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Young Lives
An International Study of Childhood Poverty

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Abstract

Ethiopia has one of the worst health outcomes in the world. In recent years, a new health policy resulted in some improvements in the population's health and a new health financing strategy led to critical changes in the financing structure of healthcare. However, user fees for healthcare remain an important element of healthcare financing. This study explored perceptions, attitudes and experiences with user fees at public health facilities among poor male and female household members. The objectives were to investigate (1) how poor households' members experience user fees at public health facilities and (2) how user fees influence health-seeking behaviours of poor household members. The study used quantitative data from Round 2 of the Young Lives study and qualitative data from a sub-study in four sites. We found that user fees can present a substantial psychological and financial burden and are one of the barriers to healthcare use, especially for poor households. For some families the costs of a sudden health shock combined with loss of income and assets can lead to indebtedness, distress asset sales and hardening of poverty cycles. Our findings suggest that pre-payment and risk-sharing mechanisms such as the traditional Eders or health tax might be an accepted and sustainable alternative to user fees and protect against impoverishment in case of major health events. To make cost-sharing for healthcare more equitable, it also needs to be based on income to be truly in accordance with 'ability to pay'.

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About Young Lives

Young Lives is an innovative longitudinal study investigating the changing nature of childhood poverty. Young Lives is tracking 12,000 children in Ethiopia, India (Andhra Pradesh), Peru and Vietnam over 15 years through a quantitative survey and participatory qualitative research, linked to policy analysis. Young Lives seeks to:

- improve understanding of the causes and consequences of childhood poverty and to examine how policies affect children's well-being
- inform the development and implementation of future policies and practices that will reduce childhood poverty.

Young Lives is a collaborative partnership between research and government institutions in the 4 study countries, the University of Oxford, the Open University, other UK universities, and Save the Children UK.

Young Lives is core-funded by UK aid from the Department for International Development (DFID) for the benefit of developing countries. Sub-studies are funded by the Bernard van Leer Foundation, the Inter-American Development Bank (in Peru), the International Development Research Centre (in Ethiopia), the Oak Foundation.

1. Introduction

Ethiopia is one of the least developed countries in the world with low development indicators even by sub-Saharan Africa standards. The Human Development Index, a composite measure of three dimensions of human development[1], for Ethiopia is 0.414, which gives the country a very low rank of 171st out of 182 countries (UNDP 2009). It is estimated that 44.2 per cent of the population of Ethiopia lives below the poverty line of under $1.25 per capita per day (UNDP 2009). This percentage is likely to rise in coming years due to short- and long-term effects of the global economic and finance crisis and rapid population growth.

The healthcare system in Ethiopia is characterised by severe long-lasting financial and human resource shortages, a weak healthcare system infrastructure and decades without a strong national health policy (Wamai 2009). Hence, Ethiopia has one of the worst health outcomes in the world. Under-5 mortality and maternal mortality rates are very high - 166 per 1,000 live birth and 850 per 100,000, respectively (WHO 2009b).

In recent years the new democratic government has undertaken important steps to improve the population's health status and to make healthcare more efficient and accessible for everybody. A new health policy resulted in some improvements in population's health indicators such as immunisation coverage and a slight decline in malnutrition rates (Wamai 2009). A new healthcare financing strategy, introduced parallel to this policy, led to critical changes in the financing structure of healthcare facilities and significant increase in governmental health expenditure. Since 2006 the Protection of Basic Services Programme (PBS), a cooperation of 12 bi- and multinational development organisations[2], further complemented government's spending on basic healthcare at *woreda*[3] level (Pereira 2009).

Nevertheless, per capita public spending for health remains far below the average for Sub-Saharan Africa. Insufficient health infrastructure with few health facilities, insufficient equipment and a shortage of health workers, plus strong bias towards curative services and little involvement from the private sector and NGOs are just a few of the persisting problems (Wamai 2009). The condition is further exacerbated by the rapid population growth with an annual growth rate of 2.7 per cent from 2005-2010 (UNDP 2009). User fees at healthcare facilities thus remain an important feature to generate resources for the heavily under-funded health sector. The Ministry of Health is currently considering raising and expanding charges further to generate additional funds for healthcare facilities.

The aim of this study was to explore perceptions, attitudes and experiences with user fees at public health facilities among poor male and female household members in Ethiopia. Important sub-questions were: (1) how do poor households members experience user fees at public health facilities? and (2) do user fees influence health-seeking behaviours of poor household members? The study used both quantitative and qualitative data. The quantitative data were collected from 20 study sites in 2006 in Round 2 of the Young Lives study. The

1 The Human Development Index (HDI) is a composite measure of three dimensions of human development: living a long and healthy life (measured by life expectancy), being educated (measured by adult literacy and gross enrolment in education) and having a decent standard of living (measured by purchasing power parity (PPP) and income).

2 The African Development Bank, the governments of Austria, Ireland, Italy, Japan, the Netherlands, Spain, CIDA (Canada), DFID (UK), KFW (Germany), the European Commission and the World Bank.

3 Woredas are administrative divisions in Ethiopia, equivalent to districts, which are managed by a local government.

qualitative data were obtained from a qualitative sub-study carried out in four sites end 2007/beginning of 2008.

The paper is organised as follows. First we present an overview of the historical development, the intended purpose and the current debates on user fees for healthcare in low-income country settings. We do not aim to provide an exhaustive review of the extensive literature on user fees, but rather a summary of different views and experiences. We go on to outline the long-standing history of user charges in Ethiopia to facilitate the understanding of the complexity of people's views and attitudes in the country context. We proceed with a description of the methodologies and data used. We conclude by a presentation of the findings and a discussion.

