies argue that this is partly due to perennial problems of poor management at the Central Medical Stores (CMS). These problems are argued to be complex and revolving around the lack of systematic ways of measuring demand. CMS simply orders drugs based on previous consumption levels. WHO (2009b) also confirms that there is still frequent stock outs of essential medicines and supplies in the public health systems and suggests that this could be due to the fact that the Malawi Standard Treatment Guidelines and Malawi Essential Drug List were not simultaneously revised and no post marketing surveillance and pharmacovigilance system was in place.

Furthermore, WHO (2009a) reports that the Malawi National Drug Quality Control Laboratory has limited capacity to conduct quality control on new pharmaceutical products such as ARVs and ACTs and argues that a drug leakage study of 2006 signals the presence of problems within the pharmaceutical sector in so far as the public health system is concerned.[8] While dissemination and enforcement of compliance with recognized/recommended treatment guidelines and compliance with prescription also remain a challenge, the critical shortage of qualified pharmacists in the country has continuously contributed to a weak supply chain management and inadequate coordination of available resources and programmes to achieve the goals of the National Drug Policy. Additionally, issues that relate to drugs and medical supplies have not been adequately addressed in the framework of supply chain management although the MoH has strengthened the capacities of existing staff in the Drugs and Medical Supplies Logistics (WHO 2009a, Pearson 2010).

Mueller et al (2011, 4) however contradict the above picture by reporting that overall, hospitals are now better equipped with drugs specified in the EHP. They argue that hospitals have more alternative drugs available which were, according to pharmacists and clinicians interviewed in their study, used when the original drug was out of stock. This study however does point out that

[8] See Drug leakage study in Malawi.

there had been 6 emergency purchases by the Central Medical Stores (CMS) during the time when the survey was conducted. Also, stock outs were not rare. This study identifies long standing problems with drug availability that include i) cumbersome and long World Bank procurement procedures, ii) insufficient qualified staff to perform quantification adequately, iii) a high turnover in staff, iv) poor warehousing and lack of space leading to drugs being pushed to the periphery too quickly and not based on need, v) poor inventory systems, and, vi) lack of capital funds to procure sufficient drugs in advance to cater for additional need and spoilage (buffer stock). The CMS was thus seen to take on the role of drug rationing as a way of resolving this challenge. Clearly, this compromises the ability of the EHP to achieve its goals. The effects of drug rationing on health outcomes can in no way be positive in the long run which this paper asserts is a detrimental short term solution to long term problems.

Malawi has had a seemingly better coordinated funding system for the EHP but challenges are nonetheless still evident. WHO (2009b, 9) asserts that unpredictable funding for commodities such as ART, other medications and test kits, procurement and supply management of drugs/commodities continues to be one of the major challenges.

Mueller et al. (2011, 1) argue that since it started in 2004, donor funds channelled through the SWAp were intended to ensure the delivery of the EHP and to ensure that the health care system was functional to deliver the EHP interventions. This led to the initiation of the decentralisation of the health systems resulting in the devolution of the drug budgets in 2006. However, these authors argue that despite this being the case, it was not until the end of 2010 that this decentralization process was completed. These authors further point out the inadequacies of the health system were also not addressed:

"Although inadequacies of the health system were well known, it appeared that insufficiencies of the health care delivery infrastructure were not sufficiently addressed before and while the EHP was put into place. Recent efforts have been made to re-design the package in terms of the number and type of services included. While this reform is arguably improving the planning and budgeting for the EHP with a more comprehensive costing as well as a further orientation at the burden of disease, our findings suggest that the degree of implementation of any package will be limited whilst the health system constraints remain as strong as they are in the case of Malawi" (2011, 8).

Bowie and Mwase 2011 argue that funding has been inadequate although the pooling of funds has aided the function of the EHP. "The actual disbursement had always been less than pledges from donors between 2002/3 and 2007/8, when in this period only 62% of pledges were disbursed. The net result was a serious under-funding of almost half of the revised EHP estimated required expenditure per capita per annum" (Bowie and Mwase 2011, 9). In this regard, WHO (2009b) summaries the main challenges as inadequate human, financial and material resources for delivery of equitable and efficient health services. It also argues that within the implementing partners, at times there were competing priorities in the implementation of programs. Resultantly, scheduled programmes are at times not implemented or are completely cancelled (see WHO 2009b, 3).

