

# Too Poor to be Sick

Coping with the costs of illness in East Hararghe, Ethiopia

**Dr Steven Russell, Dr Kunuz Abdella**



**Save the Children**

**This is the first of a series of reports and briefings by Save the Children (SC UK) that will focus on the implications of health sector cost recovery policies on the poor and vulnerable, particularly children. Every child has the right to access to basic services and the 'Coping with the costs of illness' series will seek to examine current policy and practice with a view to ensuring the most equitable outcome for the poor.**

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# List of acronyms

EB	Ethiopian Birr
ESHE	Essential Services for Health in Ethiopia
FGD	Focus Group Discussion
HCF	Health Care Financing
HSDP	Health Sector Development Programme
IP	In patient
MoF	Ministry of Finance
MoH	Ministry of Health
PA	Peasant Association
PER	Public Expenditure Review
PHC	Primary Health Care
RDF	Revolving Drug Fund
SNNPR	Southern Nations', Nationalities' and Peoples' Region
SCF	Save the Children Fund
SP	Special Pharmacy
USAID	United States Agency for International Development
US\$	US Dollar
UNICEF	United Nations Children's Fund
WHO	World Health Organisation

# Executive summary

*Too Poor to be Sick* examines the effects of a decade of health sector reforms in Ethiopia. It demonstrates that the major barrier to healthcare for the vast majority of rural Ethiopians is the high cost of drugs. It also demonstrates how the Special Pharmacies (SPs) – cornerstones of the reform to improve the availability and affordability of drugs – exclude the majority of potential users.

This report calls on the Ethiopian Government and the international community to look carefully at their cost recovery policies, and to explore the possibility of more equitable alternatives for affordable treatment to make healthcare accessible for the marginalised majority. It challenges the conventional wisdom that cost recovery is a prerequisite for sustainable healthcare. It clearly demonstrates that, in the context of poverty in Ethiopia, most people cannot afford to pay for drugs, resulting in a public healthcare system that effectively excludes half of the population. Two-thirds of those who were found to access services became further entrenched in poverty to do so.

Overall, the Ethiopian Government is demonstrating support for a good healthcare system by honouring its commitment to spend 20 per cent of its national budget on basic services,<sup>1</sup> but the international community is lagging far behind.

## Main findings of the study

- Most people do not use the public healthcare system. Only a minority of people in the study area who were ill sought treatment at public facilities, with lack of money being the main factor deterring treatment. These financial barriers were linked largely to drug shortages at public facilities which meant people had to buy drugs from private pharmacies.
- For those who did seek treatment, it was a difficult choice to make: roughly one-third of households had to sacrifice other essential spending; and another third had to adopt a cost management strategy such as borrowing, selling assets or mortgaging a crop. Evidence also suggests that these risky coping strategies are contributing to indebtedness and asset depletion.
- In most places existing exemption mechanisms are weak or not working and therefore do not protect the poor from the high costs of healthcare.

*Too Poor to be Sick* concludes that the potential of SPs to generate additional resources and increase “relative affordability” has been overstated. The majority of people are unable to pay because they lack cash to meet even basic food requirements. Slightly cheaper drugs will not change the financial cost barriers for most households, and even among those willing to pay most are either forced to sacrifice other essential consumption items or have to borrow cash or sell assets to obtain money to pay for treatment. SPs may

exacerbate geographical inequity: they will improve drug availability at facilities in urban centres and cash-rich areas, but these benefits are unlikely to reach people in rural and more marginal areas who live great distances from health centres and hospitals. This last point is linked to a wider criticism of SPs, namely that they contribute to a parallel or two-tier health system.

## Main recommendations

- **Work is needed to increase levels of public funding.** The evidence shows that policy-makers need to be cautious and realistic about the contribution user fees and SPs can make to the health sector. Donors and the government should continue to increase public funding for the health sector, and donors must add considerable support to this funding if any significant progress is to be made towards reaching the minimum funding requirements recommended by the World Bank or the World Health Organisation (WHO). To meet the WHO's target of US\$30-40 per capita, the Ethiopian Government would have to spend 100-133 per cent of its total budget on health.<sup>2</sup> The government could likely increase the share of the budget it spends on health,<sup>3</sup> but certainly not to the levels recommended by the WHO. These figures reflect the poverty of Ethiopia and the drastic need for additional external resources.
- **Invest more heavily in alternative sources of funding through a range of risk pooling and health insurance initiatives.** To date, very little has been done regarding health insurance in Ethiopia and the private sector sees very little opportunity here (ESHE/JSI 2000). While the Essential Services for Health in Ethiopia (ESHE) project has started by surveying existing health insurance schemes in the country, further study and pilot schemes should be given high priority. Particularly, the feasibility of community health insurance schemes, possibly linked to local savings societies (*eders*) should be examined.
- **Strengthen equity priorities within a national user fee policy.** User fees are an established source of additional funding for facilities and health managers, and given this reality fees are likely to be sustained. The strengthening of policy should focus on making fees more equitable or pro-poor. The main focus for more equitable user fee policy strengthening should lie with the exemption system, or a system of differential charging. Targeting in Ethiopia is currently done using an income threshold, but this is notoriously difficult to implement in practice, especially where many people's livelihoods are semi-subsistence and their incomes are highly seasonal. Information on income levels is virtually non-existent. More attention should be given to alternative exemption targeting procedures. One possibility that needs further examination is to use livelihood groups when assessing ability to pay and the potential burden of treatment costs. This could involve a relatively simple methodology similar to Save the Children's Household Economy Approach.

## Note on methodology

The broad aims of the research were to evaluate the implications that financial and time costs have for people's treatment-seeking behaviour and ability to pay for healthcare, and to use these findings to inform health policy debates in Ethiopia, particularly with respect to SPs and wider user fee policy. The specific research objectives were to evaluate: people's treatment-seeking behaviour and the factors influencing treatment strategies; the financial and time costs of seeking treatment; the availability of cash resources within the household to pay for treatment; and the strategies households adopted to pay for treatment.

A mixed method approach using quantitative and qualitative techniques was adopted to make use of the advantages of each method and to enable triangulation. Data was collected at community level through a household survey, Focus Group Discussions (FGDs) and interviews with key informants. The research was located in three local *woredas* (jurisdiction areas of between 100,000 and 200,000 people) in East Hararghe, purposefully selected on the basis of distance from the zonal capital Harar: Alemaya (relatively close), Meta (medium distance), and Grawa (distant). In each *woreda* two villages (Peasant Associations

[PAs] or *kebeles*) were purposefully selected – one relatively cash rich (highland) and one relatively cash poor (lowland) – to enable comparisons of treatment-seeking behaviour, health spending or cash availability between these different livelihood zones. East Hararghe, with a population of two million, is part of Oromiya National Regional State in eastern Ethiopia. The study was carried out in a limited geographical area of above average prosperity and results are therefore likely to be valid for large parts of Ethiopia.

The household survey covered 643 households (3,642 individuals). It distinguished between acute and chronic illness, the latter defined as an illness that had persisted for more than a month. The survey used a two-week recall period to elicit information about acute illness, and treatment and treatment costs for both chronic and acute illness.

### NOTES

1 The government spent 19 per cent of its budget in 2000/01 on health and education alone (World Bank 2001).

2 Total government expenditure on health for 2000/01 was EB794m or US\$94m (World Bank 2001).

3 Health accounted for 5.2 per cent of total government expenditure in 2000/01, compared to 21 per cent for the military (World Bank 2001).



# Part 1

## Study rationale and objectives

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### 1 Background

#### 1.1 Government failure to deliver health services

Health systems are performing badly or are in crisis in many developing countries, particularly in the poorest countries where resource shortages have undermined basic staff, drug and equipment inputs (Mills et al. 2001; SCF 1998, 2001). Recession, structural adjustment and high debt burdens since the 1980s have caused or exacerbated these problems. Typically, services beyond central hospitals are characterised by poor quality, inequity of access, low coverage with poor and vulnerable sections of the population most marginalised, and inefficiency.

Resource shortages, centralised bureaucratic structures and related poor management practices are the main reasons quoted in the literature for these service weaknesses (Mills et al. 2001; World Bank 1993). Drug shortages are a very pressing problem for poor and vulnerable groups, particularly as households must cope with a high burden of poverty-related diseases, as well as an increasing burden of chronic illness related to the HIV/AIDS epidemic. There is therefore an urgent

need for additional resources, alongside improved organisational and management performance, to enable households to access better healthcare services.

These problems are highly relevant to Ethiopia. The health financing and delivery crisis in the country is particularly severe, with government health expenditure just under US\$1.35 per capita in 1998,<sup>1</sup> compared to the US\$12 per capita that the World Bank estimated would be necessary to provide an essential package of health services in 1993 (World Bank 1993). This per capita spending is only one-third to one half the level of other low-income sub-Saharan countries (UNICEF 2001), despite the fact that government spending on healthcare has increased over the last decade. Real per capita spending has risen from about 10 Ethiopian Birr (EB) in 1990/91 to about EB19 in 1998/99.

**Access and utilisation:** On average only 49 per cent of the population have any access to modern health services at all and in rural areas this coverage can fall to 25 per cent. In 1998 there were 48,000 people per physician nationally,

compared to a low-income country average of 6,760 people (World Bank 1993).<sup>2</sup> Total outpatient utilisation of government health facilities in Ethiopia suggests that on average there are only 0.25 visits per person per year – or one visit every four years, whereas a national rural health survey indicates that Ethiopians are sick on average 7.7 times a year (Oxford-AAU 1997). In the same survey only 10 per cent of persons reporting illness actually obtained treatment for their conditions from any health facility, public or private. The main reasons given by respondents were distance or the high costs of seeking treatment. Financial and distance barriers are likely to be particularly high for women and children.

More than 75 per cent of mothers nationally receive no antenatal care and 90 per cent of deliveries take place in the home with no assistance from a health worker or trained traditional birth attendant. Immunisation coverage is very low nationally, for example BCG (tuberculosis) 46 per cent, first DPT (diphtheria, pertussis and tetanus) 45 per cent and measles 27 per cent, and only 14 per cent of children under five are vaccinated against all the major childhood diseases (Ethiopia DHS 2000).

Recent trends are not encouraging. Although government health expenditure has increased over the last three years, utilisation rates have not. This is mainly because recurrent expenditure has not been in proportion to capital spending and the expansion of infrastructure, leading to serious shortages of drugs at facility level (Report of Mid-Term Review of HSDP – MoH 2001).

**Quality of care:** Supply-side deficiencies at health facilities exacerbate access problems, since people are unlikely to travel long distances to seek treatment when staff or drugs may not be available. A survey conducted in 1996 found that only 28 per cent of health centres and 57 per cent of health stations had at least 75 per cent of the recommended supplies of drugs on hand. The quality of maternal healthcare services was a particular concern (reported in UNICEF 2001). Other aspects of quality that undermine user confidence and willingness to use public health services include absence of laboratory or x-ray services and poor staff attitudes (Kitilla 1997, reported in UNICEF 2001).

## 1.2 Addressing the problems: health sector reform

The international health sector reform agenda Since the 1980s health sector reforms have been advocated and implemented in many developing countries to address the aforementioned problems. The reform agenda has been driven by experience of reform in the West and often led by international development agencies such as the World Bank. The following are the most widespread elements being advocated (Cassels 1995; Mills et al. 2001):

- increasing resources through alternative financing mechanisms such as user fees, community financing and social insurance
- restructuring public sector organisations to make them more accountable and responsive and aware of costs, notably through decentralisation

- introducing managed competition within the public sector, for example through a purchaser-provider split and contracts between purchasers (central and regional levels) and providers (districts and hospitals)
- reducing the direct provision of services by the state and encouraging private sector and NGO providers, for example through deregulation and contracting out services.

Policy rhetoric is consistent across different countries as governments make pronouncements about their health sector reform agendas, but in practice the nature and process of reform have varied enormously (Mills et al. 2001; SCF 2001). Most countries, both industrialised and developing, have implemented at least some of the measures identified above. Notably, in sub-Saharan Africa virtually every country has introduced or increased user fees at government facilities in a context of economic recession and an urgent need to raise additional revenue (Gilson and Mills 1995; Russell and Gilson 1997).

The rationale and objectives of user fees have been discussed and summarised extensively elsewhere (Gilson et al. 1995; Gilson 1997; World Bank 1987, 1993). Both national user fee systems and more localised community financing initiatives aim to tackle problems of sustainability in the health system by raising additional revenue to improve health services, in particular to improve drug supplies. Some analysts and donors have also argued that national user fee systems would address inefficiencies and inequities in the health system (Griffin 1992; Shaw and Griffin 1995; World Bank 1987, 1993). The equity

benefits of fees, by far the more contentious claim, could be achieved if revenue were reallocated and targeted to poorer and underserved sections of society, and if an effective exemption system to protect the poor were implemented.

The claim that fees would improve equity of coverage and access, rather than deter utilisation by poor and vulnerable groups, is critically dependent on other supportive policies and contexts being in place, most importantly an effective exemption system, decentralised revenue management and service quality improvement. The claim also depends on government capacity to implement supportive measures and achieve quality improvements (Gilson et al. 1995; Gilson 1997; Kutzin 1994; Mills et al. 2001).

#### The reform agenda in Ethiopia

The 1993 Ethiopian Health Policy set out the broad principles and objectives of health sector reform in Ethiopia. This restated an emphasis on Primary Health Care, and also expressed a commitment to the

- strengthening of cost recovery measures<sup>3</sup>
- decentralisation of healthcare delivery
- promotion of private sector and NGO involvement in the financing and delivery of healthcare.

A health sector strategy for reform implementation followed in 1995, designed to provide a strategic framework for health sector reform over a 20-year period, with the overall aim of achieving PHC for all by 2017. In 1997 the Ethiopian Government, in collaboration with

donors, launched its Health Sector Development Programme (HSDP) to guide reform efforts during the first five years (1997-2002) of the 20-year strategy. The main thrust of the HSDP is to improve access to and quality of PHC, for example: to expand PHC coverage from 45 per cent to 55-60 per cent; to increase immunisation coverage from 67 per cent to 70-80 per cent; to reduce the infant mortality rate from 128 to 95 per 1,000 live births; and to increase the quality of community-based healthcare by increasing levels of staff, drugs and medical supplies in a sustainable manner.

Reforming healthcare financing is one of the strategies to achieve these objectives, and cost recovery is integral to this strategy. In June 1998 a Health Care Financing (HCF) Strategy was adopted by the Council of Ministers. A core concept of the HCF Strategy is "Health Facility Revenue", a cash fund derived from user fees, RDFs, risk-sharing schemes and donations that can be retained at the facility, and which is additional to the government budget and to be used to improve the quality and quantity of health services.

SPs, which are revolving drug funds, are at the forefront of reform efforts to increase Health Facility Revenue, and are in fact the main thrust of cost recovery reform.<sup>4</sup> SPs have dominated the HCF Strategy's agenda largely because there is significant multilateral and bilateral donor interest in funding these projects, for example from the World Bank, USAID, and the governments of Canada, Sweden, Norway, Ireland, Belgium and Japan.

SPs operate along the general principles of RDFs and their objectives are (Walelign and Yusuf 2001):

- to ensure a sustainable supply of essential drugs at affordable prices
- to support other areas of health service improvement with the revenue generated
- to improve staff motivation and reduce attrition rates by providing incentives.

The HCF Strategy aims to establish over 150 SPs across the country at hospitals (50 SPs) and health centres (100 SPs). Currently SPs operate in two-thirds of the regions, and most of those established operate at hospitals (about 30), with a more limited number (about 14) at health centres (Walelign and Yusuf 2001). The source of initial capital for these RDFs came mainly from government and donors. In September 2001 the MoH released its *Guidelines on Management and Operation of Special Pharmacies*, which the regions can adapt to their own circumstances. With respect to governance, a management committee manages the SP. The composition of the committee varies from region to region, but in most hospitals includes the Medical Director of the hospital, the pharmacist, the Matron, a doctor's representative, the accountant at the health facility and a Regional or Zonal Health Department representative.

Under the HCF Strategy, SPs can retain 100 per cent of revenue, although this contradicts MoF financial regulations and requires further negotiation between the MoH and MoF. In practice most SPs retain revenue but this is not formalised – in any region it relies on negotiation

and informal agreements between the Finance Bureau and Health Bureau (ESHE/JSI 2000). Thus SPs appear to have been accepted by the MoF as a “special fund” that can be retained.<sup>5</sup>

SPs are therefore relatively “autonomous” from the health facility where they are located, functioning as a parallel unit: they are striving to lie outside normal public sector financial regulations, to retain revenue and use different accounting systems; and they have their own management boards.

The price of SP drugs is set by the facility, usually with a 25 per cent mark-up. The SPs have their own receipts and revenue is deposited in a separate SP bank account. Guidelines state that the surplus from sales should be used to sustain and increase drug stocks, pay for staff incentives and improve other services at the health facility, for example to subsidise the government budget pharmacy at the facility or improve diagnostic services.

Evidence from elsewhere suggests that the financial autonomy of SPs, and their ability to sell drugs at a mark-up of 25 per cent, will lead to success in terms of revenue generation and the sustainability of drug supply (Litvack and Bodart 1993; McPake et al. 1992; Smithson et al. 1997). A key concern in a livelihood context of poverty, vulnerability and seasonality, however, is the question of people’s ability to pay – or whether SPs will achieve their objective of providing drugs at “affordable prices”. SPs are first and foremost retail pharmacies: they do not offer exemptions or reduced prices to those unable to pay, which raises

concern about affordability. Evidence from elsewhere shows that RDFs, due to their commercial priorities, cannot provide subsidised drugs for the poor and so exclude many people from accessing quality health services (Gilson et al. 1995; McPake et al. 1992; Smithson et al. 1997). Yet questions about ability to pay and equity of access to SPs are not raised or addressed in Strategy documents. These concerns about affordability were the underlying rationale for the research presented in this report.

#### NOTES

1 In Oromiya, the region where this study was conducted, expenditure was even less at US\$0.85 per person (Report of Mid-Term Review of HSDP).

2 In Oromiya, health service coverage was even lower at 42% in 1998; and there were 75,000 people per physician in Oromiya compared to the WHO standard of 10,000 people.

3 In Ethiopia the practice of charging the user is not new. User fees at public health facilities have existed for nearly 50 years, with users being charged for registration, drugs and laboratory tests. There is also an official exemption policy for the poor, who can apply for an exemption paper from their local authority (*kebele*/PA) (Barnum and Kutzin 1993). Three key problems with existing policy content are: (a) user fee levels have not been revised since their introduction in the 1950s, and so are nominal and not well coordinated or consistently implemented across facility levels or regions; (b) revenue is not retained at the health facility but sent to the Ministry of Finance, so cannot be used directly to improve health services; and (c) the exemption policy is poorly designed and implemented. To address drug shortages, different revolving drug funds (RDFs) have been in operation since the 1980s, including the establishment of Bamako Initiative pharmacies in the 1990s by the MoH with support from UNICEF and the WHO. RDFs have also been operating at some referral centres such as

health centres and hospitals since the early 1990s, and in the last five years have become known as Special Pharmacies (SPs), which are at the forefront of current financing reform initiatives.

4 Other financing reforms that require greater institutional and organisational capacity, such as reform of the national user fee system as a whole, or health insurance policies, have not been developed. This is because these national reforms require widespread capacity-strengthening, and partly because the organisational restructuring necessary to take forward and implement the HCF Strategy had not happened by October 2000:

the proposed HCF Secretariat at national level had not been staffed and bodies at zonal, *woreda* and health facility level had not been established (ESHE/JSI 2000).

5 In terms of wider institutional reform to improve national cost recovery performance, progress towards revision of central financial regulations to enable revenue retention has been slow. However, in one region (SNNPR) hospitals have obtained the right to retain 50 per cent of collected fees (the other 50 per cent is transferred to the Regional Finance Bureau), and two other regions (Amhara and Addis Ababa) have prepared revenue retention proposals.

## 2 Rationale for research

### 2.1 International concerns about user fees

The international health sector reform agenda has been driven by market-based and efficiency perspectives. This has raised concern that reforms overlook the question of equity (Gilson 1998; SCF 1998, 2001; Standing 1997) and they have often been imposed and poorly implemented giving rise to concern that the reforms themselves undermine the provision of healthcare and exacerbate existing inequities in health and healthcare provision (SCF 2001). User fee policies have been the source of greatest concern. This is because they have been the most widely implemented of the reform components and evidence indicates they have been damaging for the poor (Creese 1991; Gilson et al. 1995; Gilson 1997; Mills et al. 2001).

