# Assessment of the Free Health Care Provision System in Northern Ethiopia

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**Assessment of the free health care provision system in Northern Ethiopia**

By

Endale Engida, MD

**Department of Community Health**
Faculty of Medicine, Addis Ababa University

Approved by the Examining Board

Dr. Yemane Berhane _____

Chairman, Department Graduate Committee

Dr. Damen Haile Mariam _____

Advisor

Prof. Mohsen Gadallah _____

Examiner

Dr. Ahmed Ali _____

Examiner

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## Abstract

Exemptions from user charges have proven to be very hard to implement in those countries that have adopted them. Poor screening mechanisms have been the main reason for the difficulty of identifying those patients who are able to pay for granting free care services from those that don't have the ability.

This is a result of a cross sectional descriptive study that compared the characteristics of free patients with those paying at the analysis stage in the northern part of Ethiopia. In addition, it has assessed the presence and extent of under coverage and leakage in the provision of free health services. The study utilized a multistage sampling method for the household survey and systematic random sampling for exit interview. In addition, kebele free treatment letter writers, and health institution administrators were purposively selected to fulfil the study objectives.

According to the results of the study, provision of free health care represented for more than half (52.4%) of government health expenditure in the area. Even though the problem of under coverage and leakage was not very high, there was no statistical significant association between low income and getting free care in rural public health institutions. Proper registration of free treatment provision seemed to be the most important mechanism for the system to function efficiently. Even though most health institutions have registration books for recording free treatment, they were not properly using them.

As Ethiopia is one of the countries that attempts to ensure access to health care by the poor, the results of this study will help to have better understanding of the issues regarding the proper implementation of waiver and exemption mechanisms.

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## Introduction

A tradition of free public provision of health services has existed in many developing countries [1]. However, a combination of demographic and cultural factors has left important gaps between the demand for and the supply of such services. As a consequence, many peripheral health facilities operate without basic medical supplies and most of the people could hardly use them though services are available free of charge [2].

During the period of market oriented reforms in 1980s and early 1990s, the debate in developing countries whether these reforms should be implemented in the health sector centered on three issues.

1) The extent to which the reforms could improve efficiency in the public health sector.
2) The extent to which they could alleviate the severe budgetary constraints at government health facilities; and,
3) Their probable impact on equity in the utilization of medical care [3].

The argument for instituting user charges in public health facilities was based on two assumptions:

a) the revenue from user charges would be used to improve service quality and that improvement would have a positive effect on health service demand.
b) households that are unable to afford health services at prevailing user fees would be exempted from the payment of fees since revenue generated from charging those able to pay would be used for such cross-subsidy [3].

Introduction of user charges in developing countries, especially in sub-Saharan Africa, in the late 1980's and early 1990's revealed that not all the above assumptions were successful. Specifically, the number of visits to government health facilities in some countries fell substantially despite a modest increase in the level of fees.

In addition, quality improvements in government facilities generally did not materialize as anticipated [3]. Furthermore, implementing user charge programs has proven to be very hard because of difficulties in identifying those patients who are able to pay from those unable to pay. Poor screening mechanisms have been the main reasons for this difficulty. This undoubtedly led to the problem of leakage and under coverage as seen in most of the developing countries [3].

Besides instituting user charges, various other methods were explored to ensure the provision of reasonable level of care without jeopardizing equity and efficiency. Some of the options taken in this regard include: the implementation of health insurance, the rational use of donor resources, enhancing the involvement of the private sector and NGOs in the provision and financing of health care, raising of taxes, and the efficient utilization of public resources [5,6].

Ethiopia is one of the countries that provide free health services to those unable to pay. The criterion to grant free health care services is mainly based on the direct monthly income of the individual and this criterion has changed from time to time [7]. In 1967, for example, the principle of universal free medical service for all Ethiopians whose monthly income is less than 50 Birr per month was established and this was revised and changed to 105 Birr per month to get the privilege of free health care in 1977 [7]. There was a proclamation on how this rule should be practised at the kebele [farmer association] levels. This proclamation which was made in 1981 states that "The kebele urban dweller's association may examine in detail the means of livelihoods of any person who submits any application to get any kind of free service in court or government offices and grant

certificate there to" [8].

However, there are no formal assessments up to now whether the free care provision system is operating efficiently or not. There are circumstantial evidences that it is usually abused by the urban elites who are able to pay while most people in the rural areas might not even be aware of the existence of the system. Therefore, it is proper that a study should assess the situation to help to have better understanding of the issues and the experience of the waiver and exemption system in the country.