4.3.2 Zambia

Evidence from WHO shows that Zambia is also struggling with a persistently inadequate availability of health workers and health facilities (WHO 2009c). WHO (2009c) argues that the persistent inadequate availability of skilled health professionals has resulted in low access to health services in all communities and facilities. "The profile shows an aging professional cohort, particularly among medical staff. The training institutions are insufficient to meet the projected needs, with most of them operating below capacity. They are also poorly distributed, particularly among rural and urban areas…" (2009c, viii). Data from the 2005-2006 Health Facility Census in Zambia gives a ratio of 1.04 health workers per 1000 people. Approximately, there are 0.08 doctors and 0.69 nurses per 1000 people.[9] A similar case study of the human resources for health in Zambia by Ferrinho et al. (2011, 10) concludes that the case of Zambia demonstrates that training more staff is necessary to address the resource crisis but it is insufficient and has to be completed with measures to mitigate attrition and to increase productivity.

According to WHO (2009a, 12), Zambia still has significant gaps in the number and distribution of facilities that are required to cover the whole population. WHO (2009a) reports:

[9] Ratio does not take into account the skill mix and productivity levels of all health workers or the quality of care provided, (WHO 2009c, 11).

"…in total, Zambia has 1327 health facilities, including 97 hospitals, 1210 health centres, and 20 health posts. The majority of the health facilities belong to GRZ. The existing network of health facilities, especially at the lowest level, is not adequate to cater for the entire population. There is acute shortage of primary health care facilities, in particular20. For example, the target is to have 3000 health posts but currently only 20 have been commissioned; the target for health centres is 1385 but currently only a total of 1210 health centres have been built" (2009a, 12).

However, Masiye (2012) argues otherwise. He states that Zambia has significantly reduced the physical barrier to access and the virtually everyone lives within a 5 km radius of a health centre. He argues geographical access is no longer the biggest barrier to access and that the cost of travel to facilities has reduced. Given that Zambia still has vast rural areas which are not adequately covered by well-functioning health centres, the argument that geographical access is no longer the biggest challenge appears lucid as indeed, there could be bigger challenges. However, it is difficult to see how virtually everyone in Zambia lives within a 5 km radius of a health facility given the revelations of WHO 2009c. In fact, a study by Gabrysch et al. (2011,10) quantified the influence of the health service environment on women's use of health facilities for delivery in rural Zambia while adjusting for other important individual, household, and community-level determinants. It concludes that the lack of geographic access to emergency obstetric care is a key factor explaining why most rural deliveries in Zambia still occur at home without skilled care. They argue that addressing geographic and quality barriers is crucial to increase service use and to lower maternal and perinatal mortality. The 2010 government project of mobile hospitals that attempts to reach far flung areas was abandoned after the September 2011 regime change and has not been evaluated yet. Seeing that was no other intervention to remove distance barriers, it is impossible to see the reasons for Masiye's (2012) argument.

WHO reports, "Over the past 5 years, the bulk supply of essential drugs and other medical supplies were erratic, with more than 50% of essential drugs being out of stock. Shortages and inappropriate clinical use of drugs and medical supplies still remain a critical problem in Zambia," (2009c, 12-13).

The World Bank also recognizes that drug availability is a problem and points out that there are still needless deaths in rural areas due to this problem. In reference to Malaria, this survey argues that the problems in the supply chain also impact the availability of other drugs, such as

lifesaving antibiotics. It recognizes the need to step up access to essential drugs the Ministry of health and the Medical stores as well as partner organisations such as (MSL)/Crown Agents, John Snow Inc., the UK's Department for International Development (DFID), the USAID and the World Bank. This report argues that these partners joined forces to deal with the problem. Results of this joined approach are yet to be seen but it is hoped that availability of drugs will improve. Among the problems identified in this study include bottle necks in the procurement process where drug shipments get stuck in district storage facilities while health facilities experience large scale stock outs of critical drugs.

Aantjes and Chanda (2011) on the Capacity.org website report that a midterm review of Zambia's National Health Strategic Plan 2006–2010 carried out in 2008 found that there was a lot to be done to put into practice the principles of the Paris Declaration with respect to donor support. It was revealed that some donors among them the Dutch government – provide budget support under a sector-wide approach (the umbrella for the free health services), while others earmark their funding, and some do both. This study also revealed that most of the health budget came from earmarked funds and that the situation was further compounded by the large funds from the various global health initiatives that were set aside for programmes targeting specific diseases. These initiatives included the Global Alliance for Vaccines and Immunisation (GAVI), the Global Fund to fight AIDS, Tuberculosis and Malaria (GFATM), the US President's Emergency Plan for AIDS Relief (PEPFAR), the Bill and Melinda Gates Foundation, the Clinton Foundation and the World Bank Booster Program for Malaria in Africa. Calculating funds from PEPFAR and GFATM alone, public per capita expenditure rose from US$11 to approximately US$34 between 2004 and 2006 (see Aantjes and Chanda on Capacity.org 2011). This study thus concluded that earmarked funds caused serious distortions in funding priorities in Zambia and that the global health initiatives overloaded government systems and structures with their separate planning processes, financing, implementation, accounting and reporting systems – none of which was necessarily linked to strengthening the country's National Health Strategic Plan. The proposal writing processes also proved to be a major source of frustration with many proposals having to written before few donors can provide funding. Aantjes and Chanda however show that a 2011 evaluation shows some success in harmonization of budgets and priorities. It points out that