A starting point for a critique of user fees is that to achieve their objectives fees must be supported by various contexts and policy measures, and the government must have the capacity to implement these measures (Mills et al. 2001):

- a well-designed and appropriate exemption system that can distinguish between those able and not able to pay; at the least this requires information on people's income, administrative capacity, public awareness of and willingness to use the scheme, and motivated staff committed to the policy's proper implementation
- decentralised revenue retention to provide incentives to collect fees and allow quality local improvements
- accounting, auditing and financial management systems and skills, especially at sub-national levels where revenue is managed

- well-motivated staff with balanced financial incentives that encourage the adoption of new charging and management practices, but discourage overzealous or illegal charging
- central MoH leadership, training and guidance on exemption policy implementation and use of revenue
- public willingness and ability to pay.

In developing country contexts the now widely reported evidence shows that many of these pre-conditions and supportive measures do not exist, which has contributed to weak policy impacts (Kutzin 1994; Mills et al. 2001). The main points emerging from the literature are as follows:

**Low revenue:** In national user fee systems, fees have failed to raise substantial revenue; rarely are fee revenues above 5 per cent of total recurrent costs (Gilson et al. 1995; Nolan and Turbat 1993). However, at larger facilities fee revenue can be an integral part of the funds available to health managers for spending on essential items. In addition, in relatively cash-rich localities small-scale community financing schemes and revolving drug funds have had some success. Revenues have played an important role in sustaining drug supplies and improving service quality (Jancloes et al. 1982; Knippenberg et al. 1990; Litvack and Bodart 1993).

**Reduced utilisation:** Many studies have evaluated the impact of national user fee policies on facility utilisation, and show that fees deter utilisation considerably. The magnitude of these declines – falls ranging from 30 to 90 per cent in some countries – justified increasing concerns during

the 1990s that fees were reducing access to services (Bennett 1989; Booth et al 1995; Hongoro and Chandiwana 1993; Moses et al 1992; Thomason et al 1994; Waddington and Enyimayew 1989; 1990; Yoder 1989).

**Increased inequality of access:** By the mid-1990s the weight of evidence showed that user fees were deterring poor people from seeking treatment (Creese 1991; Gilson et al. 1995; Gilson and Mills 1995; Kutzin 1994; Nolan and Turbat 1993; Russell 1996; Gilson 1997; Russell and Gilson 1997). In-depth studies and qualitative evidence also showed that fees imposed access barriers and large financial burdens on the poor (Booth et al. 1995; Korboe 1995; Norton et al. 1995). A key factor underlying the inequitable impact of fees was the failure of nearly all governments to design or implement targeted exemption mechanisms for the poor (Kutzin 1994; Gilson et al. 1995; Mills et al. 2001). This is the fundamental problem for a national user fee system and RDFs: an effective targeting mechanism which reaches the target group but excludes those who are able to pay is extremely difficult to implement.

**User fees may damage assets and undermine livelihoods:** Following these findings, there is now recognition among donors and health policy analysts that user fees in developing country contexts are likely to deter access, impose damaging cost burdens on poor households, and undermine assets and livelihoods (DFID 1999; WHO 1999; World Bank 2000). When breadwinners fall ill the household may suffer from wage and production losses, and health expenditures may trigger asset depletion and

impoverishment (Corbett 1989; Pryer 1989; Russell 2001). Since the end of the 1990s donors have adopted a more cautious approach to user fees because they increase poor people's vulnerability to shocks such as illness and prevent them from building up their human assets through education and better health. Health financing debates have therefore moved away from user fees towards insurance or risk-sharing mechanisms that pool resources and reduce treatment costs for the poor (Arhin 1994, 1995; Creese and Bennett 1997).

## 2.2 Concern about the impact of user fees in Ethiopia

The research presented in this report was driven by the premise that despite serious resource shortages in the health sector, the introduction of SPs or a longer-term strategy to increase user fees at health facilities is unlikely to increase the accessibility and affordability of drugs for the majority of the population. Six broad premises or hypotheses underlie this concern. They are set out below, and form the structure of the research findings presented in Part 2.

1. **Livelihood vulnerability:** In Ethiopia many people's livelihoods are characterised by vulnerability and food insecurity, seasonality and lack of cash income. User fees are therefore an inappropriate financing strategy.
2. **A very high burden of illness and high mortality rates:** Households have to bear an increasing burden of costly chronic illnesses, including HIV/AIDS, while continuing to cope with other poverty-related diseases.

3. **High access barriers:** People are already deterred from seeking treatment at public facilities due to distance and associated time and transport costs. These access barriers may be particularly high for women and children, because they have less access to household cash resources and less autonomy to travel alone. User fees are likely to exacerbate these access barriers.
4. **High costs of illness:** People who decide to seek treatment at public facilities already incur high financial and time costs. User fees could exacerbate these financial costs.
5. **Treatment costs can undermine household livelihoods:** Spending on treatment is likely to force households to cut spending on food and other essential consumption and investment items. Women and children may be the first groups forced to make these sacrifices because they have less control over cash resources. People may also be forced to obtain cash to pay for treatment through borrowing or selling assets. These strategies are likely to have negative implications for the household economy. The cost burdens imposed by user fees accelerate these processes and damage livelihoods.
6. **Existing exemption mechanisms do not protect the poor from high cost burdens:** SPs do not offer exemptions, and the existing exemption system would not protect the poor from wider user fee increases at health facilities. There is strong anecdotal evidence and a general perception among health workers that a large proportion of the poor are not covered, while better-off households, those close to *kebele* offices, and those with political or kinship connections obtain exemption papers (SCF 2000). Recent data indicate that the rate of exemption has been declining in rural areas and is at about 10 per cent, but remains relatively high in urban areas where exemption papers are easy to obtain from local authorities (Oxford-AAU 1997).

Overall, key supportive contexts and capacity requirements for an effective national user fee and exemption policy do not appear to be in place, for example services of adequate quality, decentralised revenue retention, financial management capacity and an effectively targeted exemption system. Moreover, the depth and breadth of poverty suggest that people's willingness and ability to pay will be very constrained.

### 3 Research objectives

The broad aims of the research were: (a) to evaluate the implications that financial and time costs have for people's treatment-seeking behaviour and ability to pay for healthcare; and (b) to use these findings to inform health policy debates in Ethiopia, particularly with respect to SPs and wider user fee policy.

The specific research objectives were:

1. To describe people's treatment-seeking behaviour, and the factors influencing treatment strategies.
2. To measure the financial and time costs of seeking treatment.
3. To examine the availability of cash resources within the household to pay for different individuals' treatment.
4. To describe the coping strategies that households adopt when cash is not available to pay for treatment.
5. To explore exemption policy effectiveness (coverage of the poor) and alternative risk-sharing policy options based on the eder system.

# 4 Methodology

A mixed method approach using quantitative and qualitative techniques was adopted to make use of the advantages of each method and to enable triangulation. Data were collected at community level through a household survey, FGDs and interviews with key informants. Some data on basic structural quality of care were also collected at facility level.

## 4.1 Selection of study sites

The research was located in three *woredas* in East Hararge, purposefully selected on the basis of distance from the regional capital Harar: Alemaya (relatively close), Meta (medium distance) and Grawa (distant). In each *woreda* two villages (Peasant Associations [PAs] or *kebeles*) were purposefully selected: one relatively cash rich (highland) and one relatively cash poor (lowland), to enable comparisons of treatment-seeking behaviour, health spending and cash availability between these different livelihood zones. In general lowland areas were more distant from health facilities. Table A summarises site selection and distances from the nearest public health station.

## 4.2 Overview of methods

### Wealth grouping exercise

Key informants in the *kebele* were asked to name different wealth categories in the village, and define the characteristics of these wealth groups in terms of land, livestock assets, other work and cash availability.

### Questionnaire survey

The household survey elicited the following data: details of household members; illness; treatment in the last two weeks and reasons for treatment or non-treatment; financial and time costs of seeking treatment; cash availability and sources of cash used for treatment; coping strategies if cash was not available; household assets.

### Sample size

The necessary sample size for

- a 95 per cent confidence limit (data are correct in 95 per cent of cases)
- and a sampling error of 1.5 per cent (sample values do not deviate from the true population values by more than 1.5 per cent)

was calculated using a standard formula for estimating sample size. For this calculation it was

Table A: Nearest public health facilities to study sites

Woreda (district)	Livelihood category	Selected <i>kebeles</i>	Distance from nearest public health facility	
			(km)	(on foot)
Alemaya	Highland	Tinikie	5km	<1hr
	Lowland	Edo Belina	12km	2.5hrs
Meta	Highland	Mudi Lencha	10km	2hrs
	Lowland	Kurkura	15km	3hrs
Grawa	Highland	Mojo Sede	10km	2hrs
	Lowland	Rako Barzala	20km	4-5hrs

assumed that the proportion of people reporting illness within the last two weeks would be 15 per cent (an assumption based on previous studies). The formula was then as follows:

$$N = \frac{Z^2 \times P(1-P)}{d^2}$$

$$= \frac{(1.96)^2 \times (0.15)(0.85)}{(0.015)^2}$$

$$= 2450 \text{ individuals}$$

Assuming an average of five people per household, the minimum household sample size was 490. The target sample was 100 households per village, making a total sample size of 600 households.

#### Sampling procedure

*Kebele* household lists were used as the sampling frame, and a percentage of households in each *kebele* was selected to obtain 100 households, using systematic random sampling.

#### Recall period for illness-related data

The survey distinguished between *acute illness* and *chronic illness*, the latter being an illness that had persisted for more than a month. The survey used a two-week recall period to elicit information about acute illness, and treatment and treatment costs for both chronic and acute illness.

#### Focus Group Discussions (FGDs)

The FGDs covered decision-making processes in the household, treatment-seeking behaviour, cash availability and coping, exemption policies and *eder* organisations. The FGDs did not attempt to separate “poor” and “better-off” respondents due to time constraints. In each village, four FGDs were held: one with girls (aged 10-12); one with boys; one with women; one with men. Across the six sites 24 FGDs were conducted.

#### Key informants

In each village the following interviews were carried out: one village/*kebele* head; two *eder/afosha* leaders or elders; two traditional healers. Across the six sites about 30 interviews were conducted.

# Part 2

## The research findings – coping with the cost of illness

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### 1 Livelihoods and vulnerability in the study sites

This section:

- describes the basic demographic and livelihood characteristics of the study sites
- provides a brief overview of the assets and income of different socio-economic groups, categorised into better-off, 'middle' and poor types of household, with the aim of illustrating different socio-economic groups' potential ability to pay for healthcare
- calculates a total asset value for each household and uses this to classify households into four socio-economic groups.

Data sources: wealth ranking exercise; household survey; secondary data

#### 1.1 Brief demographic profile

The survey covered 3,642 individuals living in 643 households, distributed across the three *woredas* and six *kebeles* as shown in Table 1.1 (overleaf).

The age-gender distribution of the study population is summarised in Table 1.2 (overleaf). The age distribution shows the population to be very young, with 37 per cent under 10 years old and 62 per cent under 20. This indicates a high child-adult dependency ratio. The gender ratios in the population favour men, but the ratios of 0.96 and 0.98 for the youngest age groups, and the ratio of 0.97 for the whole population, are considered to be within a "normal" range by demographers (Agnihotri 2000). A female:male ratio of 0.95 or less is considered to suggest some bias against female welfare, and this emerges between the ages of 50 and 69 for females, but the size of the sample in these age groups may be too small to draw any firm conclusions.

Table 1.1: Study population

Woreda	Kebele	No. individuals	No. households	Average household size
Alemaya	Tinikie	642	109	5.9
	Edo Belina	575	105	5.5
Meta	Mudi Lencha	576	105	5.5
	Kurkura	669	112	6.0
Grawa	Mojo Sede / Asha	548	107	5.1
	Rako Barzala	632	105	6.0
All areas		3642	643	5.7

Table 1.2: Age-gender distribution of the sample population

Age group	Male	Female	Gender ratio (F:M)	Total	% of population
0-9	672	660	0.98	1332	37
10-19	457	437	0.96	894	25
20-29	225	254	1.13	479	13
30-39	208	202	0.97	410	11
40-49	131	120	0.92	251	7
50-59	85	48	0.56	133	4
60-69	53	43	0.81	96	3
70+	20	27	1.35	47	1
All ages	1851	1791	0.97	3642	100*

\* actually comes to 101 because figures have been rounded up

## 1.2 Livelihoods, vulnerability and poverty: an overview

The vast majority of people are farmers or agricultural labourers, and as a result cash and food availability are highly seasonal. Farmers grow cash and subsistence crops, the mix depending on

the area and socio-economic status of the farmer. In general in highland areas the agricultural economy is dominated by the cash crop *chat*, which generates a lot of income for many households but not all. At lower altitudes where rainfall is more variable cereal farming is more common, and pastoral livelihoods dominate in

Table 1.3: Summary of livelihoods in each study site

<i>Woreda</i>	<i>Kebele</i>	General description
Alemaya	Tinikie	Highland; centre for chat production; cash rich
	Edo Belina	Lowland; vulnerable to variable rainfall; cereal production and pastoral livelihoods
Meta	Mudi Lencha	Highland; chat production but less common; cereals and sweet potato
	Kurkura	Lowland; vulnerable to variable rainfall; more marginal farming; transitional zone from cereal farming to pastoral livelihoods
Grawa	Mojo Sede / Asha	Highland; some chat but less common due to distance from markets; cereal production
	Rako Barzala	Lowland; vulnerable to variable rainfall; more marginal farming; transitional zone from cereal farming to pastoral livelihoods

the dry lowlands. A brief summary of livelihood contexts or agricultural activities in each of the study sites is set out in Table 1.3.

#### Highland *chat* areas

##### Better-off households

These households make up about 20-30 per cent of households in the highland areas (wealth ranking exercise). In Tinikie (Alemaya) and Mudi Lencha (Meta), better-off households make most of their cash income from *chat* production (Table 1.4, overleaf). In 1996 large-scale farmers with pump or gravity irrigation (5 per cent of the population) could earn between EB30,000 and 40,000 (Household Food Economy Report SCF 1996). A more common level of earnings for better-off households growing 20-30 rows of *chat* was about EB2,000 per year (10 per cent of the population). Other better-off *chat* farmers might earn between EB1,000 and 2,000 and may also have one or two milk cows. These households will

have cash available to meet healthcare costs, and have assets to sell if cash is not available.

##### “Middle” households

These households make up about 30-40 per cent of households in the highland areas (wealth ranking exercise). In areas of lower altitude, cereals and sweet potato are grown, and these farmers may also own one or two goats, a milk cow or a donkey. These farmers have lower incomes because they do not grow *chat*, but *chat* still affects their livelihoods because it offers opportunities for daily labour (Household Food Economy Report SCF 1996). They can earn cash from this labour, and from petty trade or hiring out a donkey; the latter could earn them EB5-10 a day. At post-harvest times these households will have cash available to meet healthcare costs, but at other times of the year would have to borrow money, or sell important livestock assets such as cattle or donkeys to finance treatment.

**Table 1.4: Sources of cash in highland *chat* areas**

% of income	Poor	"Middle"	Better-off
Cash crops	10	30	90
Daily labour	40	30	–
Firewood/charcoal sales	20	–	–
Livestock sales	–	–	–
Petty trade	20	30	10
Other (hiring out donkeys, droving)	10	10	–

Source: Household Food Economy Report (SCF 1996)

### Poor households

These households make up about 40-50 per cent of households in the highland areas (wealth ranking exercise). The poorest households have no livestock assets, and by far the most important source of income is casual labour, with *chat*-picking the most common source of employment. In 1996 a labourer could earn EB6 a day, but only for limited periods of time. Over the year a labourer may work for two months and in total earn about EB400 a year. More recent data show daily wages range from EB7 to 12, so that a labourer can earn EB400-650 a year. Poor households also rely on firewood sales as a coping strategy in the hungry season, which earns EB3 a bundle. For most of the year these households have very little or no cash available to finance healthcare; and they have few or no assets to sell to obtain cash. They would have to rely on borrowing or gifts from better-off households.

### Lowland/marginal areas

The more marginal lowland areas of Edo Belina (Alemaya) and Kurkura (Meta), and the sites in Grawa, are characterised by rainfall variability,

livelihood vulnerability and food insecurity.

Overall cash availability is much more limited than in highland *chat* areas for "middle" and poor groups. Large sections of the population do not have the resources to meet food needs, and lack the money for essential non-food items. Table 1.5 (opposite) summarises sources of cash income for the three wealth groups in these areas.

### Better-off households

These households make up about 20 per cent of households in the lowland areas (wealth ranking exercise; Mathys 2000). Livestock and cash crops are key assets for better-off households, and a typical household might grow 50 per cent of their own food needs, own two oxen, five to ten heads of cattle and several goats/sheep. Erratic rainfall in more recent years has reduced crop yields and forced livestock sales. In this environment there is less work available for poorer households. At post-harvest times these households will have cash available to meet healthcare costs, and at other times of the year have assets to sell if cash is not available.

### “Middle” households

These households make up about 30 per cent of households in the lowland areas (wealth ranking exercise; Mathys 2000). They consume their own food crops and earn cash to purchase food and other essential items from daily labour, sale of firewood and livestock sales. A typical household might own an ox, three or four heads of cattle and three to six goats/sheep, or a donkey. In Edo Belina (Alemaya) and Kurkura (Meta) they may also grow some *chat* for sale.

Over the last few years this group has been under stress, selling assets to pay for essential food and non-food items. Declining yields, asset sales and food deficits have forced ‘middle’ households to rely on wild foods (famine foods) to supplement nutrient intake, and food gifts and relief from NGOs or government (Mathys 2000). These households are in food deficit and there is widespread concern that the “middle” are steadily becoming “poor” (Mathys 2000). For most of the year these households have very little or no cash available to finance healthcare. They have some

livestock assets to sell if cash is needed, but this would be a hard decision and a risk to future livelihood and food security.

### Poor households

These households make up about 50 per cent of households in the lowland areas (wealth ranking exercise; Mathys 2000). They have small landholdings and a few small livestock assets to sell (hens, one or two goats) or no livestock at all. Over the past few years drought has caused impoverishment as families have sold off their last livestock assets to purchase grain (Mathys 2000: 10; 14). By far the most important source of income for the poorest households is casual labour, either for better-off households in the area or through seasonal migration to highland centres of *chat* production, where they might earn EB7-12 a day and work for two months, earning EB400-650 over the year. If additional cash is needed a common strategy for poor households in the hungry season is to sell firewood for EB3 a bundle. A household would be lucky to sell more than two bundles a day.

Table 1.5: Sources of cash in lowland areas

% of income	Poor	“Middle”	Better-off
Cash crops	–	–	20
Daily labour	60	30	–
Firewood/charcoal sales	30	40	–
Livestock sales	–	30	50
Petty trade	10	–	30
Other (hiring out donkeys, droving)	–	–	–

Source: Household Food Economy Report (SCF 1996)

These households have faced food deficits in recent years (exceeding 20 per cent of their food requirements) and have relied on famine foods to supplement nutrient intake (Mathys 2000). For most of the year these households have very little or no cash available to finance healthcare; and they have few or no assets to sell to obtain cash. They would have to rely on borrowing or gifts from better-off households. However, Mathys (2000) observes that the poor have been unable to rely on these borrowing strategies over recent years, because of a “breakdown of traditional intra-community economic relationships and community coping capacity”. For example, rich households not hiring agricultural labourers when it is clear the rains are failing, or collecting their firewood and water themselves rather than hiring others, as well as a failure of normal redistribution mechanisms.

### 1.3 Household socio-economic status based on asset values from the survey data

In order to categorise the 623 households from the survey into socio-economic groups, a total asset value was calculated for each household. The asset value did not include land. This is because a private land market does not operate in Ethiopia, so land value was hard to estimate and it is unlikely that land could be sold to pay for healthcare. During the survey, respondents gave a value for each type of asset they owned. From the whole sample a mean value for each type of asset was calculated. Some mean asset values were as follows: hen EB6; goat EB57; head of cattle EB425; ox EB670; pack animal EB228.

The mean value for each type of asset was then applied to each household’s assets to obtain a consistent valuation of assets across households. Each household’s total asset value was then calculated. The mean total asset value over 643 households was EB834, and the median value EB711: about the equivalent of two heads of cattle. Highland areas had higher average household asset values than lowland areas. Edo Belina had the lowest median value (EB426), and Mudi Lencha the highest (EB1,110).