2. Background

2.1 International evidence and debate about user fees

Recessions, the negative effects of structural adjustments programmes and rising international debts resulted in severe resource shortages for healthcare systems in many low-income countries in the late 1980s (Yates 2009). Public health budgets were drastically cut resulting in a dramatic decline in quality and quantity of services provided, underpayment of staff and patient dissatisfaction. The prevalence of malnutrition increased in most developing countries and infant mortality rose despite steady improvements during the previous decade (Stewart 1989). Concerned by this development, UNICEF asked for extensive changes in the implementation focus of the structural adjustment programmes in its 1987 report 'Adjustment with a human face' (Cornia, Jolly et al. 1989). Also in 1987, UNICEF and WHO launched the Bamako Initiative, a strategy aimed to improve maternal health and reduce infant mortality in low-income countries through a reorganisation of primary healthcare systems and drug distribution (Kanji 1989).

Parallel to these developments and in alignment with UNICEF, the World Bank released the influential report on 'Financing Health Services in Developing Countries: An Agenda for Reform' (Akin, Birdsall et al. 1987). One important element of the report was the introduction of user fees. These charges at point of service delivery were aimed at improving health service quality and generating additional and much-needed revenues for the impoverished healthcare system. It was estimated that user fee revenues could cover up to 20 per cent of the operating costs. User fees should also help to curtail 'frivolous' or unnecessary demand for healthcare (Griffin 1988), encourage people to take more responsibility for their own health (including preventive health behaviours) (Akin, Birdsall et al. 1987) and reduce unnecessary referrals to more expensive tertiary treatment facilities (Kutzin 2000). Lastly, Akin, Birdsall et al. (1987) envisioned that user charges could also help to improve access to health for rural and marginalised populations as revenues from urban areas could be partly used to fund healthcare in these disadvantaged areas of a country.

With the strong support of the donor community many middle- and low-income countries decided to introduce user fees as an alternative to tax-based financing of governmental healthcare in the early 1990s. In sub-Saharan Africa virtually every country introduced or increased user fees at government health facilities as a result of the World Bank report (Gilson 1997).

Experiences with user fees

Two studies from the mid-1990s reported an increase in uptake of healthcare services in Cameroon and Niger, respectively, if revenues were actually used for quality improvements of services (Litvack and Bodart 1993; Diop, Yazbeck et al. 1995). However, both studies did not take administrative costs for fee collection into consideration and suffered from several biases and analytical weaknesses that limited the meaning of these findings substantially.

In contrast, Moses and Plummer (1992) reported a significantly decrease in the use of referral centres for sexual transmitted diseases in Nairobi, Kenya. Also in Kenya, two studies found a significant decline of curative healthcare services usage (Mbugua, Bloom et al. 1995; Collins, Quick et al. 1996). Other studies from Zambia, Kenya, Zaire and Uganda compared usage rates prior and after introduction and came to similar conclusions (except from some rural facilities in Uganda in which usage rose) (Haddad and Fournier 1995; Mwabu, Mwanzia et al. 1995; Blas and Limbambala 2001; Kipp, Kamugisha et al. 2001). In 2005 UNICEF commissioned a review of evidence on the impact of user fees on health services usage. The consultation concluded that user fees can present an important barrier to accessing health services, especially for poor people. Moreover, it was suggested that fees might negatively affect adherence to long-term expensive medical treatments such as treatment of chronic health conditions or infectious diseases, for example, tuberculosis, that required long courses of medicines and repeated health facility visits (James, Hanson et al. 2006).

One of the aims of the introduction of user charges was the generation of additional financial resources for the health sector. A review by Pearson (2004) of the revenues generated by user fees in 19 sub-Saharan African countries concluded that user charges account for an average of only 6.7 per cent of a national health budget, far beyond the initial expectations and what would be necessary to increase the quality of services significantly. A study from Zambia found that the administrative costs of collecting user fees were almost equal to the revenues from the user fees (Masiye, Seshamani et al. 2005).

User fees seem to affect poor and other vulnerable people most as they both reduce use of healthcare services and leave people at risk of impoverishment by high medical expenditure in case of unexpected health events. Witter and Babiker (2005) found that 70 per cent of people in poor areas in Sudan did not seek healthcare in case of illness due to lack of money to pay for charges. A study from Ghana also suggested that households which are unable to use services because of the charges might be more likely to purchase medication without professional advice, leading to inappropriate or risky treatment and contributing to the development of drug resistances (Asenso-Okyere, Anum et al. 1998).

Protection schemes such as fee waivers aimed at poor people have often been found to work inefficiently or suffer from complicated bureaucratic processes. Sparrow (2008) reported difficulties in targeting the health card to poor people and considerable leakage to the non-poor in Indonesia. Similar observations were made in Ethiopia by Ashagrie and Abebe (2004). Mamdani and Bangser (2004) found huge logistic difficulties in implementing fee waivers for poor households in Tanzania and concluded that an individual's negotiating skills determined user fee payments. The review also found that use of healthcare is particularly challenging for the very poor and women due to the costs and time required.

The increasing evidence of adverse affects of user fees persuaded many countries to abolish user fees completely (Uganda, Zambia, South Africa) (Wilkinson, Gouws et al. 2001; Burnham, Pariyo et al. 2004), partly (Burundi, Niger, Lesotho, Ghana) or decrease them substantially (Sudan) (Brikci and Philips 2007). Many international campaigns have strongly advocated the removal of user fees in recent years and heated and often emotional debates

arose involving policymakers, academics and international organisations (James, Hanson et al. 2006; McPake, Schmidt et al. 2008). Several international donors including the World Bank have begun to acknowledge that user fee policies did not succeed in what they intended to achieve and have offered to support governments in the removal of fees and the search for alternative means of financing healthcare such as community-based health insurance systems (Yates 2009). Nevertheless, user fees remain an important feature in many sub-Saharan African countries and several countries plan to increase fees in the near future.