despite some successful diagonal programming, the Zambian profile does not show dramatic improvement since the midterm review in 2008 particularly in terms of donor harmonisation and alignment, two of the key principles of the Paris Declaration:

"Funding structures have remained vertical. International organisations and funders decide on allocations and priority areas in reference to the national strategic framework on HIV/AIDS. There is no initial joint planning between the ministry and international organisations such as FHI and CRS, which are implementing the diagonal programmes discussed above" (Aantjes and Chanda Capacity.org 2011).

Mwanza (2011) on the global health check website also argues that few of the now well understood necessary steps for successful fee removal were taken before the implementation of the free health care policy in Zambia. He stresses:

"When the Zambian President announced the policy change in January 2006, he committed to abolish user fees in all government and mission-run facilities in rural districts from April 2006. This allowed just three months for planning and communication. When the policy came into effect, lack of resources including drugs, staff and additional funding seriously compromised the ability of facilities to meet the needs of patients. Additional health workers were not deployed to rural areas and steps were not taken to mitigate the impact on staff. Measures were not taken to reduce the risk of drug stock-outs and in the first year 60% of essential drugs were unavailable. To make matters worse, many health facilities experienced a loss of income" (Mwanza 2011).

Mwanza also points out that disbursement problems made it impossible for many districts to receive the funding grants months after the policy change despite promised compensation for the revenue loss from a UK DFID replacement. Other finance related problems such as the reductions in district non-wage and district drug expenditure are argued to have confounded the policy take off even further. Overall, Mwanza argues that the quality of health care declined and patients faced longer waiting hours, fewer drugs and an over worked staff (see Mwanza 2011).

As can be seen, Malawi and Zambia experience similar constraints to the successful implementation of this policy reform although contextual differences exist. However, what is clear is that the problems in both nations are complex and are not merely due to a lack of resources. At play are questions of stewardship and governance for health, the health systems as well as to what ought to be done to fight vulnerability and inequities in health. It is in this regard that this paper finds the conclusions of Mueller et al. (2011) very relevant. Mueller et al (2011,

10) assert that while essential health packages are an important aspect of health system development especially in the face of inequities in health that is relatively easily drawn up, solutions to the underlying problems of the supply side present a greater challenge. They argue:

"…The implementation of an essential or minimal health care package is not a panacea to the insufficiencies of a country's health care delivery system. An EHP is bound to the limitations set by its health care delivery infrastructure and system. In Malawi, as in other countries with a similar state of the health care system, the constraints to the health care delivery system must be prioritised over the design of such packages…"(Mueller et al. 2011, 10).

5.0. Discussion and Recommendations

This chapter discusses extents to which conclusions about the coverage and utilization of services as per presented results can be made. The analysis relies on the theoretical and conceptual framework outlined in chapter three. Thus, judgements made here about coverage and utilization of services have a specific context. Examination of the findings suggests that key questions about the extent to which sufficient quality services are available to the vulnerable groups through the free care policies still remain. It is to these questions that this chapter is devoted.

5.1 Coverage

Although availability of health services have increased significantly under both the EHP and waiver policy, physical coverage of health services is still limited as the number of people who live within a 5 km radius of a health facility in both nations is still small. The services are in principle free at point of use but as shown, the poor more so the rural poor still bear indirect costs to care. In the case of Malawi's EHP for example, despite having aimed to improve this situation through for instance the standardization and expansion of community level services as well as protecting key resource inputs, such as transport for referrals and a secure budget for components such as drugs in the package, the literature reviewed shows that these aim have remained largely unmet. This is a huge problem in both countries since Zambia's picture is not any different.