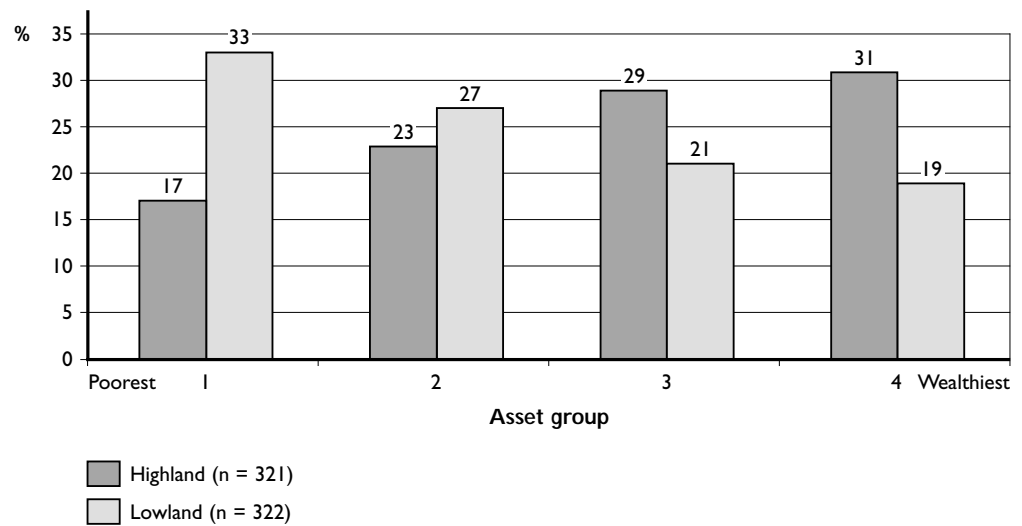
For analytic purposes, households were categorised into four different asset groups by dividing them into quartiles based on the total asset value (Table 1.6). The table shows that the poorest 25 per cent of households had asset portfolios worth less than EB296 (US\$34.00). Within this poorest group, 73 households (11 per cent of all households) had a total asset value of zero. Thus the poorest asset group had very few assets to sell if they experienced financial contingencies such as illness.

Figure 1.1 shows the proportion of households in each socio-economic group, by type of area. In highland areas the poorest households are the

Table 1.6: Asset value quartile groups

Quartile group	Asset values <sup>a</sup>
1 asset poor	0–296
2	297–711
3	712–1214
4 asset rich	1215+

<sup>a</sup> EB8.64 = US\$1.00



**Figure 1.1: Proportion of households in different socio-economic groups, by type of area**

smallest group (17 per cent) and the wealthiest households the largest group (31 per cent). Nevertheless, 40 per cent of households lie in the poorest two groups with assets valued at less than EB712. In the lowlands poor households make up the largest section of society (33 per cent), and

60 per cent fall within the poorest two groups (assets valued under EB712). In both types of area, but particularly lowland areas, large sections of the population lack assets to sell or use as a loan guarantee at times of illness when they need a lump sum of money.

## 2 Illness patterns

This section:

- describes the prevalence of chronic and acute illness among individuals (2.1)
- describes the number and proportion of households that had to cope with illness (2.2)
- examines the basic implications of these findings for household ability to cope with illness and its possible costs (2.3).

Data sources: household survey; health facility data

### 2.1 Types and prevalence of illness among individuals

Of 3,642 individuals covered by the survey:

- 331 individuals (9 per cent) reported a chronic illness, and 37 people reported that they had two chronic illnesses
- 514 individuals (14 per cent) reported an acute illness episode in the previous two weeks, and four of these individuals had had a second acute illness episode.

Reported illnesses were categorised into broad types by the researchers. The three types of chronic illness most frequently reported were:

- **Abdominal or gastro-intestinal problems** (79 cases; 2.2 per cent of the whole sample and 23.9 per cent of those reporting chronic illness), including diarrhoea, abdominal pain or swelling, gastritis and amoebas
- **Respiratory problems** (43 cases; 1.2 per cent and 13 per cent respectively of the whole

sample, including persistent coughs, chest pains, asthma, pneumonia and tuberculosis

- **Malaria** (36 long-term cases; 1 per cent and 10.9 per cent respectively of the whole sample).

Other types of chronic or long-term illness reported were mental illness of some kind, diseases of the skin, ear, heart and kidney, swelling of different parts of the body, and rheumatic or arthritic pain.

The three types of acute illness most frequently reported were:

- **Common colds** (196 cases; 5.4 per cent of the whole sample and 38.1 per cent of those reporting an acute illness)
- **Abdominal or gastro-intestinal problems**, including diarrhoea (81 cases; 2.2 per cent and 15.8 per cent respectively of the whole sample)
- **Skin disease**, mainly scabies (63 cases; 1.7 per cent and 12.3 per cent respectively of the whole sample).

Other types of acute illness reported were malaria (if it had only been diagnosed in the previous two weeks), cough, fever, eye infection, headache, glandular swelling and injury.

Information on diseases treated at the three health centres and five health stations confirm these findings, but also show that urinary tract infections were commonly treated. This disease was not reported to survey enumerators for obvious reasons (embarrassment, stigma, the need for secrecy, etc), and so indicates under-reporting and potentially higher illness prevalence rates than recorded in the survey.

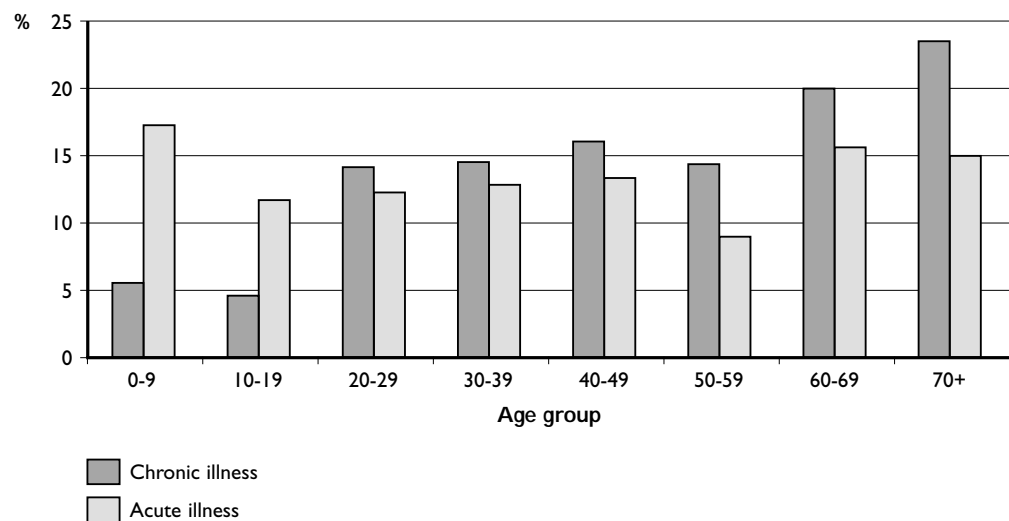


Figure 2.1: Prevalence of illness across age groups

More females reported illness than males: 175 females reported a chronic illness compared to 156 males; and for acute illness these figures were 288 and 226 respectively. Figure 2.1 shows how rates of reported illness varied with age. The proportion of people reporting a chronic illness increased with age, and among the two oldest age groups 20 per cent and 23 per cent reported a chronic illness. The youngest age group of 0-9 years had the highest rate of reported acute illness (17 per cent).

The actual numbers of people reporting illness by age group is also worth noting, because the large number of young people in the population meant a large number of those reporting illness were young. Although a low proportion of the youngest age group reported a chronic illness (5.6 per cent) this actually represented a relatively large number of individuals (74) compared to other age groups. Conversely, despite the high prevalence of chronic illness among older people,

the actual number of people over 60 with a chronic illness was relatively low (20). The high prevalence of acute illness among children under 10 years (17.3 per cent) also meant a large number reported an acute illness (231, or 45 per cent of all acute illness cases).

Prevalence of reported chronic illness by area did not vary significantly, although across the three *woredas* rates of reported chronic illness were higher in lowland areas than highland areas. This pattern is partly explained by the timing of the survey after the rainy season, when rates of reported malaria are high in these areas (in this study malaria was classified as a chronic illness if the problem had persisted for more than a month). The lowland *kebele* of Edo Belina in Alemaya had the highest rate of reported acute illness, largely due to high levels of skin disease (mostly scabies) in the area at the time of the survey. In the other two *woredas*, rates of acute illness were higher in highland areas.

## 2.2 Distribution of illness across households

A large proportion of households had at least one member with a chronic illness (280 or 43.5 per cent – see Table 2.2). In addition, a minority of households suffered from high concentrations of illness: 49 households (7.6 per cent) had to cope with two members with a chronic illness and one household had three members with a chronic illness.

The burden of chronic illness did not vary significantly with the socio-economic status of the household, but did vary by area. In lowland areas a higher proportion of households had a member with a chronic illness (47 per cent) compared to households in highland areas (40 per cent). The lowland area of Kurkura in Meta had the highest rate of chronic illness across households: 57 per cent of households in the area had to cope with at least one member with a chronic illness.

The majority of households had at least one member who had experienced acute illness in the

previous two weeks (398 households or 62 per cent). As with chronic illness, a higher burden of acute illness was concentrated in a minority of households: 97 households (15 per cent) had to cope with at least two members with an acute illness (Table 2.3).

Prevalence of acute illness did not vary across socio-economic groups, but did vary with area: 68 per cent of households in lowland areas experienced at least one member with an acute illness compared to 56 per cent of households in highland areas. The lowland areas of Edo Belina (in Alemaya) and Kurkura (in Meta) had particularly high rates of reported acute illness – 71 per cent and 70 per cent of households respectively had at least one member who experienced acute illness in the previous two weeks.

When the burdens of chronic and acute illness in the previous two weeks are combined (Table 2.4), it is evident that:

- the majority of households (516 or 80 per cent) had at least one member with either a chronic illness or an acute illness in the

**Table 2.2: Distribution of chronic illness across households**

Members with a chronic illness	Number of households	% of households
None	363	56.4
1	230	35.8
2	49	7.6
3	1	0.2
Total	643	100.0

**Table 2.3: Distribution of acute illness across households**

Members with acute illness in previous two weeks	Number of households	% of households
None	245	38.1
1	301	46.8
2	78	12.1
3	19	3.0
Total	643	100.0

previous two weeks; only 20 per cent were free of illness

- a large minority of households (38 per cent) had two or more members who suffered from illness: 180 household or 28 per cent had two ill members; 53 households (8 per cent) had to cope with three sick members; and 14 households (2 per cent) had to cope with four or more sick members.

## 2.3 Summary

The data presented in this section show there is a drastic need for good quality health services that people can access easily. Just over 80 per cent of households had at least one member with either a chronic illness or an acute illness in the previous two weeks. Nearly half of the households in the study had to cope with a chronically sick member,

**Table 2.4: Distribution of chronic and acute illness across households**

Members with chronic illness and/or acute illness in previous two weeks	Number of households	% of households
None	127	19.8
1	269	41.8
2	180	28.0
3	53	8.2
4	13	2.0
5	1	0.2
Total	643	100.0

Note: all figures are rounded up

and although HIV/AIDS was not reported by respondents it is likely that many of the longer-term health problems reported were linked to the HIV/AIDS epidemic.

In addition, over half the households in the survey (62 per cent) had to cope with acute illnesses, many of which were poverty-related diseases

such as diarrhoea or respiratory and skin diseases. Access to low-cost healthcare is particularly important for the large minority of households that had to cope with more than one illness in the family at any one time. The survey found that 38 per cent of households suffered from two or more sick members at any one time.

# 3 Treatment responses

This section:

- briefly describes the types of health provider in the study areas and features of structural quality at public facilities
- describes people's treatment-seeking behaviour and the main factors influencing this behaviour
- compares the number of people that did not seek treatment (and were mainly deterred from seeking treatment) in highland and lowland areas, and in different wealth or asset categories
- compares the number of females and males that did not seek treatment (and were mainly deterred from seeking treatment) in the different study areas.

Data sources: FGDs; household survey; health facility data

- Traditional or indigenous practitioners: for example a herbalist, a religious (Muslim) healer (*sheiker*), or local men or women with specialist skills for healing particular ailments such as tonsillitis or worms.

## Allopathic medicine:

- Self-treatment using Western drugs: using drugs already in the home, given by friends or family
- Private drug seller or shop: buying drugs from these sources could be classified as self-treatment but was kept as a separate category because of the possible financial implications
- Private clinic: with a private doctor, usually in urban areas
- Public health station: these are the lowest tier of the state health provision system, located in rural areas and staffed by a health worker with basic training (health assistant), and offering basic medicine or treatment. For each of the six study sites they are the closest government health facility. Table A in Part 1 summarises distances from each site to the nearest government health facility
- Public health centre: in each *woreda* the main town has a health centre which acts as a referral centre for the health stations. These are staffed by doctors, nurses and pharmacists, offer routine laboratory examinations (hemogram, urinalysis and stool examinations), and have a few beds for inpatient services
- Public hospitals: either in the nearest largest cities of Harar, Deder or Jijiga, or the national hospital in Addis Ababa.

## 3.1 Summary of health providers in the study areas

The diverse treatment sources available to people in the study sites might be categorised as follows:

### Traditional medicine:

- Self-treatment using traditional home remedies or herbs: for example, boiled eucalyptus leaves and honey for coughs and colds; papaya seeds and other leaves for diarrhoea; a herb named “kaasee” (taken with coffee) for fever

### 3.2 Decision-making about treatment

The FGDs generated data on decision-making processes and resource allocation within the household.

#### Decision-making processes

Within the household, decisions about where to go for treatment were often the result of consultation and discussion between husband and wife, and relatives and neighbours were also commonly consulted. But the ultimate decision, respondents argued, lies with the husband, because “he holds the money in his pocket”, or is the “decision-maker in the household”.

Women were said to know the day-to-day condition and health of their children much better than men. Men were also said to be busy earning money for the household, at work or out in the fields, and so had less time for these matters. As a result many of the day-to-day decisions about children’s health are delegated to women. Mothers had the authority to deal with minor illnesses requiring traditional herbal remedies, or for example to treat worms by rubbing the child’s anus (*hudufore*). Another situation in which women were said to have greater autonomy over health-related behaviour was with female circumcision.

For treatment that is likely to incur financial costs or require a long journey, adult respondents argued that men are dominant in the decision-making process because they “hold the money in their pocket”. Women argued they could not take

a decision independently to seek treatment that involved financial expenses. To take a child to a public facility, for example, they would have to ask their husband for the money and the time off.

Children also argued that men were the ultimate decision-makers regarding treatment, especially treatment that would incur financial costs. They argued that parents would also consult neighbours about illness and treatment, and that if a child were seriously ill then the father would ask neighbours for support to transport the child to a health facility.

#### Resource allocation

In the FGDs among adults, males and females were divided over the question of resource allocation to boys and girls. Some argued that, in general, boys are favoured over girls because girls marry outsiders and leave the home, whereas boys remain more closely linked to their parents and are more likely to contribute to the household economy when they grow up. In contrast, others argued that the status of boys and girls in the household was equal.

Children were less divided on this issue, with the majority stating that parents favoured boys as they remain to support them in their old age while girls marry outside. Parents’ response to illness was therefore much quicker for a boy so as not to risk his life. Girls from the cash-poor areas in particular argued that parents responded more quickly to illness among boys and sought more costly treatment for them.

### 3.3 Overview of treatment-seeking behaviour

The research generated data on treatment-seeking behaviour through (a) FGDs in each *kebele* site, and (b) the household survey.

FGDs identified the following general patterns for treatment-seeking behaviour:

- For minor illnesses people do not seek treatment because the illness is not considered serious, or because of the financial or time costs, or they self-treat using traditional herbal remedies that cost very little.
- Respondents in all groups – male and female, adult and children – said that when an illness is deemed to require treatment, people first seek treatment from traditional healers for nearly all types of illness.
- In lowland, cash-poor areas poorer people in particular always try traditional healers first because they are cheaper and closer than public health facilities.
- If there is no improvement, people may seek treatment from a public facility, usually the health station which is the closest modern health facility available to them.
- Adults and children argued that they knew Western medicine to be more effective, but that access barriers to Western medicine, mainly financial cost and distance, forced them to use traditional providers for most illnesses and to only use public facilities if an illness became very serious.<sup>1</sup>
- Children from poor lowland areas said that if children became critically sick, parents

borrowed money from better-off households to seek Western medicine.

The household survey provides a wider cross-sectional picture of treatment-seeking behaviour over a two-week recall period. Figure 3.1 (overleaf) summarises individuals' responses to chronic and acute illness in the previous two weeks. The main treatment patterns revealed are as follows:

- Twenty-one per cent of individuals reporting a chronic illness did not seek treatment in the previous two weeks, and more notably nearly half of the individuals reporting an acute illness did not seek or use treatment (note: 45 per cent of these individuals were under ten).
- The most common treatment response for acute illness was self-treatment using traditional herbs and other remedies (18.5 per cent); self-treatment using traditional medicine was also a common response for chronic illness (20.2 per cent).
- From the household survey only a minority of people reported using a traditional healer: 7.3 per cent for chronic illness and only 2.3 per cent for acute illness. These low figures contrast with the findings from the FGDs, and strongly suggest under-reporting for use of traditional practitioners. Respondents may have been reluctant to “admit” use of traditional practitioners in front of Save the Children staff and instead reported what they believed the researchers wanted to hear. They may also have wanted to publicly portray themselves as more “educated” in the

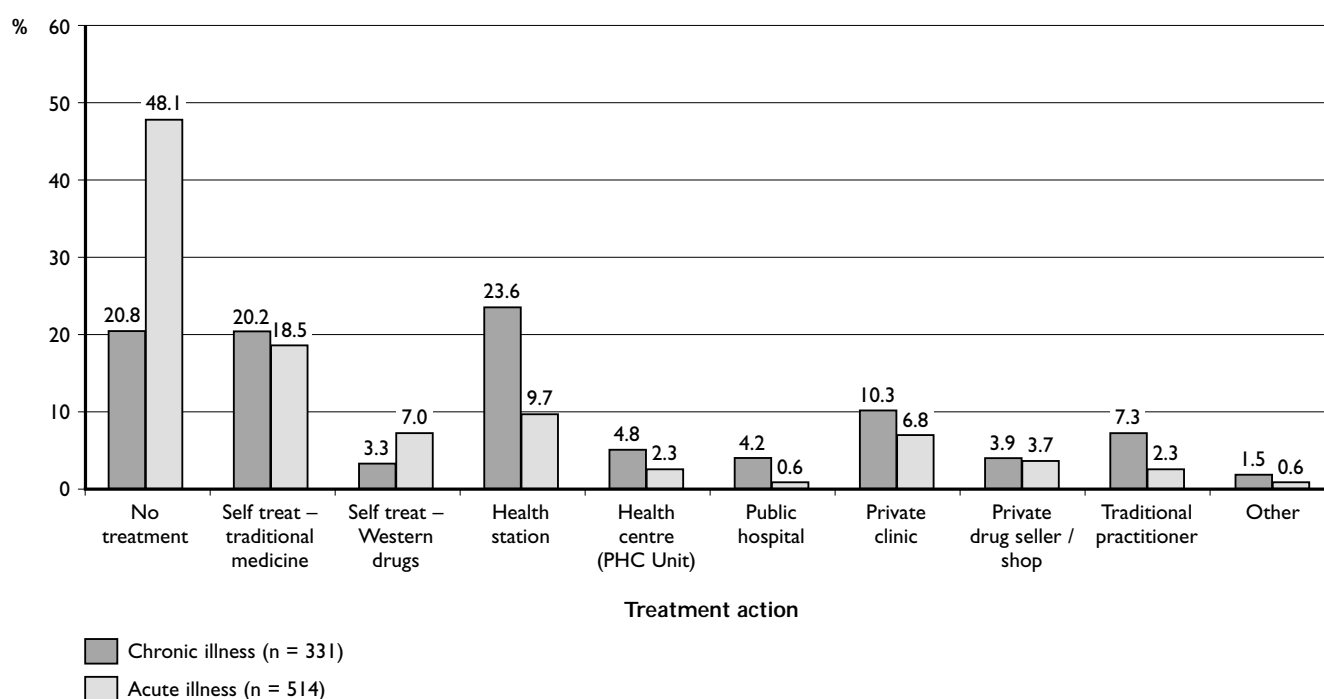


Figure 3.1: Treatment action by type of illness

eyes of the researchers (see footnote 1).

- The most common treatment response for chronic illness was to visit the nearest Western health facility – the health station (23.6 per cent). For acute illness health stations were also the most frequently used provider of services (9.7 per cent) after self-treatment.

More distant public referral centres like the health centres and hospitals were not used frequently; private clinics were more frequently used.

Overall, only about a fifth of people with an acute illness sought care from a health worker or a

person recognised as an expert: 9.7 per cent from the health station, 6.8 per cent from private clinics, 2.3 per cent from both traditional practitioners and public health centres, and 0.6 per cent from hospitals. Overall, people are not seeking care or self-treating, although from the group discussions it seems they are probably also using traditional practitioners. But what is clear is they are not using public facilities frequently. For chronic illness more people are seeking treatment from a health worker or a person recognised as an expert, but public facilities above the level of the health station are used only rarely.