This particular study was undertaken in northern part of the country and was aimed at answering the following questions:

- Is the free health care system really providing the services for those who couldn't pay?
- Does the system adequately protect those patients who cannot pay?
- How should the free care services provision be re-organized so that it will not adversely affect the public health system's cost recovery potential?

## Literature Review

## Major theoretical argument for user fees in health care services:

The main arguments for user fees are that these fees, if applied properly, could increase resources available to the health sector, permit increased spending on under-funded programs, encourage better quality and more efficiency, and increase access for the poor to basic health services by increasing amount of money available for subsidy [6].

User charges are also said to generate greater allocative efficiency and to create a sense of "ownership" which will lead to greater responsibility on the part of the users and more accountability on the part of the providers [9]. All these factors, it has been argued, will ultimately contribute to better access for all, and hence to greater equity.

Although the case in favour of collecting contribution from users has been made powerfully, some equally powerful criticisms have been raised against it. In particular the possible adverse impact of user financing on access to services, especially of the poor, has been highlighted [6].

The result of these concerns have been the development of various mechanisms, such as waiver and exemption systems, aimed at protecting the poor from the full impact of such users fees.

These systems are designed to ensure that cost recovery efforts do not create serious financial or opportunity cost barriers for the poor or other groups with illnesses that deserve exemption, which would unduly reduce their access to care [1,5,10].

## Empirical evidence on user fee and free health care services:

Access to and utilization of health services is inequitable throughout the developing world and these inequalities are particularly glaring in sub-Saharan Africa [9]. About half of sub-Saharan Africa population does not have regular access to modern medical facilities and 30-80% of government health expenditure are absorbed by urban-based hospital care in different countries[9]. For example, Newbrander in his Kenyan study, reported that there was a greater propensity for the poor in urban areas to seek care than those poor in rural areas. This may be due to the fact that the urban areas have more facilities and the facilities are closer to the sick person's home than the rural areas [2].

Studies on health care utilization in different developing countries showed that, the demand for and use of health services are initiated by perceived morbidity and further affected by factors such as distance to the nearest health care unit [11,12,13] the cost and organization of the health services [11,14,15,16]. Similarly a study in Tanzania indicated that 36% did not go for a health service because of lack of money, 20% did not go because of distance to a health care facility or in convenience [10]. And a case study in Kenya (1995) indicated that finance was the reason for 60% of the respondents seeking alternatives [2].

Moreover, a study on utilization of selected hospital, health center and health stations in central, in southern and western Ethiopia (1990) showed that nearness, good services and free treatment are the three major categories responded by patients as reasons for seeking care[17].

Other Tanzanian study indicated that 69% of all respondents stated they knew someone who couldn't go for care because they could not pay and among this group, 78% were poor. In addition to inability to pay, nearly half (49%) of the respondents stated that there were other access barriers such as distance, waiting time and quality of care, which prevented someone they knew from seeking care [10].

Grosh suggested that public health systems can have positive effect on equity if the poor have access to public care and the better of population uses alternative sources of private care on a large scale [9]. However, in most developing countries, the well offs still consume a disproportionately large share of public health services. In Indonesia in 1990, only 12% of public spending for health was for services consumed by the poorest 20% of households while the wealthiest 20% consumed 29% of the government subsidy in the health sector [9].

Moreover, an earlier study in central Ethiopia found no significant difference between the income levels of paying patients and those who got their services for free [18].

According to a study by Kloos in central, southern and western Ethiopia, awareness of the availability of free treatment privileges has been found to be greater among the educated and the non-poor rather than the poor [19]. Likewise, a Kenyan case study in 1995 reported that urban residents appeared to be more aware of waivers [2]. Similarly, in a Tanzanian case study in 1996, more people knew about an overall exemption policy than waivers and more of those who knew were non-poor [10].

Studies on the effectiveness of exemption policy generally indicate the difficulty of controlling under coverage and leakage. In 1991, Brian Abel Smith reported that, at least three countries (Costa Rica, the Republic of Korea and Thailand) operate systems by which poor people can apply annually for a certificate or card which entitles them to free health care. However, none of them have succeeded in identifying all the poor [19]. A system of investigation in Thailand for example, has shown that the cards are issued to 14-20 % of the population but that only 60% of card-holders were really poor [19]. Moreover, study results of countries' experience with targeting mechanisms found out that minimizing under coverage is poorly handled than preventing leakage [20].

Based on the feasibility study of community-based health Insurance in Ethiopia (1998), there was no difficulty to obtain a free certificate, though the process is time consuming, and the paper needs to be renewed every six months [23]. On the other hand, it is not uncommon for the free paper to be obtained under false pretences, and individuals who can afford to pay are also exempted [21].