As Larson et al (2012, 2) elucidate, distance to health services impacts on health seeking behavior. "Areas of low access are often inhabited by people who need healthcare the most. Residents in areas where access is difficult often underutilize services or present to health facilities only when their condition is grave, sometimes miss opportunities to effectively treat health problems." This assertion was found to be true in this study as literature shows that disparities between urban and rural areas are still large. Distance to health services has remained a barrier to accessibility in both Malawi and Zambia in spite of services being free. In this light, this paper also concurs with the assertions of Banerjee and Duflo's (2011) that the poor usually face structural disincentives for health care. Impassable roads, poorly distributed health centers for example are in themselves structural deterrents that require urgent attention.

In view of the above, Banerjee and Duflo (2011, 50) are on point when they explain that what the problems with lack of demand for such free services is perhaps not the lack of "ladders" per se that poor people can use to escape the trap of poor health outcomes but rather the misplacement of the "ladders" and that, "the people for whom they are meant do not seem to know how to step on them or even where to step on them." This paper thus argues for revision of the policies so that they to deal with the non-availability of health centers. This is critical if at all the MDG targets on child mortality in these two countries are to remain realistic targets. Consequently, this paper concludes that structural factors such as distance still threaten household accessibility of health services despite efforts to bring services closer to the people.

It was challenging to make an accurate assessment of the impact of the free health policy on maternal and child health between the two nations due to data inconsistencies in statistical indicators presented by various reports. The Zambia 2011 MDG report for example presented statistics from 2007 while a snapshot report from the government of Malawi had indicators from 2010. However, only slight differences exist between the two countries when indicators in Malawi's ALMA Quarterly Report of 2011 and those in the UNICEF 2010 Zambia PMTC fact sheet were compared (see Zambia MDG Progress report 2011, Malawi ALMA Quarterly Report of 2011 and UNICEF 2010 Zambia PMTC fact sheet). Review of the EHP shows that in spite of its implementation, Malawi is still unlikely to meet the MDG targets on child mortality. The Malawi MDG progress report 2010 clearly shows that Malawi will be unable to meet the MDG target on Maternal mortality (goal number five) despite the decrease in the maternal mortality ratio from 1,120/100,000 live births in 2000 to 807/100,000. The report argues, "despite this improvement, Malawi is unlikely to achieve the desired target as the projections show that by 2015, MMR will be 338 deaths per 100,000 live births which is way above the MDG target" Malawi MDG Report (2010, 35). The situation is only slightly better in Zambia where reported maternal mortality ratio adjusted for the period 2006 -2010 is 590. The 2008 adjusted ratio is 470 (see UNICEF Zambia website).

Although the Zambia MDG report does not explicitly state that Zambia will not meet the MGD target on maternal health, it does explain that meeting the target is still a very huge task despite

the hope from the declining maternal mortality rates. It affirms that even if the Demographic Health Surveys do not disaggregate data below national level for inequality assessments, there is reason to believe that maternal mortality rate is worse in rural areas, where access to health services is much poorer despite waved user fees. The number of skilled attended births between urban and rural areas for example confirms that disparities in coverage are still large. In this regard, this paper asserts that both countries are still a long way from extending health services especially on this area although one would argue that overly, Zambia is closer to the MDG target than Malawi is. However, as the findings on coverage did indicate, Malawi's EHP has produced better coverage than the Zambian waiver policy in highlighted areas. Overall, the policies have effectively increased demand for services but the supply has only marginally increased. It is in this respect that this paper asserts that coverage has not been adequately extended.

5.2 Utilization

Discussions of utilization are meshed in concerns about access. In Mooney's conceptualisation, access only becomes access (equal) if those that face equal costs have equal access. He goes further to argue; "access is wholly a question of supply; utilization is a function of both supply and demand" (in Gulliford et al. 2002, 187). Seeing that access and utilization of services are overlapping concepts that are interlinked, this review found it necessary to discuss the findings as such. To understand the issues related to access to health care as espoused in both the EHP and waiver policies, Acheson committee (1998) in Hill (2003, 172) offers us an insightful argument on access to primary health care. It notes:

"access to effective primary care is influenced by several supply factors: the geographical distribution and availability of primary care staff, the range and quality of primary care facilities, levels of training, education and recruitment of primary care staff, cultural sensitivity, timing and organisation of services to the communities serve" (Acheson 1998 in Hill 2003, 172).