### 3.4 Reasons for treatment-seeking behaviour: beliefs and access barriers

The FGDs generated qualitative data on the factors influencing treatment response. People's beliefs about the cause of an illness and the most effective therapy to deal with it had an underlying influence on treatment action. For example:

- Western medicine was not perceived to be effective against a variety of illnesses, such as “lumps” growing on different parts of the body (*gofla*), or haemorrhoids (*kintarot*); the general belief was that these illnesses were best treated by traditional methods or medicine.
- Worms in children were believed to be best treated by rubbing the anus with sticks (*hudufore*).
- Traditional medicine was usually sought for “simple” illnesses such as scabies or other skin diseases because it was perceived as the most effective and the easiest to obtain.
- People felt that diseases believed to be caused by witchcraft should be treated with religious or spiritual therapy and a religious healer (*sheiker*) should be consulted.
- People preferred to use Western medicine for some diseases, for example in the group discussions respondents unanimously said traditional remedies were ineffective against malaria.

Despite these beliefs about illness and treatment, people also argued that pragmatic factors forced them to use traditional medicine and prevented them from using Western medical facilities. People said they knew Western medicine was

better, but they could not get to it (but see footnote above). The FGDs identified the following main access barriers to utilisation of public health facilities:

**Distance:** In all group discussions respondents stated that people's first action was to go to a traditional healer because they were close and easy to visit (and cheaper). In contrast, government facilities were too far from the village and a trip was only worth the long walk if an illness was serious, particularly in Meta and Grawa where the nearest facilities were 10-20 kilometres away which meant a 2-4 hour walk *each way*. In lowland areas distance was the most serious problem mentioned by respondents. Moreover, long distances make it extremely difficult to get a seriously ill person who is incapacitated to the facility: carrying a patient to the facility is a last resort.

**Cash availability:** People used traditional healers first because they lacked the cash needed to get to public health facilities and to purchase drugs from private pharmacies (because public facilities usually faced drug shortages). This was a key argument used by all respondents (adults and children), but lack of cash was a particularly strong point made in the lowland, cash-poor areas. Western medicine was said to be expensive and the poor had to delay seeking this treatment until they could gather the money together; they visited traditional healers as a transitory measure. Children from cash-poor areas said that they were only taken to get medicine from the government facility if traditional treatment had not improved

their condition, because their parents had no money to cover the costs of going to the health station.

**Drug shortages and other quality weaknesses at public providers.** Non-availability of drugs at public facilities was the most important weakness identified by respondents. After meeting a health worker at a public health facility people usually have to purchase the prescribed medicine from a private pharmacy. Long waiting times were also a problem mentioned by respondents.

The household survey provided additional evidence about access barriers or factors influencing choice of treatment. Figure 3.2 shows that the dominant factor cited as a reason for not seeking treatment was lack of money. “Lack of money” might also include distance as an access barrier, since money is needed to pay to travel the long distances to health facilities (transport, food and lodging costs).

Self-treatment with traditional medicine was one of the most common treatment strategies (Figure 3.1), and the household survey found it was used largely because it was low cost, effective and familiar to the family. When people had sought treatment at health stations and private clinics the reasons given were also predominantly pragmatic: they were relatively close, low cost or the only place to obtain the right sort of treatment.

### 3.5 Treatment response by type of area and asset status of household

There were differences in treatment-seeking behaviour by type of area (highland compared to lowland) that indicated greater access barriers in lowland areas. Figures 3.3 and 3.4 show that in lowland areas a considerably higher proportion of people did not seek treatment for either chronic or acute illness than in highland areas.

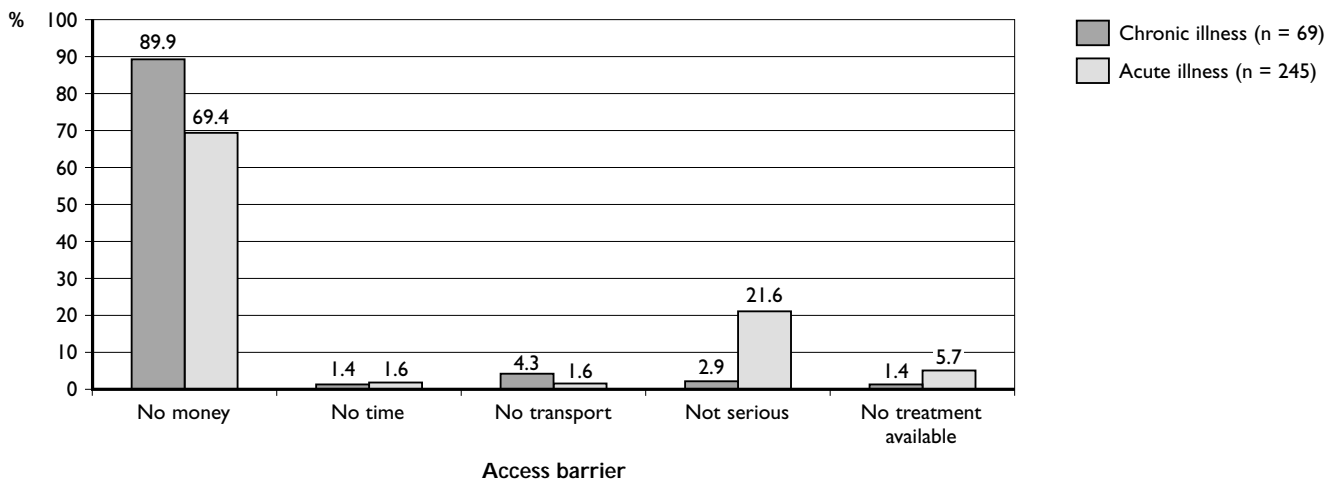


Figure 3.2: Reasons for not seeking treatment

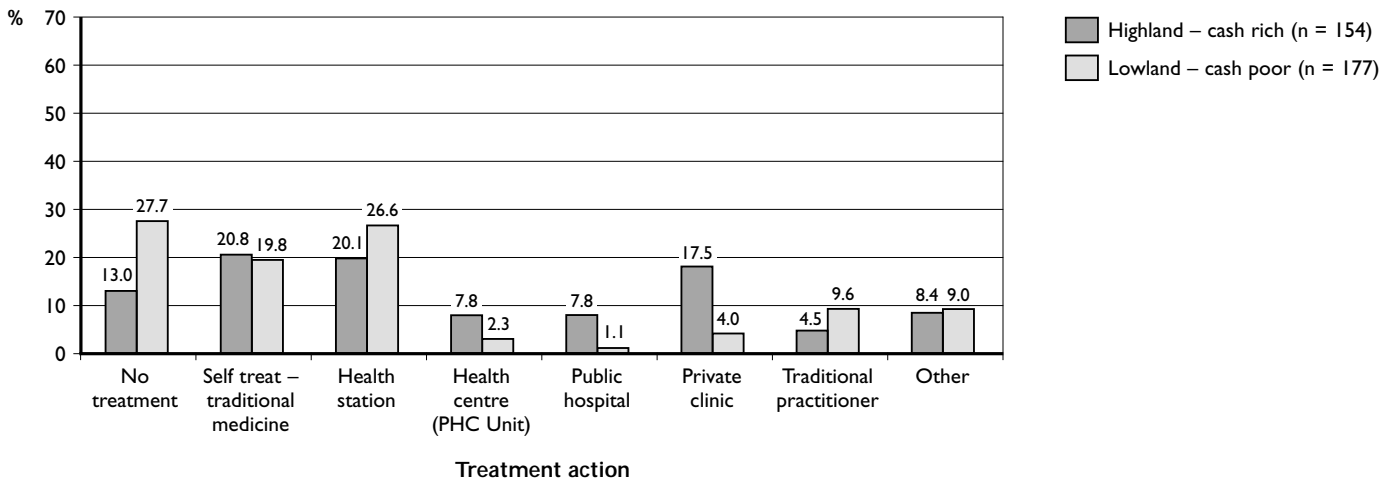


Figure 3.3: Chronic illness – treatment response by type of area

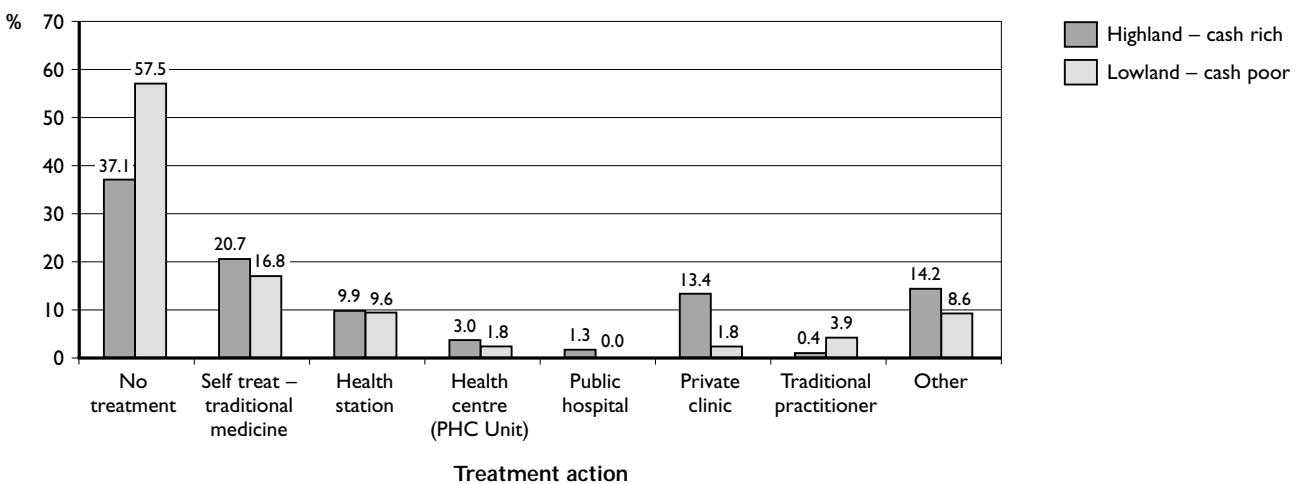


Figure 3.4: Acute illness – treatment response by type of area

For chronic illness, although a higher proportion of people used health stations or traditional providers in lowland areas than in highland areas (Figure 3.3), a lower proportion used the larger public facilities (health centres and hospitals) and private clinics. These figures probably reflect the different distances and costs associated with these

providers. In lowland areas health stations and traditional providers are relatively close and cheap compared to the more distant and costly public referral centres or private clinics. In contrast, for people in the highlands the larger public facilities are more accessible geographically (see Table A in Part 1), and more people are likely to have the

cash available to use private clinics. This was reflected in the relatively high proportion of chronically ill people that used private clinics (17.5 per cent). For acute illness these patterns were similar (Figure 3.4), with a much higher proportion of people from lowland areas not seeking treatment and a very low proportion using public health centres and hospitals or private clinics.

The greater access barriers in lowland areas reflect both distance and socio-economic factors: cash shortages and food insecurity are more widespread in lowland areas, and more people have fewer assets to mobilise if cash is needed. These socio-economic influences can be traced more directly by comparing the treatment-seeking behaviour of individuals from different household asset groups. Figure 3.5 shows that a higher proportion of individuals from asset-poor households did not seek treatment, compared to individuals from asset-rich households. This

pattern was particularly clear for acute illness: 62 per cent of individuals from the poorest households that reported illness did not seek treatment, compared to only 38 per cent from the wealthiest households. These data reinforce the argument that asset-poor households find it more difficult to mobilise cash resources to finance the costs of seeking treatment, and that a larger proportion of the poor are deterred due to lack of cash.

### 3.6 Treatment response by gender

The survey data show that lack of cash is a key factor deterring treatment, and that more people in lowland areas did not seek treatment due to cash shortages. The following data break down this analysis further, and show that higher levels of non-treatment in lowland areas are explained by the fact that more females than males did not seek treatment in lowland areas.

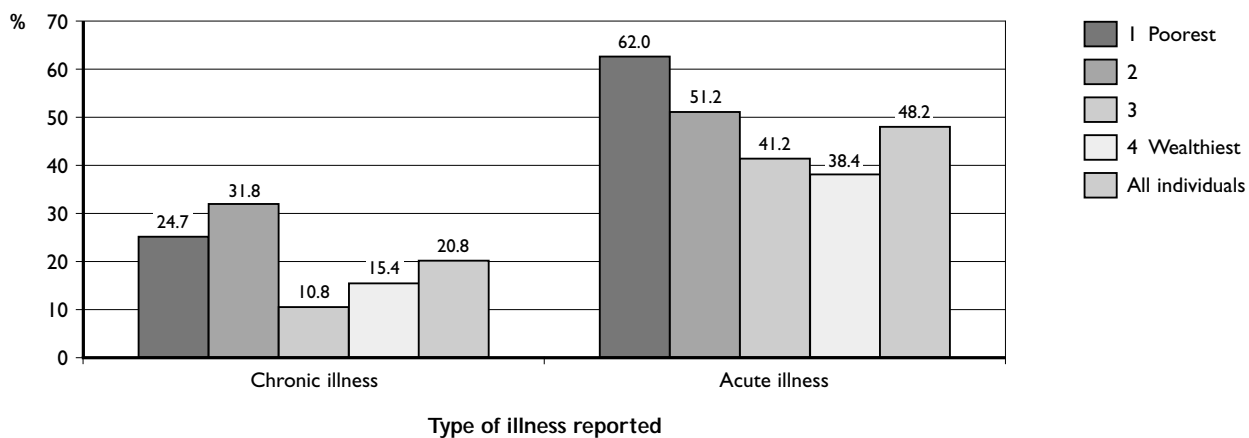


Figure 3.5: Not seeking treatment: percentage of individuals in each asset group

### Chronic illness

Overall more females reported chronic illness than males (175 compared to 156), but more females did not seek treatment: 25 per cent of females with a reported chronic illness (n = 44) did not seek treatment, compared to 16 per cent of males (n = 25). As noted above this was mainly due to lack of money (see Figure 3.2).

This meant 131 men and 131 females sought or obtained treatment, and their treatment responses

were very similar (ie, to the patterns shown in Figure 3.1). However, the gender differences by area for non-treatment of chronic illness are of more interest. When these are set out by *kebele* a pattern of bias against females in lowland areas, but not highland areas, emerges (Figure 3.6).

If the data are aggregated into highland and lowland areas, the contrast between male and female non-treatment by area becomes more marked (Table 3.1). In the highland areas only

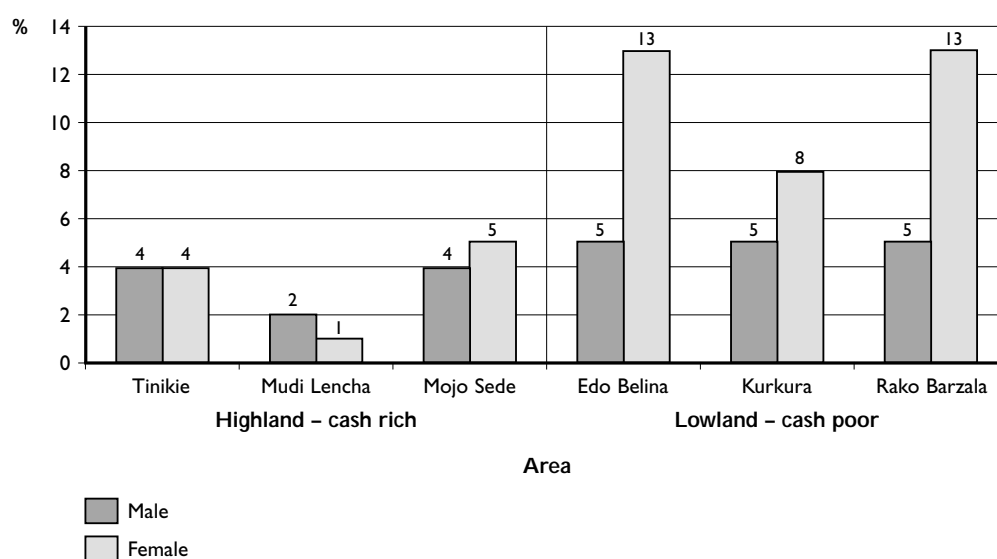


Figure 3.6: Not seeking treatment for chronic illness: area and gender differences

Table 3.1: Gender disparities in access to treatment for chronic illness

	Highland areas	Lowland areas	All areas
Male	10 (14.5%)	15 (21.7%)	25 (36.2%)
Female	10 (14.5%)	34 (49.3%)	44 (63.8%)
Total	20 (29.0%)	49 (71.0%)	69 (100%)

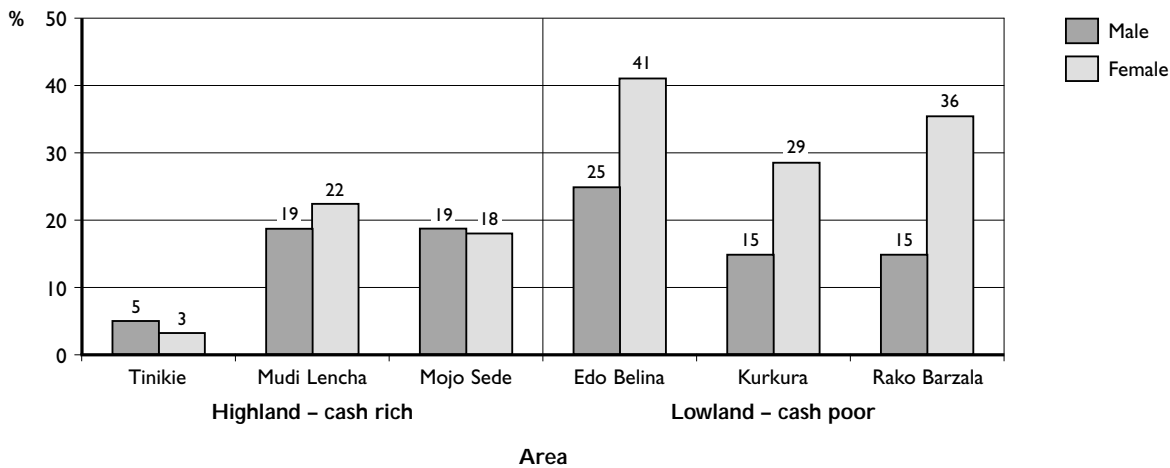
20 people did not seek care and there were no differences between males and females. In contrast in lowland areas more people did not seek care and gender disparities were more marked (34 females and 15 males). Females in lowland areas made up 49 per cent of all those not seeking care. However, a chi square test shows these disparities are not statistically significant.

**Acute illness**

Figure 3.7 shows a similar pattern of gender bias in lowland areas for non-treatment of acute illness. In the three highland cash-rich areas fewer

people did not seek treatment, especially in Tinikie, and in fact there were more males than females that did not seek treatment in Tinikie and Mojo Sede. In contrast, in lowland areas more people were deterred and far more females than males did not seek treatment.

Again, if highland and lowland data are aggregated the difference between these types of area becomes more marked (Table 3.2). In highland areas far fewer people were deterred and there were no gender differences (43 males, 43 females). In contrast, in lowland areas more



**Figure 3.7: Not seeking treatment for acute illness: area and gender differences**

**Table 3.2: Gender disparities in access to treatment for acute illness**

	Highland areas	Lowland areas	All areas
Male	43 (17.4%)	55 (22.3%)	98 (39.7%)
Female	43 (17.4%)	106 (42.9%)	149 (60.3%)
Total	86 (34.8%)	161 (65.2%)	247 (100%)

people were deterred (161 or 65 per cent of the total) and far more females were deterred than men (106 females and 55 males). A chi square test on this aggregated data was statistically significant (a 0.015 value from a Pearson Chi-Square, which means there is only a 1.5 per cent chance that the disparity is random and there is far more confidence that it is caused by social processes of some kind).

For chronic and acute illness there was not much variation in the types of treatment sought by different age groups. However, for acute illnesses the higher levels of female non-treatment identified above did vary with age.<sup>2</sup> Table 3.3 shows the number of people in each age group that had an acute illness, and then the proportion of these people that did not get treatment by age and gender. The table shows that overall a higher proportion of females that were ill did not seek

treatment (51.7 per cent compared to 43.4 per cent). However, the proportions of boys and girls under ten not receiving treatment were similar: the biggest gender disparities arose for older children and young adults aged between 10 and 29 (see shaded cells in table). This suggests young mothers and wives face the biggest access barriers.