However, user charges can have benefits in some country settings which might counter-balance some of the negative aspects. For example, in Cambodia, where government funds remain the main source of finance for health facilities, it used to be common for underpaid healthcare staff to ask for under-the-table payments of varying amounts, making costs for healthcare unpredictable for patients. Formalised fixed user fees helped to improve patient confidence in health facilities, and, as the fees are kept by health facilities, provided an important financial incentive for low-paid medical staff, resulting in greater staff motivation (Barber, Bonnet et al. 2004). Akashi, Yamada et al. (2004) reported a shift from salary-oriented to patient-oriented attitudes in healthcare staff in Cambodia after the introduction of user charges. Fees also led to large-quality improvements of health facilities and overall increased service usage (Akashi, Yamada et al. 2004). There is some evidence from Ghana showing that near-poor users are willing to pay and increase usage if the quality of healthcare services and drug availability significantly increases through fees (Nyonator and Kutzin 1999).

2.2 User fees in Ethiopia

To be able to fully comprehend households' perceptions and views on user fees it is necessary to be familiar with its long-standing practice and challenges in Ethiopia.

Service charges for healthcare were first introduced during the imperial regime of Emperor Haile Sellassie in 1951 (Nolan and Turbat 1995). Health policies at this time were mainly formulated based on the recommendations of external advisors and international organisations such as the World Bank (Kloos 1998). The fees were fixed to cover the recurrent cost of health facilities and substitute for the national health budget. However, fee collectionwas poorly coordinated and big variations in enforcement were reported. Moreover, revenues collected had to be reverted to the central treasury of Ethiopia and did not directly benefit the health facilities (Creese and Kutzin 1997). In addition to user fees, Haile Sellassie's government also introduced a health tax in 1959 to finance basic health services and strengthen the development of rural healthcare (Kloos 1998). However, most national health funds were allocated to urban hospitals, leaving local health centres and health posts (community-based health stations where 1-2 health workers with limited training offer basic medical care), especially in rural areas, severely under-resourced and underdeveloped (Ayalew 1991; Kloos 1998). Finally, preventive healthcare and epidemic control was predominantly funded and organised by external donors such as aid organisations of European governments and the World Bank during the regime of Haile Sellassie.

After the revolution in 1974, the socialist/military Derg government under Mengistu Haile Mariam had ambitious goals for the development of the health sector (Hodes and Kloos 1988). The regime strongly emphasised the development of primary healthcare and expansion of rural health services. However, the national government allocated less and less of the national budget to healthcare - 6.1 per cent in 1973/74, 3.5 per cent in 1986/87 and only 3.1 per cent in 1990/1 (Kloos 1998).

To generate more revenues for health services, the new government continued the fee-for-service practice, with a few possible fee waivers for very poor people based on monthly income and recommendation by the local community government. Additionally, all government employees had half their fees paid by their employers (Kloos 1998). Like in the previous system, there was high variety in the price settings and the costs for the same service could be very different depending on region and facility. No clear policy rationale for user fees was given by the socialistic system nor was there any consistency. According to the World Bank's health sector report from 1987 fee revenues could cover between 16-65 per cent of the operating costs of a hospital in Addis Ababa, 9-56 per cent of a rural hospital and 26-166 per cent of a rural health station (Dunlop and Donaldson 1987). However, the officially collected fees by health facilities had to be reverted to the Ministry of Health and could not be kept by the facilities. Therefore, many health facilities additionally collected unofficial 'extra' fees which they retained and used to cover ongoing costs and salaries (Nolan and Turbat 1995).

The World Bank sector review report by Akin et al. (1987) recommended that the health sector share of the public budget needed to be increased significantly to generate the urgently needed additional health revenues rather than increasing taxes or user fees for the already impoverished population. The ongoing civil war environment within Ethiopia and several famines or near-famines made this option impossible for the Ethiopian government (Kloos 1998). Lack of resources plus bureaucratic and very centralised approaches and attitudes also prevented the removal of the strong urban and hospital-bias of healthcare during the Derg regime (Kloos 1998). Quality of service was often low, drugs unavailable and health workers' coverage low in rural health facilities, resulting in a preference for consultation at more distant urban facilities (Kloos 1998). For many poor rural households this option, however, was unattainable as the combination of transport costs, loss of work income, long waiting times in overcrowded urban facilities, costs of drugs and user fees (official and unofficial) was too much to bear. This might explain why 45.5 per cent of rural households reported not to seek modern healthcare when ill or injured in the Rural Health Survey in 1982/3 (Kloos, Etea et al. 1987). Many rural households also preferred and strongly believed in traditional medical care rather than modern healthcare.

Following 17 years of dictatorship under the Derg regime, a new democratic government took power in May 1991. In 1993 the government announced its long-term plans for the development of the impoverished healthcare sector, emphasising the need for democratisation and decentralisation of healthcare, expansion of the primary healthcare services, and encouragement of partnerships and participation of private and NGO actors (FDRE 1998).

To translate these ideas into practice, the first Health Sector Development Program (HSDP-I) was launched in 1997/8 (and a modified HSDP-II (2002/3–2004/5) and HSDP-III (2005/6-2009/10). In addition, a healthcare and financing strategy (HFC) was released in the same year. Government spending for healthcare increased slightly from about 2.7 per cent in 1996 to 5 per cent in 2004/5 (FMoH 2006). Nonetheless, in 2009 the per capita spending for healthcare was still only US$4 per capita per year which is far below the average public expenditure of US$27 per capita for the rest of Africa (WHO 2009a). User fees remain an important element of the health sector development plan by the new government (Russell and Abdella 2002). The Federal Ministry of Health (FMoH) states that

> Health services at government health facilities will be based on a cost-sharing principle between the provider (government) and the receiver (client). Therefore user-fee charges need to be revised… (*FDRE, 1998, p. 4*)

The foundation of the revised user fee policy is that healthcare facilities could retain the collected revenues. These resources are meant to be additional to the governmental budget share and do not replace them. The intention is to use the fees to improve quality and quantity of the service provided at the health facilities (FDRE 1998).