In the same vein as the Acheson committee, Gulliford et al. (2002) in "what does 'access to health care' mean?" propose a four pronged approach to the assessment of access. In this approach, access to health considers service availability, personal barriers, financial barriers and organisational barriers. Service availability requires that the services purported to be provided are

available (opportunity to obtain) health care when it is needed. They posit that availability is usually measured in numbers of doctors or hospital beds per capita and that questions still arise about the level of resources or the configuration of services for example between primary and specialist care. This paper does not concern itself with the economics of this dimension for obvious scope and space constraints. However, if we are to use the hospital bed per capita or number of doctor's criteria, it is clear that access to health care on the service availability dimension either in Malawi or Zambia is inadequate given the identified critical human resource shortages despite the policy reform (see section on constraints to implementation).

Mooney in Gulliford (2002, 186) also argues for the measurement of service availability, " in terms of costs to individuals of obtaining care" and such costs include among other things travel and inconveniences incurred in obtaining care or the benefits one forgoes when they do not obtain health care. In this respect, physical distance tends to increase costs to care. However, as illustrated above, Mooney (in Gulliford et al. 2002, 187) argues that utilization is immaterial to discussions of access. He stresses that equality of access is about equal opportunity and the whether or not the opportunity is utilized is irrelevant to a discussion on access. To avoid being repetitive discussions of physical distance will not be pursued again. It is however necessary to mention here that if we are to discard questions of whether or not the opportunity was utilised from the access argument as Mooney suggests, then we should have absolute certainty that there is no barrier, direct or indirect that is responsible for the underutilization of this opportunity. Otherwise, we risk sentimentalizing the debate at the expense of the already marginalised.

However, if we use Mooney's proposed availability of services dimension to evaluate the policy effects, we see that both still falls short of access. This is mainly because as already alluded to, geographical distance was still seen as a major barrier to medical attention. If as Mooney suggests, access is wholly a question of supply, then it is also evident that access is still poor. This conclusion stems from the observation that policies are in practice demand side. They have to a reasonable extent increased the demand for services yet supply is largely uneven (the review found that there are now more people seeking services because they are free but supply of services does not equal this increase demand).

If however, we extend the debate to include Pechansky's argument in (Gulliford et al. 2002, 187) that mere availability of a health facility is not enough, (we need proof of use), then perhaps one would argue that access is being granted to the vulnerable groups under discussion as all the studies reviewed did point to the fact that utilization of services has tremendously improved post user fee removal. Although this conclusion is in tandem with literature reviewed, it is necessary to note that it is not clear whether the increase in utilization of services is due to new groups that were previously excluded now utilizing the services or it is a case of repeated use of services by the same groups of people (a case of over medication). This concern arises from the fact that the definition of utilisation used in studies like that by Masiye et al. (2010, 744) only emphasise frequency of visits to the health facility. It does not clarify if this is a frequency of one group or varied groups of users. This paper thus finds such measurement inadequate to provide conclusive evidence on increased utilization as an indicator of inclusiveness in a health service.

In fact, if as shown earlier physical distance is still a constraint to use of health care despite the waving of fees, then it cannot be ordinarily assumed that the policies have extended coverage to remotely isolated areas and persons. This measure is also unable to assess the quality of services as a factor in access. In light of these revelations, this paper argues that measuring access using only such quantitative indicators as utilization is defective. This prompts the question of the sense in which a free service can be said to be 'free' if it is largely unavailable to its supposed recipients. Since both these approaches to health purport to be anchored on the rights-based approach that treats health care as a basic human right guaranteed and accessible to every citizen, Kjønstad's arguments prove relevant.

Kjønstad (2011, 66) argues that a right that exists only on paper is worth nothing if it cannot be implemented in practice and that if a right is to be realized in the form of actual care, it is necessary for the persons needing health care to be aware of this right and be able to assert it. Indeed, people need to have the ability to receive the service when they need it otherwise improvements about utilization are largely cosmetic. Meessen (2009, 14) cautions based on observations from Uganda's experience that if free health care turns out to be a real success among poor households, the influx of users to the health centres can in fact lead to an increase in

the opportunity cost for the better off. They may then decide to shift towards private clinics. This has not happened in either Malawi or Zambia. This and the fact that better off households are benefiting more from the free services show that there still a lot of inadequacies to be addressed in the health systems. This can be taken to imply that the policies have not performed to expectation as an explosion in utilization would indicate.

In view of the evidence presented on immunizations, both nations are doing fairly well. The support from the GAVI alliance has helped Zambia to also step up its immunisation programmes. However, with respect to equity considerations, USAID on their maternal and child health integrated programme website show that the DPT3 coverage equity ratio (wealthiest: poorest quintile) in Zambia is 1.21 while that of Malawi is 1.22. This picture is reminiscent of all other immunisations in these countries. It thus shows that the equity gap is still large in both countries and more needs to be done to narrow it despite the efforts already in place. Although it is difficult to make concrete conclusions about the effects of the policies on utilization as a proxy for access using the analytical framework employed here, it can be said that utilization of services has significantly gone up after the introduction of the policies in both nations. The challenge is however that the rates are disproportionate among the different regions of both countries and progress is still slow and unsatisfactory.