### 3.7 Summary

People have to travel long distances, usually on foot, to reach the nearest public health facility. In Meta and Grawa *woredas* the nearest health station for people in the study sites was 10-20 kilometres away, a considerable distance to travel. The health centre and higher-level referral centres were even further away. In each *woreda* people in lowland areas had to travel the greatest distances to reach a government health facility. A basic

Table 3.3: Not getting treatment for acute illness: variations by gender and age

Age group	Number with acute illness			Number who were ill that did not seek or obtain treatment					
	females	males	total	Females	% of females	males	% of males	total	% of total
0-9	110	121	231	51	46.4	54	44.6	105	45.5
10-19	56	48	104	33	58.9	18	37.5	51	49.0
20-29	44	15	59	22	50.0	4	26.7	26	44.1
30-39	34	19	53	20	58.8	10	52.6	30	56.6
40-49	25	8	33	12	48.0	4	50.0	16	48.5
50-59	7	5	12	4	57.1	3	60.0	7	58.3
60-69	9	6	15	5	55.6	3	50.0	8	53.3
70+	3	4	7	2	66.7	2	50.0	4	57.1
All ages	288	226	514	149	51.7	98	43.4	247	48.1

survey of structural quality in these facilities revealed problems with basic drug availability.

The majority of people who were ill did not seek treatment at public health facilities. Instead the majority self-treated with traditional medicine, used a traditional practitioner or did not seek any treatment at all.

The main reason people gave for not seeking treatment at public facilities was to prevent or minimise potentially high financial and time costs. It was too far to walk and it cost too much to travel or obtain drugs, or once you got to the facility you had to wait a long time. In contrast, traditional healers lived locally, could be seen quickly and were cheaper.

These time and financial cost barriers will apply to a wide range of household types, given the precarious livelihood situations that the poor and “middle” or middle wealth groups currently face. Moreover, these access barriers appear to be particularly high for people living in lowland areas because they are more distant from facilities, and

for the asset poor because they lack cash or resources to meet even their food needs, let alone items such as healthcare.

In lowland areas access barriers were particularly high for young women. This tentative finding requires more in-depth research, but it is likely to be the case because young women who are recently married and have moved away from their own home often lack decision-making authority and access to cash. In a context where household budgets are under strain, young women are likely to be the first group to have to make sacrifices.

#### NOTES

1 This type of “public” statement might be used by some people in the context of a group discussion to portray a certain image of themselves to the research team or other respondents, for example that they are educated and familiar with the benefits of “modern” medicine. In fact they may use traditional medicine because they believe in its benefits, but may not want to admit this in this particular context.

2 For chronic illnesses higher levels of non-treatment among females in lowland areas were fairly constant across age groups.

# 4 The cost of illness

In this section the direct costs of illness are defined as all expenditure linked with seeking treatment, including transport, food and drink on a journey, gifts to healers, etc. This section:

- Describes the average direct financial costs of illness for individuals that sought treatment (4.1)
- Aggregates individual direct illness costs to show average household direct costs of illness (4.1)
- Describes how the direct costs of illness are distributed across households to show what proportion of households experienced different levels of cost burden (4.2)
- Describes the time costs of seeking treatment (4.3)
- Assesses the implications of these illness costs for household ability to pay for treatment (4.4).

Data sources: household survey; secondary data on household livelihoods and food economy (Mathys 2000; SC UK Food Economy Zone Reports (1996)

## 4.1 Average direct costs of illness

### Average costs for individuals

Data on the direct costs of chronic illness derive from 262 individuals who sought treatment in the previous two weeks (331 individuals had chronic illnesses; 69 did not seek treatment). For the 37 individuals that had two chronic illnesses and that sought treatment for their second illness ( $n = 32$ ), the costs of treatment for both illnesses were added together.

Data on the direct costs of acute illness derive from 265 individuals who had sought treatment in the previous two weeks (514 individuals with an acute illness; 247 did not seek treatment, and two had a “don’t know” treatment response). Some people took a second action for the acute illness, and the costs of this second action were added to the costs of the first action to reach a total cost for the acute illness episode.

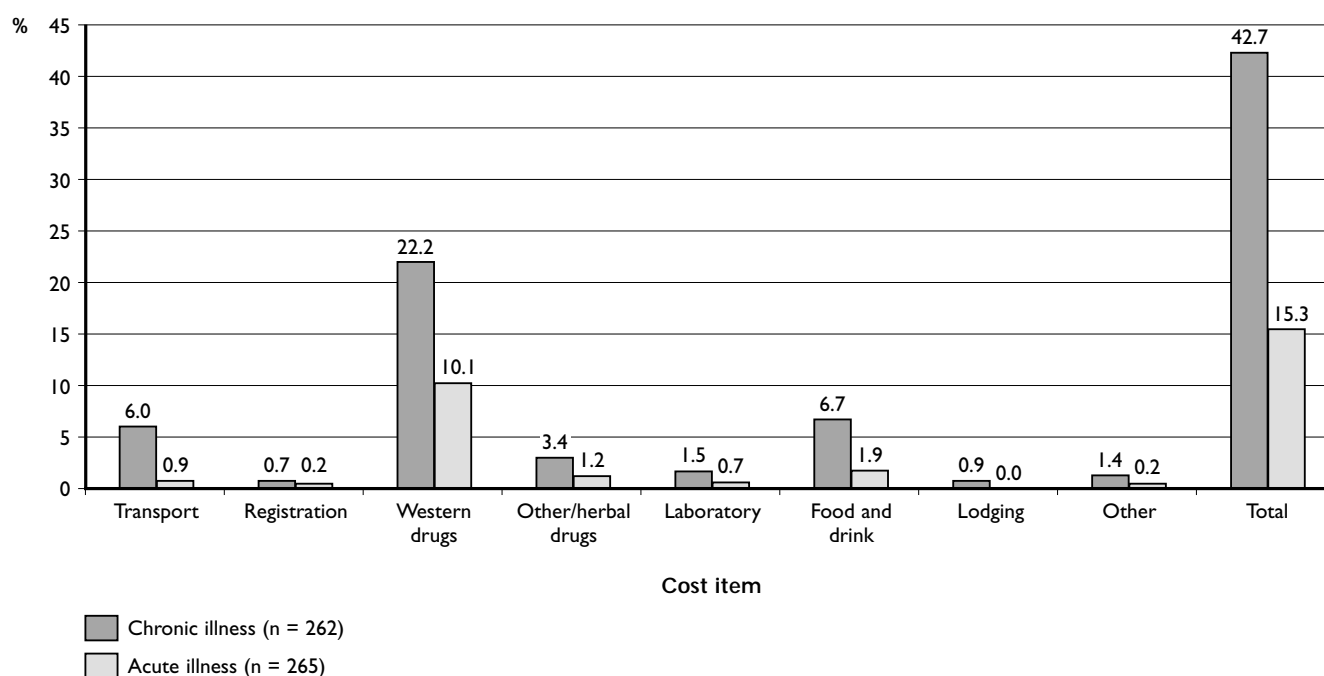
Table 4.1 (overleaf) summarises the total spending on acute and chronic illness in the six study sites over the two-week recall period. Spending on chronic illness was over twice the amount spent on acute illness. For both types of illness spending on Western drugs made up a large proportion of total spending (52 per cent for chronic illness and 66 per cent for acute illness), and other major cost items were transport and food and drink while seeking care.

Figure 4.1 (overleaf) summarises mean spending by individuals that used or sought treatment for chronic and acute illness over the two-week recall period. Mean total spending on chronic illness

**Table 4.1: Total spending on chronic and acute illness by individuals in the previous two weeks**

	Chronic illness (n = 262)		Acute illness (n = 265)	
	Sum (Birr)	% of total spending	Sum (Birr)	% of total spending
Transport	1560	14.0	242	6.0
Registration	184	1.6	64	1.6
Western drugs	5811.5	52.0	2671.25	66.0
Other/herbal drugs	878	7.9	323.25	8.0
Laboratory	394	3.5	186	4.6
Food & drink	1764	15.8	497	12.3
Lodging	227	2.0	4	0.1
Other	362	3.2	62	1.5
Total	11180.5	100.0	4049.5	100.0

Note: all figures are rounded up



**Figure 4.1: Mean spending by individuals on treatment action(s) for chronic and acute illness in previous two weeks**

was EB42.7 per person that sought treatment, nearly three times higher than mean spending on acute illness (EB15.3 per person that sought treatment). The dominance of Western drug costs is also highlighted by these mean figures, and suggests that people are spending a lot at private pharmacies to obtain drugs.

Notably, median expenditure on seeking treatment was zero for all cost items except Western drugs. For chronic illness, median spending on drugs was EB13.5 and median total spending was EB20, a much lower figure than the mean of EB42.7. For acute illness, median drug spending was EB2 and median total spending was EB5, again a much lower figure than the mean

(EB15.3). Lower median values show that the distribution of direct illness costs is positively skewed – the majority of individuals incurred costs lower down the spectrum of costs, but a minority had higher costs that pulled the mean upwards.

Figures 4.2 and 4.3 break down the average direct costs of illness by source of treatment. The main cost patterns indicated are as follows:

- Self-treatment using traditional remedies is a low-cost strategy, and very low if median spending figures are used. This treatment response is therefore likely to be one of the strategies that people adopt if they need to prevent or reduce direct illness costs.

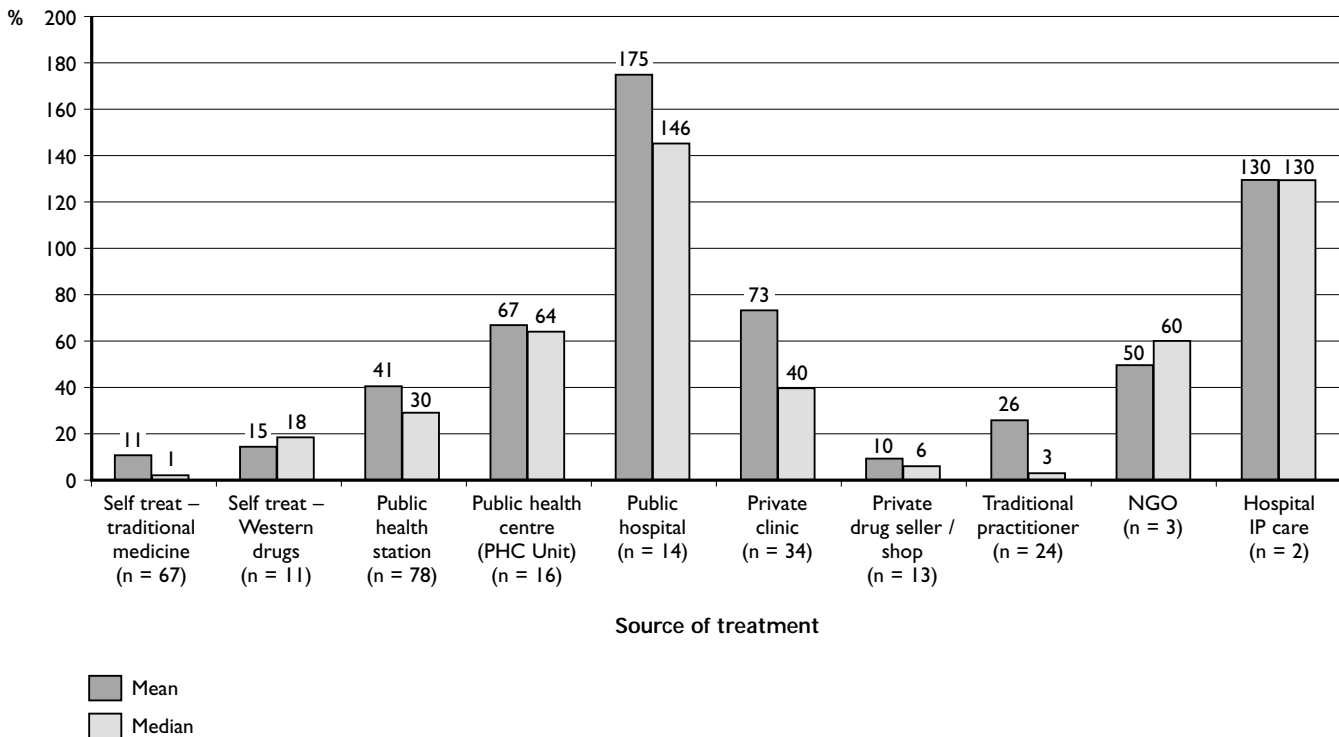


Figure 4.2: Treatment for chronic illness: average cost by source of treatment

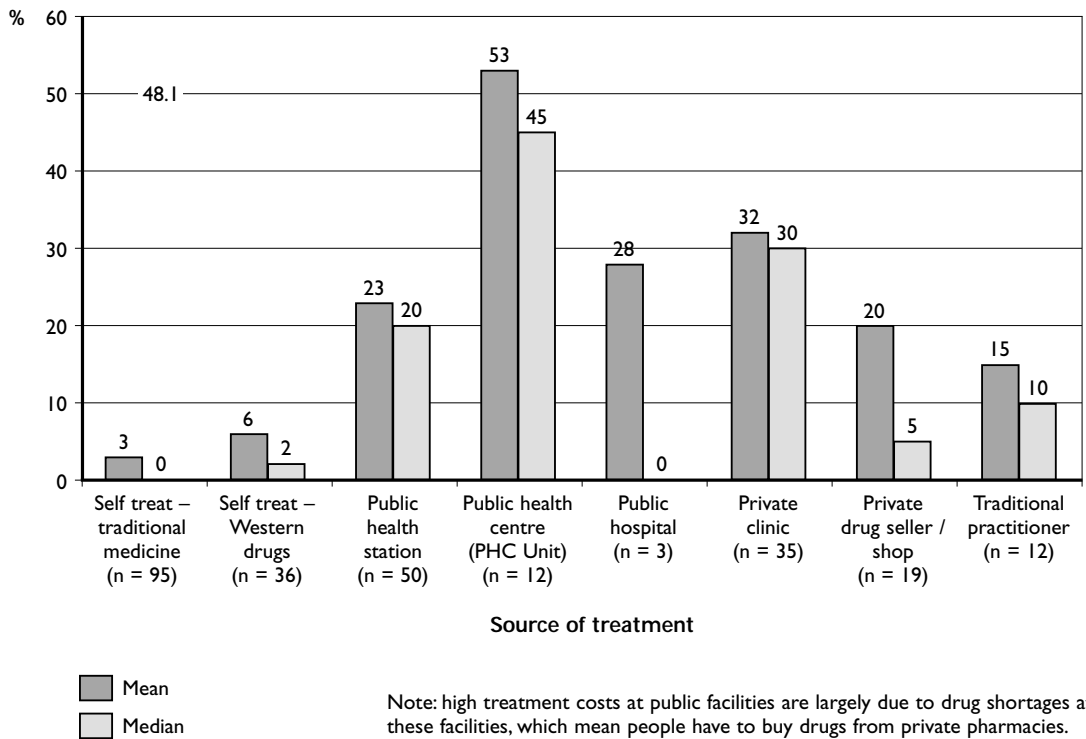


Figure 4.3: Treatment for acute illness: average cost by source of treatment

- Use of traditional practitioners and buying drugs from shops and sellers are also relatively low-cost strategies compared to using government facilities, even the health station.
- The median cost of seeking treatment at a public health station was relatively high: EB30 for chronic and EB20 for acute illness. These costs are high and must be interpreted cautiously, because people visiting public facilities usually had to buy drugs from private pharmacies. It is likely that high treatment costs at public facilities derive from these privately purchased drugs (survey enumerators should have kept the costs from public health facilities and private pharmacies separate but this was not the case). Despite this public/private mix of costs, the dominant conclusion from these data is that in the current situation the cost of seeking modern medicine from a public facility is very high and likely to be prohibitive for many people.
- The median cost of seeking treatment from the public health centre was very high: EB64 for chronic illness and EB45 for acute illness. These costs are likely to be prohibitive for many people. For chronic illness the highest costs of treatment were incurred when seeking care at public hospitals, for either outpatient or inpatient treatment (EB146 and EB130 respectively).

- If median figures are used then private clinics appeared to be a cheaper source of treatment than public health centres, possibly because people are travelling shorter distances or purchasing incomplete drug regimes.

The overarching message from the above data is that the costs of seeking public treatment are high, because of transport costs and the costs incurred at the facility itself (registration fee, lab tests and payment for drugs), and because of drug shortages that force people to go to private providers.

#### Average costs for households

Analysis of the household costs of illness included all households that had a sick member that took action to seek treatment:

**Chronic illness (n = 225):** 280 households (43.6 per cent) had at least one member with a chronic illness, and of these 225 households had

a member with a chronic illness that received or sought treatment.

**Acute illness (n = 217):** 398 households (62 per cent) had at least one member with an acute illness in the previous two weeks, and of these 217 households had a member with an acute illness that sought treatment.

**Chronic and acute illness (n = 365):** 516 households (80 per cent) had at least one member with either an acute or chronic illness; only 127 households (20 per cent) experienced no illness at all. Of the 516 households that experienced illness, 365 had a member that sought treatment for either acute or chronic illness in the previous two weeks.

Figure 4.4 shows average (mean and median) household direct costs for treatment of chronic and acute illness, and treatment of all illnesses. Households that treated members with chronic

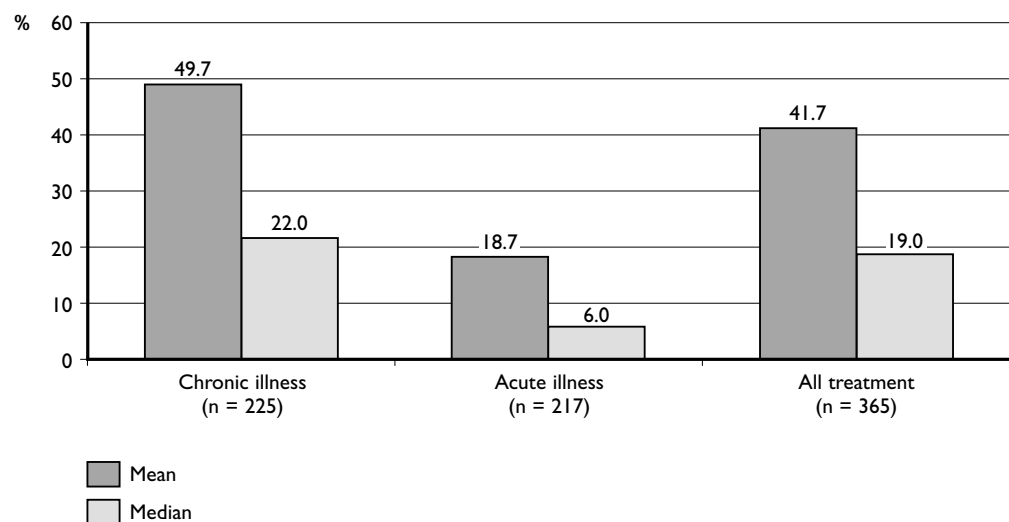


Figure 4.4: Average household direct costs of illness

illness had to cope with higher costs than households that treated members with acute illness. The mean total cost of illness for households was EB41.7 and the median cost was EB19. In other words, of the 365 households that sought treatment for illness in the previous two

weeks, over 50 per cent incurred costs of EB19 or more.

Households spent more on treatment (acute and chronic) in highland areas than in lowland areas (Figure 4.5). Average household spending on all

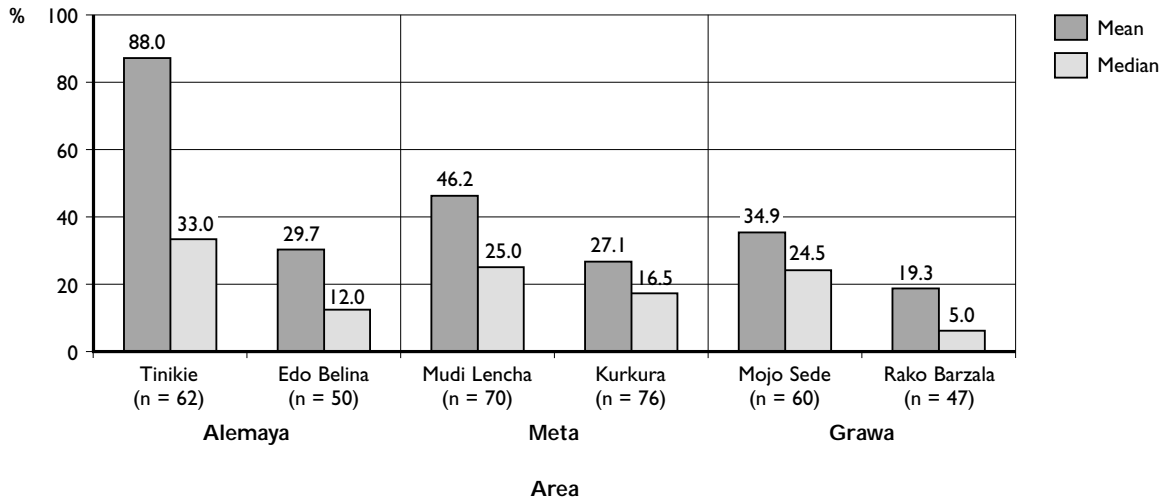


Figure 4.5: Average household direct costs of illness for all treatment, by area (n = 365)

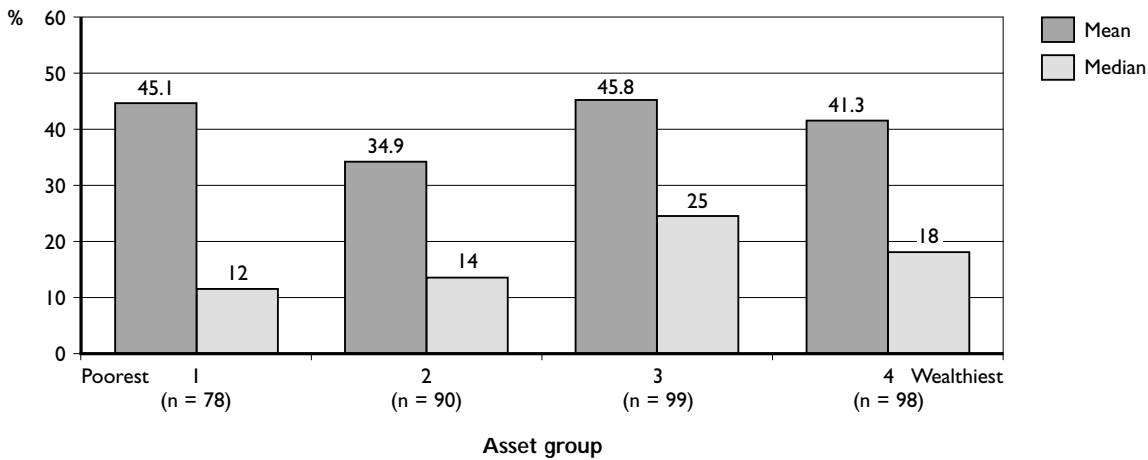


Figure 4.6: Average household direct costs of illness by socio-economic status (n = 365)

treatment was particularly high in Tinikie (median EB33), and lowest in the lowland area of Rako Barzala in Grawa (EB5). These differences between highland and lowland areas were expected, because in general cash availability is greater in highland areas.