The new Health Financing Strategy also led to an increase in the amount of user fees that patients had to pay at the facilities, in many instances fees more than doubled, ranging from 35 per cent to 200 per cent (Russell 2002). Health facilities charge separately for every type of service provided including registration, consultation, laboratory investigation and inpatient treatment, etc. Fees for drug prescriptions equal the purchasing price of the drug or are even slightly higher, with mark-ups ranging from 20-40 per cent for imported drugs and 5-10 per cent for local manufactured drugs (FMoH and WHO 2005). Different market reform measures and the increase of private sector involvement in healthcare led to a significant rise in the prices for health services and drugs in the last decade, increasing the cost burden of healthcare for poor households even further (Lindelow 2003; Asfaw and Braun 2005). Fee waivers and exemptions aimed at protecting poor households were found to often suffer from leakage, under-coverage and problems with targeting (Woldie, Jirra et al. 2006). (Carasso, Lagarde et al. 2009) also found that waivers often did not cover the entire treatment, leaving substantial fees (for example, costs for drugs and laboratory investigations) for the patients to pay. These shortcomings can particularly affect very poor and vulnerable households.

According to the 3rd National Health Account (NHA), private households provided 31 per cent of the total health expenditure in 2004/5, making them an important financial source for national healthcare. The government covered 31 per cent, donors and NGOs 37 per cent and other private employers and funds 2 per cent (Wamai 2009).

To mobilise new financial resources for healthcare and to protect poor households from impoverishment brought about by covering medical costs for catastrophic illnesses and injuries, the government is currently developing and pilot-testing community-based health insurances schemes with strong support from various donors such as USAID and WHO (Ghebreyesus 2009; WHO 2009b; Abt-Associates/USAID 2010). The Ministry of Health is planning to introduce nationwide health insurance schemes in the near future (Abate 2010).

3. Methodology

For this study we used both quantitative data from Round 2 of the Young Lives survey and qualitative data collected in a cross-sectional, descriptive study conducted in a sub-sample of four of the 20 Young Lives study sites. The analyses of the quantitative data from the four sites were used to identify broad issues concerning user fees and healthcare financing, while the qualitative study aimed to explore these issues in more depth and provide a deeper understanding.

3.1 Sampling and data collection

Sampling

Young Lives is designed as a panel study that has followed 3,000 children in each of the four Young Lives countries (Ethiopia, India (state of Andhra Pradesh), Peru and Vietnam) since 2002. The sample consists of two cohorts: a Younger Cohort of 2,000 children who were aged between 6 and 18 months when the first round was carried out in 2002 and an Older

Cohort of 1,000 children then aged between 7.5 and 8.5. For the Ethiopian sample, the children were selected from 20 sentinel sites that were chosen across the country using a purposive sampling. The purposive methodology was followed to ensure that the sample had a pro-poor bias. In Ethiopia the Young Lives study collects data in four National Regional States (Tigray, Amhara, Oromyia and Southern Nations, Nationalities and Peoples Region (SNNP) and Addis Ababa City. The first round of quantitative data collection took place in 2002 and the second round took place in 2006. Questionnaires were used to interview the caregivers, the Older Cohort children and key community members. This study uses only quantitative data from Round 2 complemented by qualitative data collected from four sites.

For the qualitative part of this study we selected four out of the 20 sites using a purposive sampling approach to include a range of sites with households with different experiences with terms of user fees. To explore experiences in all four National Regional States of Ethiopia we chose one site from each. We did not include a site from Addis Ababa as the new health financing strategy was not rolled out there at the time of this study. We chose three rural sites (one each in Tigray, SNNP, and Amhara) and one urban site (in Oromyia). As it is estimated that up to 90 per cent of Ethiopians live in rural areas, we were particularly interested in the perceived effects of user fees in rural sites. Our intention was to investigate the experiences with user fees in a varied sample of men and women from different household backgrounds. This is why we chose female and male caregivers and female and male heads of households. The participants were aged between 20 and 50 years and belonged to the lowest to medium-low socio-economic classes. We decided to focus on Younger Cohort households only as we expected a higher prevalence of early childhood illnesses in younger children and therefore more frequent visits to health facilities.

The number of individuals interviewed in each site was determined by logistical and cost considerations (see Table 1 for the sample composition).

Table 1: *Characteristics of study population (n= 64)*

Study population	**Total**
Female caregivers	20
Male head of households	32
Female head of households	12
Age	
40-50 years	14
20-30 years	50
Education	
None	39
Basic primary	15
Upper primary	7
Secondary	3

Data collection

Based on analyses of Round 2 quantitative data we developed a broad questions guide on households' experiences with user fees. Interview topics included households personal encounters with user fees, strategies employed to pay user fees and views on possible alternatives to user fee structures. Interviews were carried on an individual basis to encourage open discussions about private and sensitive issues of health expenditures and their impacts on the households.

The interview guides were pilot-tested in a rural community located in Amhara and modified based on the debriefing with fieldworkers and interviewed participants.

The interviews were carried out by eight research assistants with extensive experiences in qualitative research, local language skills needed for the four sites and familiarity with the sites. As health issues can be a sensitive topic and to minimise observer bias we purposely recruited five female fieldworkers to interview all female study participants and three male fieldworkers to interview the men. The fieldworkers attended a two-day training in which they were informed about the purpose of the study, ethical and child protection issues and the consent procedure, the semi-structured interview schedules and methods of probing during the interview. The qualitative research was carried in December 2007/January 2008 in all four study sites. Ethical approval was granted by the University of Oxford. Informed consent was collected and voice recorded from all study participants. All discussions and interviews were recorded and local languages were used.

3.2. Data analysis

Descriptive statistics of the quantitative data were done using cross-tabulations, chi-square tests and t-tests as appropriate in STATA. The presented quantitative data refer to the whole Younger Cohort sample of 20 study sites. The quantitative analyses took place before the qualitative research as the findings were essential to develop the qualitative interview guides. The qualitative data analyses took place from March 2008 to October 2008. The recorded interviews were transcribed and translated into English. Content analysis methodology was employed to: (1) identify key information on perceptions, experiences and views on user fees, (2) group that information into categories and (3) determine larger subtopics. Nvivo qualitative analysis software programme assisted in coding, cross-referencing, storage and retrieval of data.