5.3 Implementation constraints

Gilson and McIntyre in Yates (2009,1) argued that the removal of user fees should not in any way be thought of as a panacea that can be implemented at the stroke of a pen but should rather be implemented in a package of broad health-systems reforms. They state, “these reforms should include improved management supervision to ensure that formal fees are not replaced by informal fees charged by health workers.” Indeed, in light of the reviewed literature, these comments are relevant. Practices of health facilities having no drugs yet health personnel have privately run ‘drug stores’ from which prescriptions can be purchased are a case in point.

Yates argued for practical steps to the implementation of free health care policies such as the setting of a clear timetable for the complete roll out of these policies, then developing countries

and their patterns developing and implementing health financing strategies to increase coverage within this set time frame as well as targeting specific cost and non-cost barriers to health access such as informal fees, travel costs, poor geographical access, low quality services and discrimination against disadvantaged groups. An evidence based approach to the implementation of these policies was very critical. However as we have observed in this paper, this appears not to have been the case especially in the Zambian policy.

The Malawi case was properly planned due to the technical assistance received from myriad partners but the same cannot be said of Zambia where the policy was born out of a presidential declaration. The implementation does not seem to have been systematically planned (see the Anglican Health Network 2010, 2). Further, Hadley (2011, 246) points out that health workers are confused as to who to exempt from fees. The categories "those who can afford to pay" is not clearly understood by health care professionals. She further argues, "…indeed, a system to identify those unable to afford and cover the costs incurred by the waiver of user fees by these patients did appear to be well functioning and led to both confusion and inconsistent application of exemptions. Individual decisions were the order of the day." Health care workers in health facilities are thus left with the discretion to decide who is to be exempted: "….anyway, there are few who can't pay…we use our discretion. We see how they are; if they have work, where they come from…we use our discretion. If someone comes with nice plaits in her hair but says she can't afford…we don't believe," reports a Health worker in (Hadley 2011, 248).

Indeed, what this shows are the inherent weaknesses of means targeting for social services. To infer from van Oorschot (2002, 173-193), means testing as an administrative method has the function allocating welfare to claimants on the basis of their financial resources. However, seeing that the supposed recipients in Zambia's case for example were meant to be rural and poor populations, the aged and children, it is difficult to understand why people in rural areas were still being means tested. Improperly coordinated means tests have the tendency to keep people out of services as Hadley demonstrates in her study. In a country with soaring poverty rates, such a needs assessment criterion is completely inadequate to achieve the policy goals. Furthermore, it also opens up the service for abuse by health workers. Although it can be argued that they are

expected to act "knightly" and seek to serve the population for which such a service is meant, there is no guarantee that close relations and friends may be asked to pay if such a service is completely at their disposal with no clear guidelines of user selection but the health workers discretion. Such problems arise also due to lack of understanding of what the policy entails from health managers at facility level. This lack of understanding of what the policy entails on the part of health facility staff was also prevalent in Malawi as the review demonstrated. It thus is necessary to relook at these strategies and ensure that reforms which are meant to be safety nets do not end up making the conditions worse for some. As Hadley highlights, quality of services should be paramount and informal fees and costs need not be tolerated.

To ensure inclusiveness, it suffices to point out that the policy should have clear eligibility guidelines because as it stands, the policy is open for knavish activities that benefit neither the users nor the state's objectives. There thus needs to be a more concrete and standardized eligibility criteria. Offices charged with this responsibility should be trained and accorded the tools to deliver objective needs assessments. Otherwise, the tests should be scraped off. Further, health facility managers should be trained to understand what the policy involves. This would make the removal of user fees more effective. Indeed, it is impossible to speak of equitable health care and assume that removing fees will improve health outcomes for the vulnerable segments of society if in the first instance the cost and non-cost barriers to health care are still prevalent.

There is a choice of policy conclusions to be drawn from these findings. Splitting the management of health services into the type of system as proposed by Le Grand would prove helpful for systematic management. In such a system, the health authorities take on the role of purchasers and in exceptional cases, providers. In view of Hill (2003, 157-179), this implies that health authorities; in this case the MoH enter into specific contracts to secure the services needed for the patients in a particular area. Hill's posits that this system does not imply that the health provider has to be in a particular geographical patch. The providers can be private organisations.