Households in the lowest asset category had the lowest median spending of EB12 (Figure 4.6). Nevertheless, this figure shows that over 50 per cent of the poorest households that sought treatment for illness incurred costs of EB12 or more. Moreover, the poorest group experienced a higher mean direct illness cost than asset groups two and four (wealthiest). This indicates that some asset-poor households experienced very high illness costs (see distribution of costs in Section 4.2 below).

## 4.2 Distribution of direct costs among households

While average costs provide a summary indicator of the costs facing individuals or households, these can be disaggregated to show how different proportions of households faced different cost burdens. Figure 4.7 shows the proportion of households (out of 365) that faced different levels of total cost burden for all treatment (acute and chronic illness). A large minority of households ( $n = 64$  or 17.5 per cent) did not incur any costs, and 23 per cent ( $n = 84$ ) incurred a total cost of EB10 or less.

However, the majority of households seeking treatment ( $n = 217$  or 60 per cent) incurred direct costs of illness above EB10. This suggests

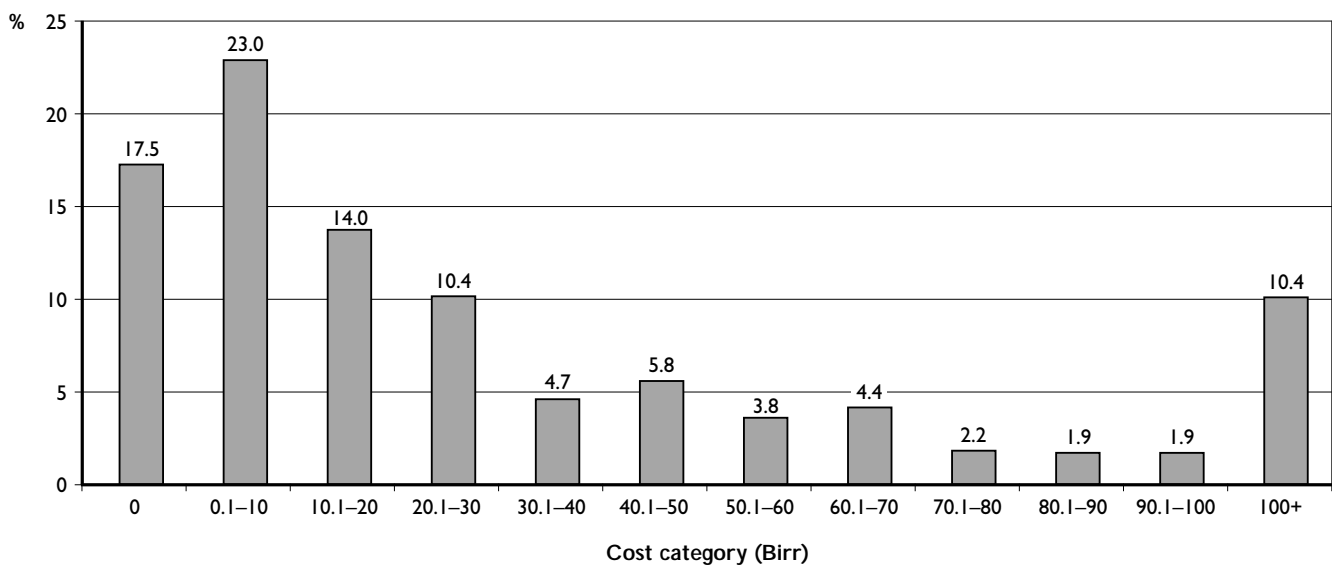


Figure 4.7: Distribution of total household direct illness costs (for chronic and acute illness)

that treatment costs which are high relative to daily wages are extensive and potentially damaging to poorer household budgets. Figure 4.7 also shows that a large minority incurred costs above EB20, and that 10.4 per cent of households had to cope with costs above EB100. Applying these figures to all the households in the survey (n = 643), over one-third (n = 217 or 34 per cent) incurred direct illness costs over EB10 in a two-week period, and 6 per cent (n = 38) incurred costs over EB100.

When this household cost distribution is broken down into costs for chronic and acute illness, the costs of chronic illness are shown to be the main source of higher cost burdens for households (Figure 4.8).

### 4.3 Time costs of seeking care for individuals

In addition to the direct financial costs of seeking treatment, people incur indirect costs through the loss of time. Indirect illness costs can be of two types: the time taken to seek treatment; and the time lost from routine or productive activities when a person suffers from an incapacitating illness. Other people who are not sick, but who accompany the sick to get treatment or who care for the sick, can also incur time costs for the household as a whole. In some circumstances these time costs are converted into a financial figure, for example lost wages or profits due to time off work, or reduced crop yields because of

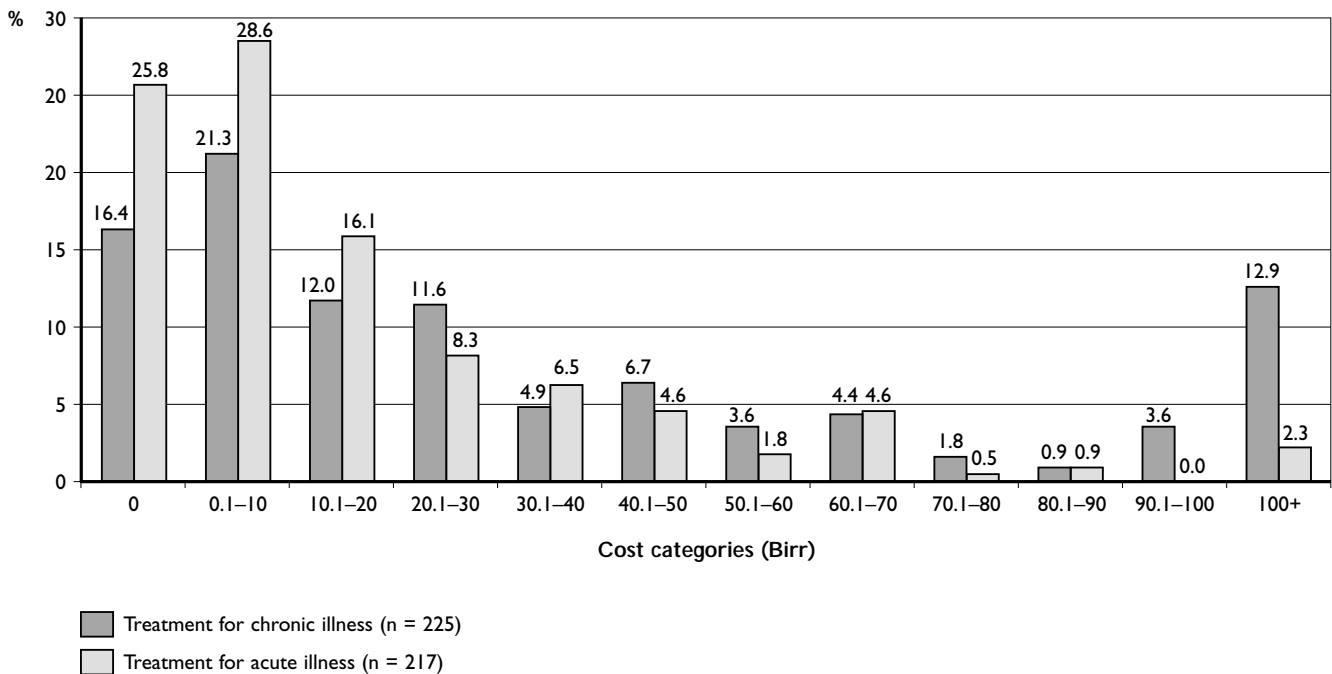


Figure 4.8: Distribution of household direct costs for acute and chronic illness

illness that prevented the harvest being brought in on time.

This research measured only the first type of time cost: the time costs of seeking treatment, and it did not try to convert these time costs into financial figures because the method is fraught with difficulties. Nevertheless, time costs of seeking treatment are an important measure of the additional costs and inconvenience associated with seeking treatment, and influence treatment-seeking behaviour.

Table 4.2 shows the mean and median time (in hours) it took for individuals to seek treatment for chronic and acute illness. The mean time costs are very high because of a few high figures that

Table 4.2: Average time costs of seeking treatment (hours)

	Mean	Median
Chronic illness (n = 262)	17.5	3.0
Acute illness (n = 265)	8.3	1.0

dragged the mean upwards, but the median figures show that 50 per cent of people seeking treatment for chronic illness took at least three hours to get treatment, and it took at least one hour to get treatment for acute illness.

Figure 4.9 breaks down these figures to show median time costs by source of treatment. The patterns are similar to those shown for the direct

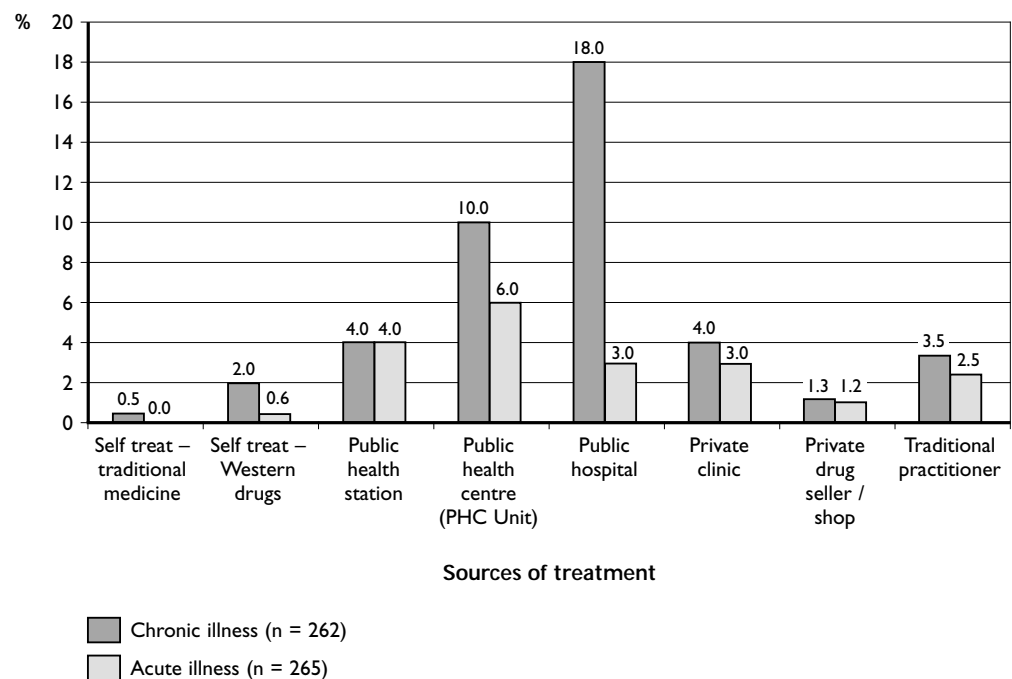


Figure 4.9: Median time costs of seeking treatment

financial costs of seeking treatment in Figures 4.2 and 4.3, namely:

- Self-treatment using traditional remedies is a low-cost strategy, and very low if median figures are used. This treatment response is therefore likely to be one of the strategies that people adopt if they need to prevent or reduce indirect illness costs.
- Use of traditional practitioners incurs lower time costs than using a public health facility, as well as lower direct financial costs.
- The median time cost of seeking treatment at a public health station was relatively high, being four hours. This adds to the relatively high direct financial costs of seeking treatment at public health stations (EB30 for chronic illness and EB20 for acute illness). These time and financial costs combined are likely to be prohibitive for many people and help to explain why only a minority of people used health stations.
- The median time cost of seeking treatment from a public health centre was very high, and adds to the high financial costs of seeking treatment at these larger public facilities.

Overall, these figures confirm the ease of using traditional herbal remedies and the difficulties people face in accessing treatment from public facilities.

#### 4.4 Summary: Cost burdens and their implications for ability to pay

The summary of livelihoods and food security in Section 1.2 provided simple data on different wealth groups' assets and income flows that can be used to interpret whether the costs of illness described above are likely to be "affordable".

Section 4.1 showed that individuals' mean spending on chronic and acute illness was EB43 and EB15 respectively. Table 4.3 shows the median spending on treatment and breaks these figures down by type of area.

The mean total household cost of illness was EB42, and the median cost was EB19 (see Figure 4.4). This showed that of the 365 households that sought treatment for any type of illness in the previous two weeks, over 50 per cent incurred costs of EB19 or more. Looking back at Figure 4.5, which shows the median cost of all treatment by area, households in the highland *kebeles* incurred median treatment costs in the range of EB25-33, and in the lowland *kebeles* these costs were lower, ranging from EB5 to 17.

The direct costs of seeking treatment from a public health facility were even higher, although these high costs stem from the dual strategy of

Table 4.3: Median direct costs of treatment for individuals

Treatment for:	Highlands	Lowlands	All areas
Chronic illness	30	10	20
Acute illness	10	3	5

visiting a public facility and buying drugs from a private pharmacy. The median direct cost of seeking treatment from a public health station was EB30 for chronic illness and EB20 for acute illness. At health centres these median costs were higher (EB64 for chronic illness and EB45 for acute illness).

Section 4.2 showed that the majority of households seeking treatment (n = 217 or 60 per cent) incurred direct costs of illness above EB10, which suggests that high treatment costs relative to daily wages are an extensive problem and potentially damaging to poorer household budgets (see below). Moreover, a large minority incurred costs above EB20, and 10.4 per cent of households had to cope with costs above EB100. Overall, over one-third of households in the whole survey (n = 217 or 34 per cent) incurred direct illness costs over EB10 in a two-week period, and 6 per cent (n = 38) incurred costs over EB100.

#### 4.4.1 Affordability for different wealth groups in highland chat areas

##### **Better-off households (20-30 per cent of households)**

A common level of earnings for better-off households growing 20-30 rows of *chat* was about EB2,000 a year (10 per cent of the population). Other better-off *chat* farmers might earn between EB1,000 and 2,000. These households might also have one or two milk cows. The average household treatment costs for highland areas noted above (EB25-33) would be affordable for this group of households. They would have cash available to meet healthcare costs, and at other

times of the year would have assets to sell if cash were not available. However, the treatment costs of several illness episodes within a family, or more serious illness that required hospital admission, could still go beyond the household budgets of many of these farmers, particularly if serious illness incapacitated the main breadwinner (eg, *chat* or cereal farmer).

##### **“Middle” households (30-40 per cent of households)**

These farmers grow cereals and sweet potato, and may also own one or two goats, a milk cow or a donkey. They have lower incomes because they do not grow *chat*, but can earn additional cash from labouring on *chat* farms, and from petty trade or hiring out a donkey; the latter could earn EB5-10 a day. At post-harvest times in a good year these households might have the cash available to meet the median treatment costs noted above. However, in recent years of poor harvest these households have been in food deficit. In addition, during the kiremt or lean season of food and cash shortages they would not have enough cash after meeting food needs to cover additional treatment costs of EB20-30. They would have to borrow, or if this was not possible, sell one of their few important livestock assets such as a head of cattle or a donkey to finance treatment.

##### **Poor households (40-50 per cent of households)**

These households are the most vulnerable to sudden treatment costs that can easily go beyond their daily budget. The poorest households had no livestock assets and the most important source of income was casual labour. Daily wages range from EB7 to 12, so a labourer working for two

months in the year can earn EB400-650 a year. Poor households also rely on firewood sales as a coping strategy in the hungry season, which earn EB3 a bundle. Even in the limited months when daily labour is available, a treatment cost of EB5-10 would go beyond a daily labourer's budget for that day after food needs had been met. And for most of the year, particularly the kirempt season, these households have very little or no cash available to finance basic food needs (they rely on famine foods and relief food and experience food deficits), so any healthcare expenses would inevitably require borrowing. The FGD data in the next section (Section 5.3) also stress that the very poor find it difficult to borrow money, yet they have few or no assets to sell. Treatment costs incurred at public health facilities would therefore be beyond them.

#### 4.4.2 Affordability for different wealth groups in lowland areas

##### **Better-off households (20 per cent of households)**

Livestock and cash crops are key assets for this group and a typical household might grow 50 per cent of their own food needs, own two oxen, five to ten heads of cattle and several goats/sheep. Erratic rainfall in more recent years has reduced crop yields and forced livestock asset sales. At post-harvest times in a good year these households will have cash available to meet typical healthcare costs. At other times of year they would have to borrow or sell assets to finance treatment costs, particularly if the illness were more serious and required more costly hospital treatment. In bad harvest years when the household is already selling assets to meet food requirements, additional asset

sales to meet treatment costs may damage livelihoods.

##### **'Middle' households (30 per cent of households)**

Households in this group consume their own food crops and rely on daily labour, and firewood and livestock sales to earn cash to purchase food and other essential items. A typical household might own an ox, three or four heads of cattle and three to six goats/sheep, or a donkey. In Edo Belina (Alemaya) and Kurkura (Meta) they may also grow some *chat* for sale. Section 1 noted that this group has been under stress in recent years due to drought, selling assets to pay for essential food items. Declining yields have forced asset sales and a reliance on wild foods (famine foods) to supplement nutrient intake, and there is widespread concern that the "middle" are steadily becoming "poor". For most of the year these households have very little or no cash available to finance the median treatment costs described above. They have some livestock assets to sell if cash is needed, but this would be a hard decision and a risk to future livelihood and food security.

##### **Poor households (50 per cent of households)**

These households have a few small livestock assets to sell (hens, one or two goats) or no livestock assets at all. Over the past few years drought has caused impoverishment as families have sold off their last livestock assets to purchase grain. By far the most important source of income for the poorest households is casual labour, for which they might earn EB7-12 a day and work for two months, earning EB400-650 over the year. If additional cash is needed a common strategy for poor households in the hungry season is to sell

firewood for EB3 a bundle. A household would be lucky to sell more than two bundles a day. For most of the year these households have very little or no cash available to finance the typical treatment costs described above. For example, the lowest median household treatment costs were EB5 in Rako Barzala (Grawa) (see Figure 4.5), but for poor households in these areas even such “low” costs are either prohibitive or will necessitate “coping” of some sort. At times when work is available or firewood can be sold, health

expenditure of EB5 could make up 100 per cent or more of a household’s daily budget. They have few or no assets to sell to obtain cash, and would have to rely on borrowing or gifts from better-off households. Thus it is likely they would seek care from the cheapest sources.

The next section looks at how households managed costs if they did decide to seek treatment but lacked cash.

# 5 Ability to pay: cash availability, opportunity costs and coping

Evaluation of ability to pay for healthcare has so far looked at treatment-seeking behaviour and whether people are deterred, and the costs of illness. The conceptual framework outlined in Part 1 also argued that ability to pay relates to questions about the other aspects of the household economy. This section briefly examines these other aspects:

- cash availability to pay for treatment
- the opportunity costs of spending this available cash on treatment, as opposed to other essential food or non-food items
- the coping strategies adopted by households when they lack cash to pay for treatment
- the implications of illness costs and coping strategies for household budgets, debt levels, assets and other aspects of livelihood.