The results of the quantitative and qualitative analyses will be presented distinct from each other.

4. Results

Sixty-four in-depth interviews, lasting around 45 to 90 minutes each, were conducted by the eight research assistants. The following four main themes were identified during the data analysis.

4.1 Household members' experiences with user fees at public health facilities

The quantitative data shows that households in the younger Young Lives cohort paid on average 136 Birr/per year (£6.9 GBP) for healthcare (including fees for consultation, laboratory investigation and drugs). This is about 11 per cent of the average non-food expenditure per household per year. The range of spending on healthcare was very wide, from none at all up to a high of 12,000 Birr in the last 12 months. The mean expenditures for healthcare were more than two times higher in urban compared to rural areas, 161 Birr per year versus 77 Birr per year. According to the HFC, there is no difference in the amount of user fees for low- and high-income households. Nevertheless, richer households (as

determined by a wealth index)[4] were more likely to spend significantly higher amounts of money on healthcare than poorer households, suggesting more frequent and extensive use of services. More than 80 per cent of households in the Young Lives sample in both rural and urban areas reported being concerned about costs of healthcare. However, when households were compared according to wealth quartile, we found that richer households were less often worried than poor and poorest households about the costs.

In the qualitative sub-study, participants described hugely varying amounts of user fees they had to pay per visit. The treatment of chronic illnesses, such as HIV/Aids, cancer or cardiovascular diseases, was described as particularly expensive and burdensome because frequent visits to the healthcare facility per year were required and so the cost cumulated.

> If somebody is ill for a long time it is very bad because of many costs and visits to hospital. We do not save money for health. (*Male caregiver, 47 years old, SNNP*)

Many expressed the costs in terms of food or other household utilities the household had to forgo in exchange for healthcare.

> …Last time I went to the health centre in Mekelle I was very sick and needed a lot of treatment, my husband paid about 400 Birr. It is almost half of the money I have for food for the whole year… (*Female caregiver, 20 years old, Tigray*)

> I spent perhaps 1,000 (Birr) for food and things in a year and then 100 (Birr) for health. The money we paid at the health centre could have paid for a month [of food and other household things] for all of us. (*Caregiver and female head of household, 38 years old, Tigray*)

> …When somebody (from his household) is very sick and has to go to hospital, I have to pay. We then sometimes don't have food because there is no money anymore. (*Male head of household, 27 years old, Amhara*)

Most household members perceived the cost burden of user fees as very different depending not just on the service required but also on the level of health facility they visited. Fees at the local health post are usually very low or even free of charge, and participants felt that these low costs are not a problem for the overall household budget most of the times. The cost burden of a visit to a higher-level health facility such as a hospital was described as much greater by most participants, especially when taking the additional costs of transportation, loss of work income and the time required into account.

> …At the health post we pay little money, for medicine most times. This is not a too bad. But when we go to hospital or woreda health centre we pay much more. That is because if any of our family goes to such places, we pay for many things like transport and it takes time to reach there; we also cannot work that day. (*Female caregiver, 30 years old, in Oromyia*)

4 Based on the Young Lives data, a household wealth index was constructed as an average of three components providing a score between zero and one: (1) housing quality, which is the simple average of rooms per person, floor, roof, and wall; (2) consumer durables, being the scaled sum of nine consumer durables (radio, bicycle, television, electric fan, motorbike, refrigerator, land phone, mobile phone and car/truck); and (3) services of drinking water, electricity, toilet and fuel. The wealth index was divided into four groups: < 0.25 the poorest, 0.25–0.5 very poor, 0.5–0.75 less poor, >0.75 richest. As the sample size for the richest households is very small in the Ethiopian Young Lives sample, the less poor and the richest quartile were collapsed for the descriptive statistic.

Despite the higher fees, many adults said they would rather go to a higher-level health facility when a household member was seriously ill because the quality of treatment was felt to be much more comprehensive and better. The quality and quantity of services one could receive at local health posts was portrayed as inferior and often not reaching 'beyond pain medicine and deworming treatment'.

> If you go to a hospital, you can get better treatment. The disadvantage is you spend more money and time travelling from home. (*Female caregiver, 25 years old, Oromyia*)

In some cases people were convinced that they would receive better treatment at a higher-level facility and went directly to a hospital for treatment without presenting the health problem at a nearer, and often much cheaper, lower-level facility. For example, in one rural community in Amhara, a child could have been treated for pneumonia at the nearest government healthcare facility for 10 Birr. However, the parents decided to consult the district hospital and spent 24 Birr for transportation, about 10 Birr for meals and 15 Birr for consultation and treatment, which adds up to 49 Birr. This behaviour is understandable when one considers the long-lasting neglect of rural lower-level health facilities during the Derg regime.

However, many people were aware that an expensive treatment in a higher-level health facility was not a guarantee for cure and that visiting a higher-level facility could have long-lasting financial consequences for a poor household.

> Better medical treatment might be available at the hospital or health centre. However, the illness may not be cured. Sometimes people invest all their money for medical services, transport and other things without any result. (*Female caregiver, 22 years old, Amhara*)

4.2 The influence of user fees on health-seeking behaviour

The quantitative data analysis showed that almost all households in the Young Lives sample have access to a public healthcare facility (98.3 per cent). Child immunisation coverage, often used as an indicator for access to healthcare, is also high ranging from 95-98 per cent depending on type of immunisation. In the case of serious illness or injury of a child, higher-level health facilities such as hospitals and government health centres were the preferred first contact point for treatment for most households - 72.5 per cent and 63.8 per cent of all households, respectively. Local health posts or NGO-run facilities were consulted by less than 5 per cent of the sample in the first instance. Private doctors and clinics were the first contact facilities for about 15 per cent of all households. There was no significant difference between the health facilities households visited depending on socio-economic status. However, significantly more rural households than urban households reported seeking healthcare at a private health facility when seriously ill or injured. This preference for private facilities could be due to the limited accessibility of public facilities in rural areas or the perceived higher quality of private health services. Self-medication and consultation of traditional healers in the case of serious illness or injury of a child was reported by less than 3 per cent of the households as the first contact point. The percentage of people who visited traditional healers for treatment of minor illness might be considerable higher; however, Young Lives data provide no further information on this point.