The proposal matches evidence reviewed which indicated that some services that the target groups of the EHP and waiver policy require are not provided in private hospitals leading to out of the pocket for these additional needs. To use such a delivery system, the health authority

would enter into a contract with the private organisations to provide these services for free or at a subsidised rate. This system would meaningfully extend coverage but despite the system being highly feasible and plausible with respect to health needs of vulnerable groups, Malawi and Zambia have not attempted it. They continue to use the traditional command and control approach to social delivery that relies on the state and treats private care providers as rivals.

Evidence reviewed also showed that private hospitals have higher quality services than government facilities where the EHP and waiver policies are in effect. Using the networking approach would extend health coverage in those areas where the public hospital network is weak. This system would generate what has been termed a 'quasi-internal market' in health. In this case, the system of purchasers and providers of services takes the cost away from the individual yet gives them the ability to enjoy the quality outcomes of a market like approach to health provision. Although such an approach requires a more complex system of management, evidence does point to that fact that it is in effect an even more efficient system in both resource use and in responding to the needs of consumers, (see Hill 2003, Lavalette and Pratt 2006, Le Grand 2011).

As Le Grand demonstrates in the 'Invisible Hand' this approach likely to substantially meet the goals of a good public service elaborated earlier. In this way, we can have a realistic hope of improving the health outcomes of the vulnerable. Observers like Powell (1991) in (Considine and Lewis 2003, 132), offer this network approach as a significant alternative to both markets and hierarchy (systems as exhibited in both Malawi and Zambia). This system draws its theoretical underpinnings from both the virtues of markets and third-sector alternatives to the state, as well as from a belief in the virtue of competition, choice, and multi-agency collaboration. Le Grand (2011) argues this approach to the social services was critical for the success of both the educational and health services under the third way approach of the Blair government in Britain. What this paper proposes in view of these insights is an approach to dealing with the implementation problems of the free care policies by a mixed economy approach in the public sector. This creates a synergy between the private and public sectors, making use of the dynamism of the market in one hand and public interest in the other. Lavalette and Pratt (2006,

263) actually point out that this way represents an acceptance that the market is the most effective way of organising economic activity, albeit with some role for the state as regulator.

In their assessment of the impact of removing user fees in health care McPake et al (2011, 2), argue that the removal of user fees sets off a chain reaction throughout the health system, which can improve access to services for the population. Based on their review of literature, they argue that the removal of user fees can lead to increases in utilization rates and that the benefits associated with the policy change can be maximized through adequate planning. They thus suggest a reform that this paper finds useful in light of the implementation problems identified in this review. This reform proposes a systematic process of six sequential steps including analysis of start-up position, estimation of the impact of fee removal on utilization, estimation of additional requirements for human resources and drugs, mobilization of additional financial resources, the building of political commitment for the policy reform, and communicating the policy change to all stakeholders if gains are to be made meaningful (see McPake et al. 2011).

Based on Malawi's more successful funding harmonization due to basket funding under the SWAps, this paper advocates for basket funding mechanisms for Zambia too. Besides, basket funding is more in line with the Paris declaration. If support is fragmented and not properly coordinated, efforts are merely duplicated and gains from waiver policies will remain marginal. Thus, this paper is of the view that the state in both nations has a greater role and opportunity to broaden their social protection budgets for health in these countries as vulnerability in health is indeed a major cause of vulnerability in life. In the words of Rasanathan K et al (2011, 659), "health services are necessary but insufficient to achieve health equity." It is in this respect paramount to also focus on public policy aimed at inter sectorial action and inter professional collaboration in order to address social determinants,achieve universal coverage, reform of service delivery and the reconfiguration of health leadership and stewardship. It is essential to revitalize the Alma Ata principle of acting across and beyond the health sector.

The findings of this review also resonate with views expressed on the global extension of social security (GESS) website which argues that, "the design and implementation of social protection systems requires a coherent policy framework which includes long-term strategies and planning."

GESS does point out that research shows that, when taken as part of a package of measures supported by international community, government-led social protection programmes are both affordable and necessary for sustained economic growth in low income countries. However, they stress the importance of the development of administrative and management capacity, in order to ensure that such schemes are simple yet well-operating.