Data sources: FGDs; household survey

just to eat, such as borrowing from better-off households and selling firewood, livestock or their own labour (often promising to labour in the future).

The household survey was conducted in October/November at a time just before harvesting or when harvests had just started in cereal-producing areas. Many poor households in non-*chat* areas are likely to have faced cash shortages at this time.

Section 3 showed that of 331 people with a chronic illness, 69 (21 per cent) did not seek care, the vast majority (90 per cent) due to lack of cash. Of 514 people with an acute illness, 247 (48 per cent) did not seek care, most (69 per cent) due to a lack of cash. The individuals that did seek treatment are more likely to have come from households that had some cash available – otherwise they may have been deterred. Table 5.1 breaks down the people who sought treatment into those that did not incur costs, and those that did incur costs and either had cash available or not available.

## 5.1 Cash availability

Seasonality of cash flow was a key factor influencing ability to pay. In highland and lowland areas FGD participants stressed that the period called the *kiremt* from June to September was a time of severe difficulty, when people's food stocks have been depleted and the next crops are not ready for harvesting. Households classified as "poor" in each village, and some of the less poor or more average households, do not have money at this time and must adopt coping strategies

Of the 262 people that sought treatment for chronic illness, 148 (56.5 per cent) had cash available, although this spending may have had opportunity costs (see below). About a quarter of the people (23.3 per cent) that sought treatment for chronic illness did not have the cash available to cover the costs. For acute illness 51.7 per cent of people seeking treatment had the cash available, and about a fifth (20.4 per cent) that sought treatment for acute illness had no cash available.

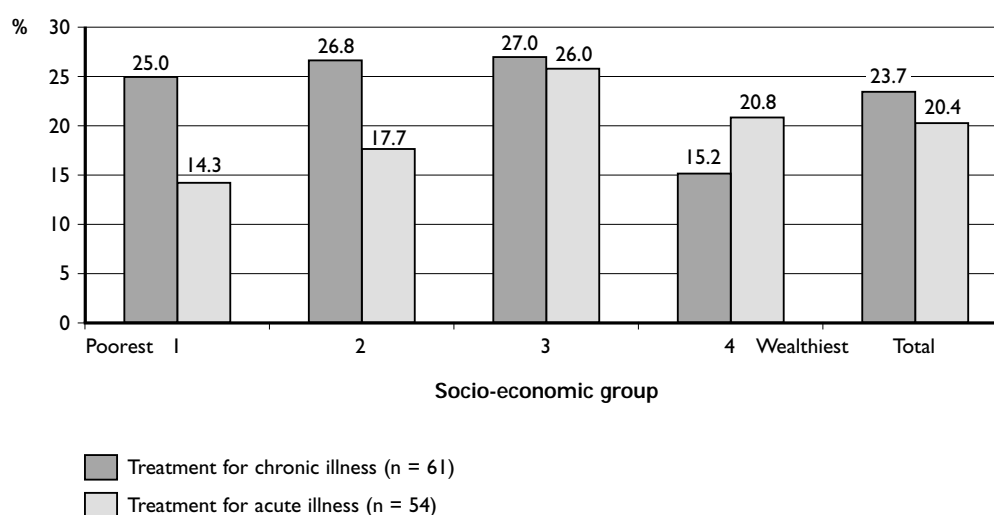
**Table 5.1: Cash availability among individuals that sought treatment**

	Chronic illness	Acute illness
No costs incurred	50 (19.1%)	72 (27.2%)
Costs incurred and cash available	148 (56.5%)	137 (51.7%)
Costs incurred but no cash available	61 (23.3%)	54 (20.4%)
No data	3 (1.1%)	2 (0.7%)
Total seeking treatment	262 (100.0%)	265 (100.0%)

People that sought treatment but had no cash available to pay for it were not disproportionately from the poorest asset groups. Figure 5.1 shows the proportion of people from each asset group that sought treatment and lacked the cash to pay for it. For treatment of acute illness, the poorest group had the lowest proportion of people facing cash shortages. For chronic illness, the poorest

group had lower levels of cash shortage than the two relatively wealthier groups above them. The third group faced cash shortages most frequently.

These counter-intuitive patterns reflect the fact that a higher proportion of people from poorer households did not seek treatment if they lacked cash. In contrast, people from wealthier

**Figure 5.1: Proportion of individuals seeking treatment with no money available to cover the costs of treatment**

households are more likely to seek treatment, despite having no cash available, because they can more easily borrow, draw on stronger social networks or sell assets to pay for treatment (see below).

Cash availability did not vary greatly by type of area (highland versus lowland). For treatment of chronic illness for example, 23 per cent of people seeking treatment in lowland areas lacked cash, compared to 24 per cent in highland areas. Again these counter-intuitive patterns reflect the fact that a higher proportion of people in lowland areas did not seek treatment at all if they lacked cash.

## 5.2 Opportunity costs of spending money on treatment

The money that people had available to pay for treatment was not necessarily planned for this purpose:

- Of 148 people who had cash available to pay for treatment of chronic illness, 112 (76 per cent) stated they had intended to spend the money on other essential items.
- Of 137 people who had cash available to pay for treatment of acute illness, 91 (66 per cent) stated they had intended to spend the money on other essential items.

The sacrifices or opportunity costs of health expenditure that respondents cited are summarised in Figure 5.2. Most stated that the money was intended for other basic necessities such as food, clothing, education and fuel.

## 5.3 Coping with the costs of illness: cost management strategies

A traditional system of social security in the study areas involves better-off households providing assistance to poor households through a variety of mechanisms when they require essential food or non-food items. An earlier study by Save the Children (Mathys 2000) identified a breakdown in these usual intra-community relationships between wealth groups, for example richer households less frequently sharing cash or food with poorer neighbours.

According to the FGDs, the main coping strategy available to the poor when they need money is to borrow from better-off households with a repayment plan. If children are critically sick, for example, parents will take a loan from better-off households to finance the treatment. If more money is needed or a loan cannot be taken, the next and more risky strategy is to sell livestock, or to borrow money in exchange for a standing crop. The most costly strategy reserved for more desperate situations is to rent out land or make a promise of future labour in return for a loan. From the discussions, relationships of bonded labour as a result of indebtedness appeared to be common and a heavy burden on poor households.

Group discussions in both areas revealed that better-off households would not lend to poor households that were not in a position to repay:

“Nobody lends to the very poor who have no hope of repaying, and the chances are they will die” (FGD in highland area).

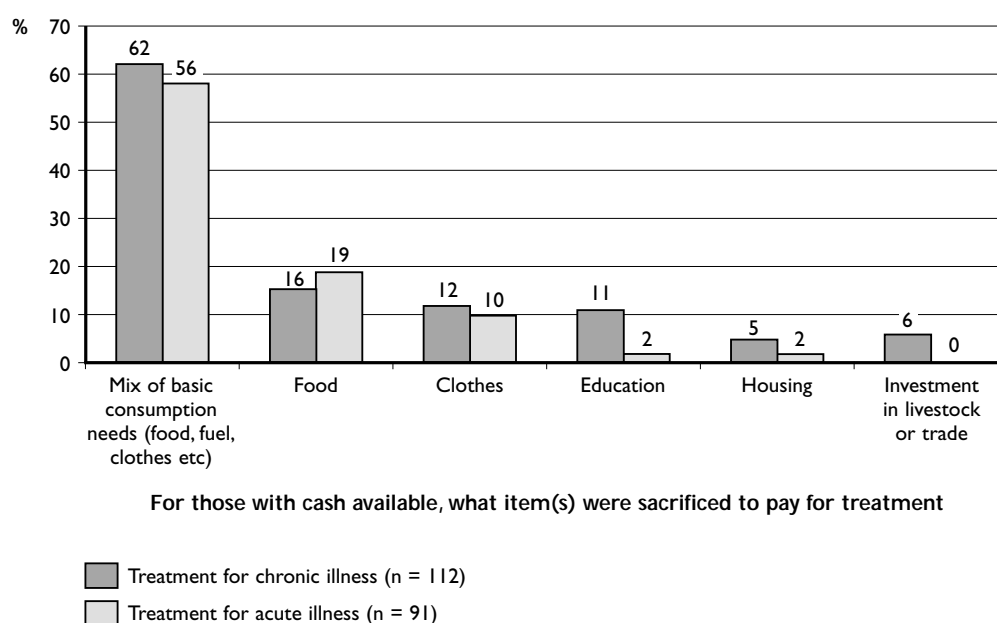


Figure 5.2: Spending on illness: what were the opportunity costs?

“The rich only provide loans if they feel the poor can repay the debt, for example if they can see they have a standing crop... The poor who have one or two donkeys can obtain a loan because the lender can see he will repay the debt by selling firewood that can be collected using the donkeys. Otherwise one cannot get loans” (FGD in lowland area).

Poor households without crops to be harvested or livestock assets could not get a loan. Estimates of the proportion of the population that might face difficulties in obtaining credit for treatment vary, but they are likely to be a significant minority of the population in the study sites, particularly in the marginal farming areas since livestock assets are depleted due to drought. For example, from food economy studies the very poor in the Kolla zone of Grawa who have no livestock and rely on

labour make up 10-20 per cent of the population (Mathys 2000: Section V:10).

Using the household survey data Figure 5.3 (overleaf) summarises the strategies that people adopted when they lacked money to pay for treatment. Borrowing with no interest from better-off households or neighbours was by far the most common strategy, followed by borrowing from family. Gifts from family or neighbours were also a common strategy used, although the nature of these gifts and the obligations generated by them were not clear.

The risks to livelihood associated with these borrowing strategies were not clear, but from the group discussions it was clear these loans were often given in return for a crop or for labour in the future, which could undermine future food

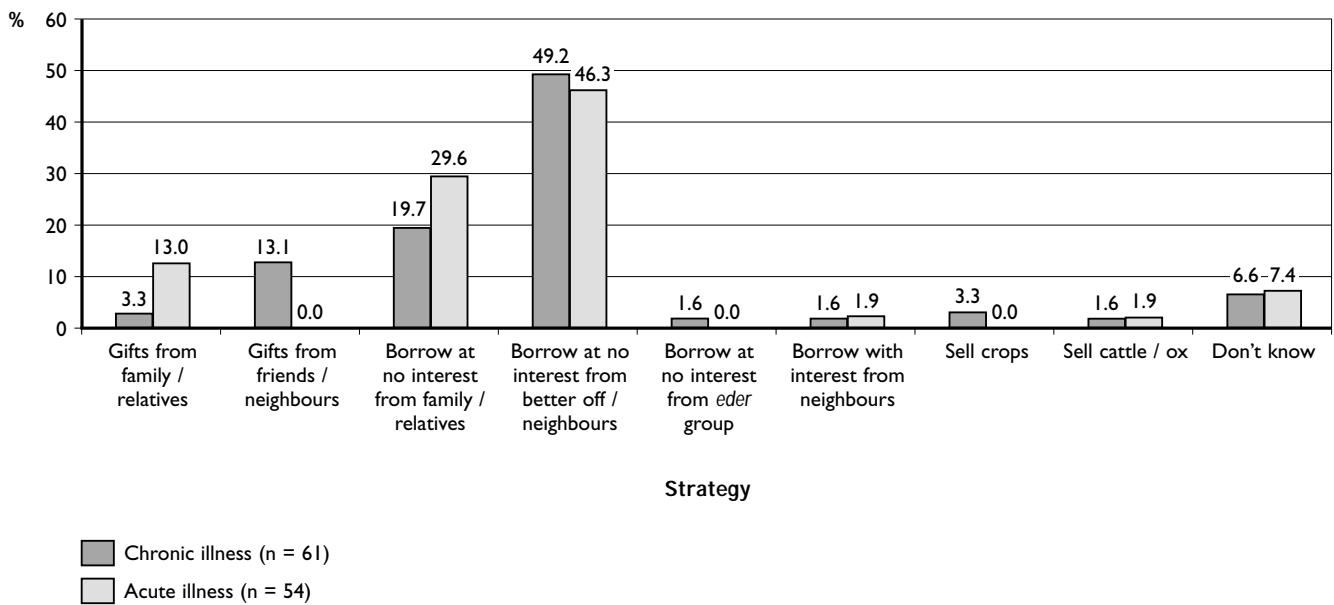


Figure 5.3: Household strategies to manage individuals' financial costs of illness

security or earnings. High-risk strategies such as livestock sales were also identified although they were less common. There were no differences in the types of coping strategy adopted by age, gender or the socio-economic status of the household.

#### 5.4 Implications of coping strategies

Table 5.2 summarises the implications that the aforementioned coping strategies had for household livelihoods. In about a quarter of cases there were no implications, but for the majority there were consequences, the most common being cuts in household consumption, and several respondents stressed these cuts were at a serious level, with people going hungry. Other common consequences were household concerns about

persistent indebtedness and livestock sales to pay debts. Implications categorised as “other” included selling crops such as chat or firewood at a low price and being forced to “wear torn clothes”.

#### 5.5 Summary of ability to pay problems

In Section 3 it was shown that of 331 people with a chronic illness 69 (21 per cent) did not seek care, usually due to lack of cash. Of the 262 people that did seek care:

- 112 (43 per cent) had cash available but had to sacrifice other essential consumption or investment to cover the financial costs of illness
- 61 (23 per cent) did not have cash available so had to adopt a cost management strategy, usually borrowing but in some cases asset sales

**Table 5.2: Implications of coping strategies adopted to finance treatment**

	Acute illness		Chronic illness	
	No.	%	No.	%
No implications	16	29.6	14	23.0
Concern about still being in debt	9	16.7	9	14.8
Cut household consumption to repay debt	10	18.5	17	27.9
Additional labour to repay debt	3	5.6	4	6.6
Forced to sell livestock to repay debt	6	11.1	7	11.5
Plan to sell livestock to repay debt	2	3.7	2	3.3
Other	8	14.8	8	13.1
Total	54	100.0	61	100.0

Note: all figures rounded up

- 47 (18 per cent) were in households that suffered wider livelihood problems due to these coping strategies.<sup>1</sup>

Of 514 people with an acute illness 247 (48 per cent) did not seek care. Of 265 people that did seek care:

- 91 (34 per cent) had cash available but had to sacrifice other essential consumption or investment to cover financial costs of illness
- 54 (20 per cent) did not have cash available so had to adopt a cost management strategy
- 38 (14 per cent) were in households that suffered wider livelihood problems due to these strategies.

The data presented so far show that a considerable minority of people do not seek treatment, and

those that do seek treatment incur costs that force them to cut spending on other basic needs or to adopt coping strategies that put them into debt or deplete their assets. The poorest were, in particular, less likely to seek treatment and were less able to cope with cost burdens because they could not obtain loans and had no assets to sell. These data suggest that large sections of the population require better geographical access to health facilities and more protection against the financial and time costs of treatment.

#### NOTE

<sup>1</sup> These problems include renting land to better-off households, migrating in search of additional labour opportunities, and slowly falling into destitution because of these coping strategies.

## 6 Protection against the high costs of illness: are government and community mechanisms working?

The previous analysis has shown that large sections of the population need protection against the financial costs of illness, including better drug availability at public facilities, and better geographical access to health facilities. Two mechanisms currently operating at facilities or in the community are fee exemptions for the poor, and the *eder* community organisation in each village that mobilises community labour or cash resources to help people in need, usually for weddings, funerals or when somebody is sick and needs to be carried to a health facility. This section briefly reviews these measures, in terms of:

- whether exemptions protect the poor from direct financial costs of illness (6.1)
- whether *eder* enable the poor to cope with illness and illness costs (6.2).

### 6.1 Exemption policy and practice

In the FGDs the consensus among informants was that exemptions were usually a worthless benefit because drugs were not available at the facilities anyway and you had to buy them from private pharmacies. The exemption paper only helped you to be registered free of charge, which was a small saving.

The majority stated that it was not difficult to obtain an exemption paper from the *kebele* leader, although several constraints were mentioned:

- *Kebele* officers only work in the *kebele* office two days a week so it is often difficult to get the paper on time, especially in an emergency
- Some people do not obtain an exemption paper because of the stigma of being labelled poor
- Health workers have a better attitude to a patient if they pay
- The main problem was said to be lack of awareness: people are not aware of the exemption benefit, their eligibility for it, or the fact that they can obtain it from the *kebele* office.

Some informants argued that there was no “leakage” of benefits to the non-poor, but others stated that the non-poor could also get access to an exemption paper if they wished. The main reason for this was that relatively asset-rich households might have no cash available at the time of an emergency and be unable to pay, so asked for an exemption paper with some justification. *Kebele* leaders might also consider some people to be eligible, despite coming from better-off households, because they have a long-term illness. Others also noted that corruption and favouritism could play a role, for example the better off might obtain a certificate through bribery (even small offers of *chat*, cigarettes etc).

Because the exemption papers were perceived to be relatively worthless, informants noted that people (who were aware of the policy) did not usually bother to obtain a paper from the *kebele* office. The survey data confirm this observation.

Of 110 people who sought treatment for chronic illness from a public facility, only six obtained an exemption:

- At **health stations** only one person out of 78 received an exemption: this person was from an asset-poor household, but 15 other individuals who sought treatment at a health station were from the poorest household group and did not get an exemption.
- At **health centres** three out of 16 people seeking treatment obtained an exemption: two of these people were from the poorest household group, and the other was from the second poorest group.
- At **hospitals** two out of 16 people obtained an exemption: this person was from the third household asset group (second wealthiest).

For acute illness, of 68 people who sought treatment at a government facility only three obtained an exemption:

- At health stations 50 people sought treatment but NONE obtained an exemption.
- At health centres 12 people sought treatment but NONE obtained an exemption.
- At hospitals three people sought treatment and one obtained an exemption; this person was from the poorest household category
- At the specialist malaria centre three people sought treatment and two obtained an exemption.

Exemptions for inpatient treatment at hospitals were also rare. Of the 54 people admitted for inpatient treatment in the previous year, 52 went to a public hospital and only five (9.6 per cent) obtained an exemption.

Data from the five health stations and three health centres surveyed suggest a moderately higher rate of exemption than that indicated from survey responses. At health stations 30-40 per cent of patients seen were classified as free patients. At Alemaya and Meta health centres the proportion of free patients was lower at 20 per cent and 25 per cent respectively, but in Grawa health centre free patients made up 75 per cent of total patients.

Lower exemption rates reported by the household survey may stem from the drug shortage problem. People may have stated they did not get an exemption because they did not receive free drugs and had to buy them from a private provider, even though they were classified as a free patient. Overall, until drug shortages at public facilities are overcome, exemptions cannot protect the poor from the largest cost burden they face when they are ill. And if drug availability was improved and the demand for exemption papers dramatically increased, a whole range of administrative capacities would have to be developed for targeting to be effective (see Section 7).

## 6.2 Eder (Afosha): a policy alternative?

*Kebele* leaders stated that the *eder* provides two important types of support or informal social security to those who are sick:

- transporting (often carrying) sick people to a health facility
- doing the farm work of people incapacitated due to illness.

However, *eder* do not provide savings facilities and do not collect and pool money that would provide a fund when people need money to finance their healthcare costs. One group stated there had been a plan to develop a scheme in which everybody contributed to a health fund (possibly EB2 per month) which would help to finance people's treatment costs, including transport costs, but this plan was dropped because:

- the number of ill people was steadily increasing and so the scheme was not financially possible
- villagers do not have regular income, and would find it difficult to contribute on a regular basis
- different people would have to contribute different amounts, depending on ability to pay, and this would be difficult to organise and sustain.

*Eder* associations provide important insurance against the costs of weddings and funerals, and labour-based support at times of illness. However, the research found that:

- there was no tradition of *eder* being used as a form of insurance against the direct costs of illness

- there were major obstacles to developing *eder* into a form of risk pooling or health insurance mechanism, including the large burden of illness falling on communities at the present time, poverty and people's inability to contribute, and a likely unwillingness for the better off to subsidise the poor through such schemes.

Thus although as an institution the *eder* offers the potential for expansion and development into a health insurance scheme, there are likely to be limits to the funds that can be raised for healthcare, and key questions of fund management and management capacity remain, both at the community level and for levels of government that would need to initiate and support these schemes. This is an area for future research (see Section 7).

The limits to exemption policy and the *eder* associations as mechanisms to protect the poor suggest alternative financing initiatives are required. These are discussed in the final section of the report below.

# 7 Conclusion and policy recommendations

The Ethiopian Government is committed to increasing public funding for health services and has partly met this commitment through increased resource allocations under the Health Sector Development Programme (1997-2002). The government, with donor support, is also committed to improving health service capacity and delivery under the HSDP. These commitments to improve health services are to be applauded. Nevertheless, despite increased public financing, absolute levels of funding remain extremely low (about US\$1.50 per capita) and public facilities face drug, staff and equipment shortages, low staff morale and poor maintenance.