The analysis of the qualitative data suggest that health-seeking behaviour for adults might often differ from children and be more directed by the desire to save money. Self-medication and consultation of traditional healers was often mentioned as a first option for medical treatment because it was often cheaper and easier to access, especially in rural areas. If these treatments did not improve the health problem, the household had to generate enough

money to be able to consult a more expensive higher-level health facility. This delay in the presentation of a disease to the health facility might result in a progression of an illness and requirement of more expensive and extensive treatments when presented.

> My husband has been sick seriously. He stayed in bed for a month. We paid 5 Birr for a traditional healer but he did not get well. He did not do any work for a month. Finally we sold our goats and went to the hospital. (*Female caregiver, 31 years old, Amhara*)

User fees for healthcare seemed to be an important deterrent for many participants who would have liked to attend or were referred to a higher-level health facility.

> ...I went to the hospital. The doctor said I had to stay in hospital but I had no money. Therefore, I just went home and cried. (*Female caregiver, 20 years old, Oromyia*)

> If somebody from my family is ill and I go (to the health facility) without any money, health worker would not look at me and say I have to go home. (*Female head of household, 29 years old, Tigray*)

> If I don't have money I can not go to the health centre, the health worker would turn me away without treatment (*Female caregiver, 27 years old, Amhara*)

In general, the men and women interviewed did not criticise health staff for the collection of user fees and felt that health workers merely 'take actions according to the government's law'. Several participants even described how health workers in some facilities had developed personal strategies to be able to treat seriously ill or injured people, and especially children, who were not able to pay the fees. For example,

> Sometimes health workers pay from their pocket if the child is a severe case. Otherwise, the facility does not give free medical treatment for children. (*Male caregiver, 27 years old, Amhara*)

> They would not send me back if I go to the health post without money. They would let me get the service if I promise that I pay the next day. (*Female caregiver, 35 years old, Tigray*)

4.3 Strategies households employ to pay for user fees

The ability to raise the necessary amount of money to pay fees in a higher-level health facility in case of a referral was a concern for 84.5 per cent of all households in the Young Lives sample. There were no significant differences between rural and urban households; however, rural households reported additional worries about transportation and accommodation in town while urban households worried more about the time requirements. Most households in the sample answered that they would require one week or more to raise 100 Birr for healthcare fees. In comparison, rural households reported significantly shorter lengths of time. Strategies households would use to raise money for healthcare also vary significantly by area of residence (see Table 2).

Table 2: *Strategies to raise 100 Birr for healthcare, by area of residence*

Source	Urban (n/%)	Rural (n/%)
Ask friends/relative	384 (53.1)	386 (33.8)
Use own savings	161 (22.3)	71 (6.2)
Ask money lender	70 (9.7)	132 (11.5)
Sell cattle	31 (4.2)	321 (28.1)
Sell crops	1 (0.1)	121 (10.6)
Ask microfinance institute	35 (4.8)	16 (1.4)

The in-depth interviews revealed some further strategies households had employed in the past to raise money to pay user fees for healthcare. Some of these strategies are mainly suitable to raise smaller amounts of money and are unlikely to have any long-term consequences for the economic well-being of the household.

> All my children collect firewood and sell it at the market to pay for treatment. (*Female caregiver, 36 years old, Amhara)*

> I borrow money from relatives or I work somewhere for money for a whole day to get money to pay for healthcare. (*Female caregiver, 23 years old, SNNP*)

Other strategies used are less sustainable and might have devastating, long-term effects on a household's economic situation and chances to escape poverty. For example, one 40-year-old male head of household from a rural community in Tigray was forced to sell all his seeds for the coming year to be able to pay the treatment of his son. He said that he could not afford to buy new seeds and therefore won't be able to plant crops in the coming season, dragging his household further into poverty and increasing vulnerability to further ill-health events.

Several other male and female participants described how they had to sell their oxen to raise money for healthcare. Oxen are considered as one of the most valuable productive resources in Ethiopia. They are essential for small-scale crop cultivation and extremely well adapted to ploughing heavy soils in the dry climates of Ethiopia. Losing an ox means that households are forced to pay up to 50 per cent of their next harvest to borrow an ox from another farmer (Aune, Bussa et al. 2001).

A few participants explained how they had used up all their savings to pay for healthcare for a sick household member, leaving the household with no savings to cope with further health-related or other unexpected events.

People also said that they borrowed money from money lenders or credit institutions, leaving them to deal with often high debts as a consequence.

> I had to get a credit and loan to pay for treatment for my ill health. (*Male caregiver, 54 years old, SNNP*)

Several study participants also described how they spend less or no money on various household supplies in order to save money to pay for healthcare. One young mother from Oromyia, for instance, said she used the money she initially wanted to use to buy exercise books and pens for her children to pay the fees for the treatment of her daughter's severe cough.

4.4 Suggested alternative mechanisms to pay for healthcare

In the quantitative survey all Young Lives households were asked how they would prefer to pay for healthcare. Around 40 per cent of all households stated that they simply could not afford to pay at all. Only a small percentage (13.1) of the richer households reported that they could not pay for user fees at all, while almost half (43.2) of the poorest households claimed this. A total of 15 per cent suggested the use of *Eders* to finance healthcare. *Eder*s are indigenous social institutions that originally were established to help members to deal with the financial burden of burials and bereavement. In the *Eder* households usually pay a fixed amount of money per month when either a member of the *Eder* or someone from a member's family dies. *Eder* members then handle the burial and all related ceremonies for the affected household (Mariam 2003). *Eder*s have developed a lot over time and many have diversified their activities to include water and sanitation community projects and networks to help each other with caring for sick family members. Many *Eder*s have a legal status and are registered with the ministries for justices and internal affairs.