6.0 Conclusion

This review set out to study the effects of the free primary health care policy on health service coverage and utilization by marginalised (vulnerable) social groups. It gave a brief background of how the policy terrain in Malawi and Zambia has evolved and explained the objectives of the current policies. Through a review of available literature, the study went on to show the effects of the policy on coverage, utilization vis-à-vis access to health services and constraints confronting their implementation. The results obtained are mixed and only slight differences exist between the two countries. Throwing a blanket conclusion on the findings of this review would thus be treacherous. Despite the mixed results and the many implementation challenges observed, the policies were still seen to provide protection for the poor. It is thus not a question of if the policies should be continued or not. Rather, the real challenge is how to make them more efficient and effective in meeting their ends. Doing so will have greater rewards for the vulnerable and their ability to achieve their full capabilities as human beings. It goes without saying that without health, one cannot be thought to achieve his or her 'beings and doings' as Amartya Sen proposes we see the process of development. This is important in these nations whose national health profiles show a strong link between poverty and health outcomes.

What this study has shown is that much has to be done to improve the livelihoods of people in Malawi and Zambia. The efforts so far are laudable but current strides need to be made more concrete. The findings of this study show that while waiving user fees of itself is earnest, at least from a social protection standpoint, the larger framework of the health system and its other components are critical to the sustainability of any gains. Care has to be taken to ensure that formal fees are not replaced by informal fees. Non fee barriers should also be targeted and in this

respect, this paper echoes the remarks of Masiye et al. (2008) that fee removal is better than targeted exemptions as seen in the differences between Malawi's EHP and Zambia's waiver policy. Adequate planning and systematic management are cardinal pillars for health reforms.

This review has shown that the removal of user fees requires a lot of preparation especially in the context of nations with systemic weakness and economic challenges. While good intentions are estimable, strong actions are needed to make meaningful changes in people's livelihoods. Overall, the burden of care for poor and rural households is still large. Rigorous and consented efforts are needed to make sustained strides out of poverty and into wellbeing for the vulnerable Malawian and Zambian. Arguably, the social protection budgets in these countries need to be increased. The social constructionist approach to this study demonstrates that context is indeed a key determinant of policy success. As was shown, context shapes and influences the position of various actors in both the content and implementation of the policy process. As an area for further research, this review finds that there is a knowledge gap on what the policy impacts are on actual health outcomes for the populations that the policies were meant to serve. Current studies have tended to focus either only on cost effectiveness or quantitative analysis of utilization. This study thus calls for research into the qualitative impacts of the policies on the lives of the poor people.

Given that the findings in this study suggest that there is still a lot to be done to protect the poor from poor health outcomes and perpetual vulnerability, it would be natural to propose community health insurance schemes as a possible solution. However, this area is broad enough for its own investigation and since there is neither the space nor the time to delve deeply into its intricacies, it will be proposed here as one area that requires exploration for further research. Though the results of Rwanda and Uganda are promising, most countries in Africa only have social assistance programmes for the poor and the introduction of these schemes for the informal sector has been problematic. This matter needs to be approached with caution hence the need for explorative research in the case of Malawi and Zambia.

7.0. Caveats and Limitations to the study

A number of methodological challenges confronted this study. These are outline below:

This study was a literature review of secondary data from both published and unpublished documents. A deliberate step was taken to include only scientific resources as can be accessed from journals, books and research articles. However, such data suffers from significant inadequacies as it tends to focus on what is going wrong rather than progress made and review and dialogue are usually not synchronised (see Vaillancourt in Pearson 2010).The lack of consistency in indicators in the various different studies reviewed made it difficult to accurately compare outcomes. This proved not only difficult but also very limiting in terms of data scope as not all relevant information could be accessed in these sources. In fact, even though a lot of recent literature on the subject exists, most of it uses baseline data from the DHS of 2004 and before which means it cannot be used to assess current progress. Furthermore, some government policy documents could not be accessed online. This made it even more difficult to make an objective comparison of the two cases. Other more grey literature such like websites were at times consulted in order to enlighten the contextual understanding of the case under study.

A number of institutions that conduct research in both countries were contacted but their studies focus mostly on cost effectiveness. The study however deliberately left out economic efficiency debates as the researcher had no technical competencies in that area. It is evident that there is a knowledge gap regarding the actual outcomes of these policies from a social protection view.

Overall, what is presented in this report is a synthesis of available trustworthy material on the effects of the policies. The approach taken is social constructionist which means the study findings cannot be uncritically generalised. This study synthesises social protection and public management in the delivery of social services. It is not a study in public health although the cases under study are traditional public health issues. Further, this study was undertaken within a period of six months as per requirement of the MIS programme. Judgements in this study and about this study thus should be made with these considerations in mind.

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