More resources are clearly needed. The 1993 Health Policy listed various cost recovery measures that could be developed or strengthened. These involved risk pooling or insurance measures (public and private) as well as user fees. However, the government, with support from bilateral and multilateral donor agencies, is currently focusing on two strategies that represent a shift towards the privatisation of health financing policy in Ethiopia:

1. Deregulation of private sector provision to enable the private sector to act as a partner in health delivery and to encourage those who are able to pay to seek treatment from private providers. The main rationale is to reduce patient loads in public facilities, especially for outpatient treatment.
2. Increase cost recovery through user fees, notably the creation of SPs at public hospitals and health centres (see Part 1 Section 1.2). No action has been taken to strengthen user fee policy across the health sector as a whole.

For example, registration and laboratory test fees have not been increased, there have been no measures to improve billing and collection of these fees, and no measures to allow revenue retention at facilities or to strengthen exemption systems.

The fact that financing reform has focused on SPs indicates a strong emphasis on charging users directly. The evidence presented in this report shows that the prices charged by SPs will only be affordable for a minority of the population. The study was carried out in a limited geographical area of above average prosperity and the results are therefore likely to have a broader validity within Ethiopia.

## 7.1 The evidence: charging the user to recover costs is only suitable for a minority

International evidence on the impact of user fees in other parts of sub-Saharan Africa shows that user fees limit access and deter service utilisation (see Part 1 for details). The evidence presented in this report, complemented by other household livelihood research conducted by Save the Children, shows that the fee levels proposed for SPs would be beyond most households' budgets and would impose damaging cost burdens on the poor. Higher user fees for other aspects of health service provision (eg, registration, laboratory tests, inpatient fees) would also add to access barriers or impose damaging cost burdens, and would have to be supported by an effective exemption system for the poor and vulnerable groups. The evidence

supports the six broad justifications for concern about user fees that formed the rationale for the study (Part 1 Section 2.2):

### 1. Livelihood vulnerability and food insecurity

In the cash crop areas better-off households make up about 20-30 per cent of the population. It is this group for whom fees at SPs may be affordable, as long as cost burdens are not high due to serious illness, or regular due to chronic illness. However, for the rest of the population – about 70 per cent – livelihoods are seasonal and vulnerable, food security precarious, and cash availability limited to post-harvest times. Any financial contingency requiring cash would be beyond daily or monthly budgets except after harvest, and would inevitably require asset sales or borrowing which could further undermine livelihoods. “Middle” households (30-40 per cent of the population) lack cash and face food shortages for large parts of the year. Over the last few years variable rainfall and reduced yields have forced asset sales. Poor households (40-50 per cent) have no livestock assets and their most important source of cash is labour, with a daily wage of EB7-12 that can be earned over a two-month period. For most of the year these households are in food deficit and have very little or no cash to pay for non-food essentials. They would have to borrow (if possible) to obtain cash for any treatment.

In the more marginal agricultural areas, with greater rainfall variability, fewer cash crops are grown and greater vulnerability and food insecurity exists. These areas have been badly affected by drought and declining yields over recent years which have triggered asset sales

among all groups. Better-off households make up 20 per cent of the population and rely on cash crops and livestock, and would have cash available for healthcare costs only in post-harvest times, or assets to sell if they experienced a financial contingency. But again, about 80 per cent of the population would face difficulties in obtaining cash to meet treatment costs. “Middle” households (30 per cent) are steadily becoming poorer due to drought-induced asset sales: they have faced food deficits over recent years; have little or no cash available except at post-harvest times; and have few livestock assets to sell. Poor households (50 per cent) have few or no assets and are cash poor, dependent on their small-holdings and daily labour. They are in a situation of persistent food deficit, indicating they lack cash to purchase adequate food items and would certainly lack cash to cover treatment costs.

### 2. High burden of illness

In addition to poverty-related diseases there is an increased burden of disease resulting from the HIV/AIDS epidemic. This study recorded a high burden of illness across all households: 44 per cent had at least one member with a chronic illness; 62 per cent had a member with an acute illness in the previous two weeks; and 80 per cent had at least one member with either a chronic or an acute illness. Moreover, 38 per cent of households had to cope with at least two sick members in the previous two weeks.

### 3. Widespread access barriers and reluctance to use public facilities

The majority of people who were ill did not seek treatment at public facilities. Data from FGDs showed that for most illnesses people self-treated

with traditional medicine or first visited a traditional healer because they are close and relatively low cost compared to the cost of accessing public “modern” services.

Data from the household survey confirmed that only a minority sought treatment at public facilities: 33 per cent with chronic illness and 13 per cent with acute illness. The majority either did not seek treatment (21 per cent of those with chronic illness, 48 per cent of those with acute illness), self-treated with traditional medicine (20 per cent with chronic illness; 19 per cent with acute illness), or used private clinics (10 per cent; 7 per cent) and traditional providers (7 per cent; 3 per cent). Lack of money was the main factor deterring treatment. Among those not seeking treatment for chronic and acute illness, 90 per cent and 69 per cent respectively were deterred due to lack of money. These financial barriers were linked to drug shortages at public facilities, as people often had to purchase drugs from private pharmacies.

Financial barriers apply to a wide range of household types, due to the precarious livelihood situations that the poor and middle wealth groups currently face. These access barriers are particularly high for people in marginal areas because they are more distant from facilities, and for the asset poor because they lack resources to mobilise to meet basic food needs, let alone healthcare costs. In marginal areas, access barriers were particularly high for young women because they have moved away from their own home and often lack decision-making authority and/or access to cash.

4. People who do seek treatment incur high financial costs relative to wages and assets. The median household cost of all illness over a two-week period was EB19 (see Figure 4.4). Looking back at Figure 4.5, which shows the median cost of all treatment by area, households in the cash crop areas incurred median treatment costs in the range of EB25-33, and in the marginal areas these costs were lower, ranging from EB5 to 17.

Of the 365 households that sought treatment, the majority (n = 217 or 60 per cent) incurred direct costs of illness above EB10 (see Figure 4.7), which suggests high treatment costs relative to wages are an extensive problem and potentially damaging to household budgets. Moreover, a large minority (48 per cent) incurred costs above EB20, and 10 per cent of households had to cope with costs above EB100. Overall, over one-third of households in the whole survey (n = 217 or 34 per cent) incurred direct illness costs over EB10 in a two-week period, and 6 per cent (n = 38) incurred costs over EB100.

Spending on drugs was the main item of expenditure that caused high treatment costs. The direct cost of seeking “modern” treatment was particularly high because public health facilities often lacked drugs and people had to buy drugs from private pharmacies. This high level of spending on drugs – by the minority who decide to seek “modern” treatment – is likely to be interpreted in two different ways, leading to two different policy conclusions.

**Interpretation 1:** People are willing to pay for drugs, and are currently using their scarce cash

resources to buy drugs from the private sector. This is partly due to drug shortages in the public sector. A logical policy response is to channel money back into the public sector by charging users for drugs at public facilities, which will generate essential revenue to increase and sustain public drug supplies. Fees would benefit users because public facilities would charge less than the private sector and prescription practices would be better. If people are willing to pay, why not tap these resources to improve the public sector? The logic of this policy is clear and has been used by the World Bank as a key rationale for user fees since the 1980s. It is the main rationale currently driving the establishment of SPs in Ethiopia.

A second interpretation, outlined below, argues that this rationale must be viewed with extreme caution because: (a) the majority of households are unable to pay the fee levels charged at SPs; and (b) those that are willing to pay still face ability to pay problems in terms of the sacrifices made to other essential household consumption (eg, investment in education), and the damaging borrowing or asset strategies adopted to obtain money to pay for drugs. Willingness to pay does not necessarily reflect ability to pay.

5. Treatment costs can undermine the household economy and livelihood

**Interpretation 2:** In cash crop areas, better-off households (20-30 per cent) would have cash available to meet average household treatment costs (EB25-33), or assets to sell if cash were not available. However, the treatment costs of several illness episodes with a family, or more serious illness that required hospital admission, could still go beyond the household budgets of many of

these farmers, particularly if serious illness incapacitated the main breadwinner.

For the remaining 70-80 per cent of the population these average household treatment costs would go beyond household daily or weekly budgets for most of the year. 'middle' households might have this money available at post-harvest times in a good year, but in the *kiremt* or lean season of food and cash shortages these households do not have enough money to meet food needs and would not have additional cash to cover a basic fee for a course of antibiotics at about EB20-30. These costs would certainly be beyond the budgets of poor households that rely largely on daily labour that earns EB7-12 a day.

In marginal areas these patterns would be similar, but cash availability is even more limited. About 20 per cent of the population classified as better off would have cash available only at post-harvest times in a good year, and at other times of the year would have assets or could borrow money. However, for the majority of the population cash availability is limited and highly seasonal. For poor households even a "low" cost of EB5 would be prohibitive or necessitate some sort of coping strategy.

Some of the implications of these cost burdens were outlined in Section 5. Of the 262 people that sought treatment for a chronic illness, 112 (43 per cent) had cash available but had to sacrifice other essential consumption or investment (eg, education) to cover the financial costs, and 61 (23 per cent) did not have cash available so had to borrow money or sell assets. Of the 265 people that sought treatment for an

acute illness, 91 (34 per cent) had cash available but had to sacrifice other essential consumption or investment, and 54 (20 per cent) did not have cash available so had to borrow money or sell assets.

The above data show that over 50 per cent of people spending money on treatment either had to sacrifice other essential areas of spending (eg, children's education) or adopt risky coping strategies leading to indebtedness and asset depletion. This interpretation indicates that willingness to pay does not reflect ability to pay, and that user fees should be considered with far more caution.

#### 6. Existing exemption mechanisms do not protect the poor from high cost burdens

The logic of the first interpretation – that existing willingness to pay should be tapped by the public sector – is also founded on assumptions about supportive measures such as revenue retention, effective exemptions and organisational capacity to bill, collect and use revenue to improve quality (Gilson et al 1995; Mills et al 2001). The limited evidence from this report shows that the exemption system is weak or not working, and there is widespread anecdotal evidence to show that a system for effective exemptions is not in place. More research on exemption coverage and the factors influencing effectiveness is needed to inform policy-makers about ways to improve the system.

Evidence presented in this report also suggests that informal safety nets that the poor might rely on at times of illness and financial stress are under strain and cannot be relied upon. The very poor

cannot obtain loans from better-off households because they cannot guarantee repayments, and in general transfers between better-off and poorer sections of society appear to be on the decline. The traditional solidarity system of *eder* is an important source of financial support and labour inputs for weddings and funerals, and communal labour is offered at times of sickness. But, *eder* do not offer financial contributions to cover the costs of illness, and their capacity to do so appears to be limited. Even now there is anecdotal evidence that the *eder* system for funerals is being stretched due to an increased mortality burden, likely as a result of AIDS. More research is required on the potential for *eder* to be expanded into informal health insurance.

## 7.2 Policy debates and recommendations

The evidence presented in this report indicates that the majority of people are unable to pay high prices for drugs or other treatment. This has four broad policy implications.

#### The limits of Special Pharmacies

This report acknowledges that SPs have the potential to achieve certain health system objectives, but that there are limits to what they can achieve. SPs will generate additional resources and ensure a more reliable and sustainable supply of essential drugs at referral centres. The prices charged will be consistent, regulated and possibly slightly lower than private pharmacy charges, increasing the “relative affordability” of essential drugs for the minority of the population who already pay for drugs at

private pharmacies. Prescription practices at SPs are also likely to be better regulated than those at private pharmacies.

In theory, revenue from SPs can also be used to improve other aspects of health service quality, in particular staff motivation. Surplus transfers from the SP to the health facility, can provide more resources for the government budget pharmacy, equipment and diagnostic services. Moreover, SPs can be viewed as a first stage in a phased approach towards capacity-building for wider improvements to cost recovery policy. For example, a USAID review of the HCF Strategy claims that SPs are a good opportunity to test and practise the new concept of “health facility revenue”; and SPs will help to develop the systems and skills required for decentralised revenue management associated with cost recovery and other reforms. Finally, USAID argues that SPs will contribute to quality improvements, which are a necessary precondition for more widespread user fee increases across the system (ESHE/JSI 2000).

Despite these potential benefits, the limits of SPs with respect to the contribution they can make to health system objectives must also be stressed.

**Access and affordability:** The major objective of SPs is to improve the availability, accessibility and affordability of essential drugs (Walegn and Yusuf 2001). SPs are likely to increase drug availability, but under present arrangements will not contribute greatly to accessibility or affordability. The research presented in this report showed that only a minority of the population are willing to pay prices similar to those charged at SPs. The majority were unable to pay because

they had very low income, cash availability was highly seasonal, and for most of the year they lacked cash to meet basic food requirements. The majority did not seek treatment, self-treated using traditional medicine or visited traditional practitioners. Lack of money and distance were the main reasons given for not seeking treatment at public health facilities. Drugs sold at SPs may be slightly cheaper than those sold at private pharmacies, but this will not change the financial cost barriers for most households.

The research also showed that among those willing to pay for drugs, the majority were either forced to sacrifice other essential consumption items (eg, education) or had to borrow cash and sell assets to obtain money to pay for treatment. If a household experienced frequent acute illness (as those with several small children often do), or had to buy drugs on a regular basis due to chronic illness, these sacrifices would have to be long term and lead to permanent cuts in food consumption, clothing or education, indebtedness and asset depletion. Such “willingness to pay” cannot really be equated with ability to pay. Yet these economic implications for household livelihood are rarely addressed by willingness to pay statements about “out-of-pocket payments that can be tapped from the community”.

**Lack of exemptions:** By definition SPs are retail outlets and cannot grant exemptions or reduced prices for the poor. This begs the question: how can SPs achieve the objective of supplying essential drugs at affordable prices? The analysis of livelihoods in Part 2 (Sections 1 and 4) estimated that only 20-40 per cent (depending on the year and the season) of the population would have

cash available or the social networks and assets to mobilise cash in order to pay for essential drugs. Exemptions are necessary if drugs are to be affordable for a large section of the population.

**Geographical inequity:** SPs will improve drug availability at facilities in urban centres and cash-rich areas. But these benefits are unlikely to reach people in rural and more marginal areas who live great distances from health centres and hospitals, and there appears to be no system in place to improve drug supplies at health stations. Existing resource inequalities between richer and poorer areas are likely to increase with 100 per cent decentralised revenue retention. This last point is linked to a wider criticism of SPs, namely that they contribute to a parallel or two-tier health system – one for the better off where drugs are available, and one for the poor where drug shortages are the norm.

Donors have focused their efforts on SPs, possibly because they lie outside the national health system and the bureaucratic regulations that accompany it. Yet donors and government should place more emphasis on:

- increasing levels of public funding for health
- reducing user charges, particularly at lower levels of the health system, and investing more heavily in alternative sources of funding through a range of risk pooling and health insurance initiatives
- strengthening equity priorities within a national user fee policy.

**Continue to increase public funding for the health sector**

User fees were often the first financing reform to be implemented in many sub-Saharan African countries, often hurriedly and with little attention to design and implementation, because they appeared to be a relatively quick and easy remedy. Evidence shows that policy-makers need to be cautious and realistic about the contribution that fees can make to the health sector, and that the government and donor agencies need to remain committed to increased public funding for health.

The WHO's Commission on Macroeconomics and Health argues that developing countries need to spend US\$30-40 per capita on health in order to provide basic health services. To meet this target, the Ethiopian Government would have to spend 100-133 per cent of its total budget on health.<sup>1</sup> The government could likely increase the share of the budget it spends on health,<sup>2</sup> but certainly not to the levels recommended by the WHO. These figures show the poverty of the Ethiopian Government and the drastic need for additional external resources. The Poverty Reduction Strategy Paper currently under development will only lead to a marginal increase in health sector investment and the feasibility of increased user fees are limited. Hard choices will have to be made, both by the donor community and the government.

**Invest more heavily in developing capacity for health insurance**

Government and donor agencies should invest more heavily in developing alternative sources of funding through a range of risk pooling and health insurance initiatives. To date, very little has

been done regarding health insurance in Ethiopia and the private sector sees very little opportunity in this sector (ESHE/JSI 2000). While the Essential Services for Health in Ethiopia (ESHE) project has started by surveying existing health insurance schemes in the country, further study and possibly pilot schemes should be given high priority. Particularly, the feasibility of community health insurance schemes, possible linked to *eders*, should be examined.

Risk pooling and health insurance initiatives could extend coverage at low cost to individuals, and enable people from different income groups to use the same health services. It must, however, be realised that the gap between economic possibilities and even the most basic minimum health package remains enormous.

**Strengthen equity priorities within a national user fee policy**

The previous points advocate that SPs and wider user fee policies must be viewed as small components of a wider health sector financing strategy. Nevertheless, user fees are an established source of additional funding for facilities and health managers. Given this reality on the ground, user fees are likely to be sustained, but the strengthening of policy should focus on making fees more equitable or pro-poor.

For user fees to be strengthened equitably across health facilities, various other public sector reforms and investments in capacity are required *before* fees are introduced, for example with respect to decentralised revenue retention, billing and collection systems, revenue management,

service quality improvements and an effective exemption system. Donor support will be crucial to realising these improvements in capacity.

The main focus for more equitable user fees should lie with the exemption system, or a system of differential charging. The key question is how to target benefits effectively (ie, reaching the target group and preventing leakage to the non-eligible). Targeting in Ethiopia is currently done using an income threshold, but this type of targeting is notoriously difficult to implement in practice, especially in contexts where many people's livelihoods are semi-subsistence and their incomes are highly seasonal. Information on income levels is virtually non-existent.

An alternative way forward is to target exemptions by using more identifiable characteristics, for example:

- **Health service level:** no fees to be charged at health stations
- **Age, gender or type of illness:** for example exemptions for children, pregnant women, people with chronic illness or children with common serious acute illnesses
- **Geographical or agricultural zone:** no fees or lower fees to be charged at health stations located in marginal livelihood areas, for example in the lowland areas of East Hararghe where both willingness and ability to pay were lower than in the cash crop areas
- **Season:** lower prices during the *kiremt* or lean season.

These exemption mechanisms are relatively easy to implement but policy-makers may reject them

because they do not precisely distinguish between individuals who are able and unable to pay. Rather they target population groups.

A second alternative is to use ability to pay as the targeting criterion, but to use livelihood groups rather than income categories, as this report did when assessing ability to pay and the potential burden of treatment costs. This would involve a relatively simple methodology similar to Save the Children's Household Economy Approach:

- In each *woreda*, identify different types of food economy or agricultural zone (for example highland *chat* growing; cereal growing; lowland semi-pastoral etc).
- In each food economy zone, Department of Health officials could work with PA or *kebele* leaders to identify different livelihood or wealth groups, focusing on key variables such as assets, food sources and levels of food deficit, and cash availability for non-food essentials.
- Attention to detail and differentiation would enable several livelihood groups to be identified, possibly more than just poor, middle and better off.
- Different types of health card could then be distributed to members of different wealth groups, for example: for the poorest an exemption card that can be used for the whole year; for vulnerable groups "above" the poorest an exemption card that can be used during the lean season.

This system has several targeting advantages. Firstly, the method is established and already used by agencies to target food relief. Second, it uses

local knowledge essential for describing people's complex livelihoods, but Department of Health officials would also be present during the process of wealth categorisation and help make decisions about which groups to exempt and the distribution of the cards. Thirdly, it identifies groups of vulnerable people so does not incur the cost of targeting through means testing each individual. Fourthly, it can use a combination of identifiable criteria to target health cards: for example livelihood group, food economy zone and season. An example would be an exemption card for the 'middle' livelihood group in the marginal food economy zone during the lean season.

Clearly this is a long-term project that would require research, awareness-building, piloting and support across government. And because a large proportion of the population is likely to receive an exemption, particularly in rural and more marginal food economy zones, cost recovery would be limited and uneven geographically. This is why continued public funding and alternative insurance mechanisms remain critical.

### 7.3 Research priorities

The above policy debates indicate the need for more research in the following areas:

- Household level: the costs and sacrifices (eg, children's education) incurred when seeking healthcare, across seasons, and the impact of illness costs on debt levels, assets and food security. This should include the question of gender differences in households.

- Cost recovery practice: evaluation of SPs, focusing on the characteristics of users (socio-economic status, type of illness, residence), and the equity impact of SPs, and ability to pay studies in the community.
- Exemption systems and practice: effectiveness of existing system and factors influencing effectiveness; the feasibility of targeting exemptions based on livelihood groups through a Household Economy Approach and community-based targeting.
- To identify risk-sharing alternatives for poor and vulnerable groups: for example the feasibility of developing *eder afosha* capacity to perform health insurance or pre-payment roles.

#### NOTES

1 Total government expenditure on health for 2000/01 was EB794.2 million or US\$94m (World Bank 2001).

2 Health accounted for 5.2% of total government expenditure in 2000/01, compared to 21% for the military (World Bank 2001).

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