Other suggested alternatives to pay healthcare user fees included formal health associations or the payment of an annual health tax. There are significant differences in the proposed financing alternatives of households with different socio-economic status (Table 3). *Eder*s were a preferred option for the poorest households but not so much for the richer ones which favoured the payment of an annual health tax. Poorer households were also more likely than richer households to suggest more unsustainable mechanisms such as selling household assets.

Table 3: *Some suggested alternative mechanisms to pay for healthcare, by wealth index*

Mechanism	Poorest (n/%)	Poor (n/%)	Richer (n/%)
Annual health tax	82 (6.1)	57 (17.4)	7 (30.4)
Can not afford to pay	585 (43.2)	111(34.6)	3 (13.0)
Health association	116 (8.6)	31 (9.5)	5 (21.7)
Eder	238 (17.6)	31(9.5)	1 (4.4)
Ask friends/relatives	121(8.9)	38(11.6)	1 (4.4)
Sell assets	47 (3.5)	6 (1.8)	0 (0)

In the qualitative study we found some gender differences in the preferred mechanisms to pay for healthcare. While women preferred the structures of informal and more flexible *Eder*s that are based on personal familiarity and mutual understanding among the members, men often proposed more formal health associations that would pay out an agreed sum of money in case of illness and would not provide any further services such as networks of shared care for ill members. However, many men at the same time raised concerns about the 'willingness of people to cooperate in such kind of cooperation' and that *Eder*s or paying an annual health tax might work better.

Two male head of households from Oromyia suggested paying with labour for healthcare and one young mother from Amhara expressed the opinion that user fees should be set at a fixed low level of 8-10 Birr independent of what treatment or services one required.

Several participants voiced the opinion that 'very poor people in the community that have not even a home, food to eat and clothes' should be provided with healthcare free of any charge.

4.5 Experiences with fee waivers and exemptions

The majority (94.5 per cent) of Young Lives households stated that they had to pay for medical treatment at a public health facility in the case of a severe illness or injury. No differences could be found between the poorest and better-off households, suggesting that the poorest households did not receive exemptions or that the exemption did not cover the entire fees. The analysis revealed, however, a significant difference between urban and rural areas, with urban households being much less likely to be asked to pay than rural households.

In the qualitative component of this study the challenges of fee waivers and exemptions became much clearer. While all participants were aware of possible waivers and exemptions and appreciated the concept for very poor people in particular, they were also conscious of the very bureaucratic process of applying for them and problems with targeting. Often exemptions were only accepted by certain health facilities, while other, mostly higher-level facilities, refused free treatment despite the exemption.

Additional concerns were about the quality of care one would receive with a fee exemption letter.

> Exemption letters may not be as good as paying cash for treatment because old drugs may be given to these kinds of patients (the one using exemption letters). (*Female caregiver, 29 years old, Amhara*)
>
> Health workers might not look at you as well if you have an exemption and the medicine might not be of good quality.' (*Male head of household, 36 years old, Tigray*)

Many men and women we interviewed said that that they had tried to use exemptions and waivers at one point of time, but then decided against it after being refused and treated less well at a health facility.

5. Discussion

Healthcare financing remains a challenge for most low- and middle-income countries where disease burdens are high due to HIV/Aids and rising prevalence of non-communicable diseases, scarce resources and constantly competing priorities on the public budget (Gottret and Schieber 2006). Out-of-pocket payments for healthcare continue to be an important source for revenues for underfunded health systems in many developing countries.

The findings of this study need to be interpreted in the context of various limitations. Most questions in the quantitative survey and the qualitative sub-study referred to costs and experiences with user fees during the last visit or the last 12 months. Recall bias might have affected some of the answers, and differences and changes in local price settings might have had an effect. Findings of this study refer to Ethiopian settings only and transferability to other country-settings might be limited by different historical backgrounds in user charge collection.

However, the quantitative survey data and the qualitative interviews showed that user fees can present a substantial psychological burden, especially for poor households in Ethiopia. People were thereby especially worried about major unexpected illnesses of a family member that would require expensive treatments not planned for in the household budget. User fees were less of a concern for less poor households

User fees were perceived as a financial barrier to healthcare usage, especially by poor households. Delayed or no medical care-seeking behaviours or inability to undergo prescribed hospital treatments was reported. Raising money to pay for healthcare in case of unexpected severe disease or injury could thereby easily result in further impoverishment of already poor households. Many households had no savings for healthcare and were forced to sell productive assets, starting a vicious cycle as income-generating means are lost and households left more vulnerable to the effects of future health events. A potential impoverishing effect of user fees in case of unexpected health shocks was also reported from many other low-income countries (McIntyre, Thiede et al. 2006; van Doorslaer, O'Donnell et al. 2006). While healthcare costs for unexpected major health events could drag households deeper into poverty and present a huge worry, the small costs households had to pay for the treatment of minor illness was perceived as manageable by many less poor households.

User fees were not the only financial barrier. They were often mentioned together with transport and lodging costs not only for the sick person but also for other family members/caregivers, plus loss of work time and income. Transport costs especially can be significant in low-income country settings, for example, up to 28 per cent in Burkina Faso (Ensor and Cooper 2004). In this context, we found a strong preference for treatment in urban, often more distant, high-level health facilities. Low-level local health facilities were generally perceived as of low quality and often directly passed over. The belief in the superiority of high-level health facilities is widespread in developing countries and regularly leads to overcrowding of hospitals with patients with often minor health problems such as diarrhoeas or colds that could easily be treated in local health posts. In the case of Ethiopia, long-standing experiences with the neglected, underfunded rural healthcare facilities during the Derg regime might contribute to people's lack of trust in rural health posts. Strengthening of resources (drugs, equipment and financial means) and abilities of low-level, rural health facilities is important for building up people's trust and willingness to consult local facilities. Moreover, community awareness of the services that local facilities can provide needs to be raised and might be an important factor in reducing households' overall health expenditures and taking some of the burden from overcrowded high-level facilities.

We found a great range in the amounts of user fees people had to pay per visit. No differences in the user fees amounts are made according to income, which can have dramatic consequences for the overall annual budget of a household (as described by several participants). For a more equitable and sustainable financing system, user payments or other methods need to be progressive whereby richer people contribute a higher percentage of their salary than poorer people for healthcare. Additional, more efficient healthcare financing should also involve cross-subsidising from rich to poor and healthy to ill (McIntyre 2007).

These variations in the amount of fees patients have to pay might be explained by the type of services received and the location of the health facility. However, informal payments might have also played a role as reported, for example, by Lindelow (2003) in a qualitative study with Ethiopian health workers. In their study the researchers found that patients are typically asked to pay for every single service and item, 'from hospital admittance to having a bed changed to drugs and supplies'. Confusion about what are official or unofficial payments is rife (Lindelow 2003). 'Under-the-table' payments for healthcare were described in studies from many low-income countries and are often an important contribution to the salaries of heavily underpaid health staff (Lewis 2007). To make healthcare costs more equitable and

predictable for users in Ethiopia, informal payments and their underlying causes need to be addressed by the government and clear control mechanisms introduced.

Ethiopia has a long history and tradition of user fees for health service and it is in this aspect very different from most of the developing countries that introduced fees in the 1980s. Most Ethiopians might have never experienced free healthcare in their adult lives. This 'tradition of user fees' might explain why the majority of households, even among the poorer ones, suggested alternative payment mechanisms for healthcare financing rather than a complete removal of fees because of inability to pay. Pre-payment approaches that would spread costs over time and protect from impoverishment in case of unexpected diseases were repeatedly proposed. *Eder*-based health insurance systems were thereby the preferred option. These community-based associations which are strongly based on interpersonal contact and solidarity were perceived as more successful in mobilising people than more formal, impersonal health insurance schemes. An exploratory study by Mariam (2003) on the feasibility of *Eder*s as an alternative financing mechanism for healthcare in rural Ethiopia came to a similar conclusion. More than 85 per cent of the participants in his study said they were willing to participate in *Eder*-based health insurance systems. Another study explored the role of *Eders* in HIV/Aids control and prevention in Ethiopia (Pankhurst and Mariam 2000). Apart from interviews with *Eder* leaders, the study extensively reviewed the historical development of *Eders* starting in the early twentieth century and their position in the three different regimes. A deeper understanding of the historical development of *Eders* can help to evaluate their possible future involvement in healthcare provision better. The authors concluded that *Eders* could play an important role in community-based and organised HIV/Aids control and prevention.

Another prepayment funding mechanism that was preferred by richer households in our sample would be a regular health tax.

There was a clear consensus between all participants that very poor individuals and their households should receive medical care free of charge. Based on predominantly negative experiences with exemptions and waiver targeting, there seems to be a strong need for better and more transparent mechanisms to identify eligible households (see, for example, McIntyre 2007 for targeting mechanisms). However, as described above, this presents the problem that narrow targeting inevitably leads to complex, costly and not always transparent processes for judging need which often fail the poorest households. Policymakers therefore need to weigh the balance between narrow targeting to contain costs and wider access which may reduce the administrative costs and more effectively reach the poorest people.

When talking about user fees in Ethiopia, it should be considered that fees currently account for up to 31 per cent of the overall public healthcare expenditure in Ethiopia. Their removal without a substantial and more than 31 per cent increase in public spending might result in a devastating decline in quality of service, as experiences in Uganda showed. There the removal of user fees combined with increased public healthcare spending led to a significant increase in healthcare usage. However, the loss of fee revenues that could be retained by facilities resulted in a decline in health staff morale because the fees had been used as an important supplement to very low public salaries. Moreover, workload increased by 47 per cent, drug shortages became common, and maintenance and cleanliness decreased dramatically (McIntyre 2007). Informal payments increased sharply, partly replacing previous official user fees. This experience demonstrated that a removal of fees requires careful planning and consideration of possibly unexpected short- and long-term consequences.

5.1 Conclusion and recommendations

- User fees can present a substantial psychological and financial burden and one of the barriers to healthcare use, especially for poor households who are themselves likely to be particularly vulnerable to ill health. Where sudden health shocks occur to families not protected against costs, the combination of loss of earnings with high health costs harms livelihoods, can lead to indebtedness, distress asset sales and hardens poverty cycles.
- Pre-payment and risk-sharing mechanisms such as the traditional *Eders* or health tax might be an accepted and sustainable alternative to user fees and protect against impoverishment in case of major health events.
- Financing and cost-sharing for healthcare needs to be more equitable and based on income in accordance with 'ability to pay' to help overcome key barriers to health access.
- Removal of user fees needs to be planned and combined with a substantial increase in public health spending and having alternative financing mechanisms in place to prevent negative consequences on healthcare quality or triggering the growth in informal charges and other barriers to accessing care.
- Experience elsewhere shows that the narrow targeting of fee waivers is likely to be problematic. Such systems are administratively costly and burdensome and in consequence many of the poorest households do not benefit. If fee waivers are narrowly targeted on the 'poorest' households, policymakers need to consider carefully how to ensure these people will be effectively reached.
- Our evidence suggests many households use health services less than they would like because they cannot afford to access them. Therefore a more accessible health system would increase costs as demand would rise. More people using health facilities would be a real success but the rising demand would need to be planned for.
- Finally, respondents often reported preferring higher-level (secondary care) health facilities, even though in some cases closer services might be able to address needs with less expense. This suggests looking for ways of strengthening primary care facilities though increasing resources and addressing quality and reputation issues.

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