Overall, targeted interventions (waiver and exemption) in developing countries have been compromised by a variety of difficulties, including excessive leakage, subjective exemption criteria, informal identification and verification procedures and excessive costs where limitation in institutional and administrative capacity underlie each of these problems [9].

Therefore, there is a need for a thorough groundwork for establishing fee for service systems that would also effectively protect the poor from the effects of service charges. In the absence of improved quality of care, user fees generally have negative effect on equity. If the revenue generated from the fees retained and used by the charging facilities and if quality of care improved as the results, fees can be progressive under the right circumstances. Here, policy for protecting the poor is clearly necessary in the context of widespread user fees for health services.

Thus this particular study is aimed at assessing the practice of providing free care in the Northern part of Ethiopia to come up with recommendation that might be of interest at policy level.

# Objectives

## General Objective:

- To assess and describe the pattern of free health care system at the government health facilities in Northern Ethiopia.

## Specific Objectives

- To review the guidelines for free health care provision at the policy and administrative levels.
- To assess the application of the guidelines at the kebele and health facility levels.
- To describe the magnitude and pattern of free health care provision.
- To assess the perception of the community about free health care services.
- To compare the socio-economic status of those getting free care with those paying.

# Methodology

## 1) Study Design

This is a cross sectional descriptive study which compares the characteristics of free patients with those paying at the analysis stage.

## 2) Study Area

The study was carried out between the months of May and July 1999 in the urban and rural areas of Bahir-Dar Town and Bahir-Dar Zuria Wereda respectively. The area is located at $11^0$ 35'N latitude and $37^0$23'E longitude and is bounded by: South Gonder in the east, Lake Tana in the north and other parts of West Gojam in the west.

The projected population of Bahir-dar, and Bahir-dar Zuria Wereda in 1998 were 112,009 and 178,468 respectively[22]. The town is divided into two Weredas and 17 kebeles while Bahir-dar Zuria Wereda has 38 farmer Associations.

The town has one hospital, one health center, one health station and a total of 21 private clinics (one special, one higher, six middle and 13 lower private clinics). There are five health stations and six health posts in the zuria wereda. Using a 10 km radius geographic accessibility, health services coverage of the town is estimated to be 100%. The health services coverage of the zuria Wereda is very low since most of the farmer associations are beyond 10 km radius of the conventional health institutions.

## 3. Study Population

Both urban and rural population of Bahir-dar Town and Bahir-dar Zuria Wereda were included as the study population.

The study subjects included: heads of households for the household survey, health services utilizers for the exit interview. Kebele free treatment paper writers for self administered questionniare and health institutions' administrators for indepth interviews were also included as the study subjects.

The division of interviewees into the discrete categories of poor and non poor was based on the definition of the Negarit Gazeta Proclamation number 4/85, article 10, subarticle 9, 1977[9], which considers those whose monthly income is less than or equal to 105 Birr as poor for urban areas, for the purpose of granting the privilege of getting free health services. In the case of those who live in rural areas, even though policy at the national level could not be found, those who have no ox are considered as poor and can get the free treatment privilege. This is according to the local community practice of granting free treatment certificate in the area.

## 4. Instrument Design

Questionnaire design relied on a thorough review of the related literature and survey instruments used for similar studies. The interview questionnaire was prepared in English and translated to Amharic. The format of the questionnaires was both closed and open-ended.

## 5. Interviewer Selection

The type of questions asked during the interview, particularly those concerning household income were sensitive and people are more comfortable discussing sensitive issues with people with whom they feel more of the same standard. For this reason, a team consisting of ten 12$^{th}$ grade students who have lived in their respective communities since their childhood were used as interviewers. These data collectors were trained for five consecutive days before conducting the pre-test.

## 6. Ethical Considerations

Data collection was performed after getting informed consent from patients, heads of households, health institution administrators and kebele free treatment paper writers. Every attempt was also made to conduct the interviews with privacy.

## 7. Pre-test

The questionnaire was pre-tested 30 households in two kebeles and 30 patients in three private clinics in the study area. This was done to determine the knowledge and skills of the interviewers and to find out whether each item of the questionnaire was understood by the respondents. The information obtained was used in redesigning the contents and retraining was given to the interviewers to ensure their proper administration after the pre-test.

## 8. Sampling and Data collection methods

### *8.1 Health Facility Information*

One hospital, a health center, three health stations were sampled in the study area for both quantitative and qualitative data collection. The reports and records of these institutions were reviewed and in-depth interviews with the proper officials were conducted on the issues related to the study.

Quantitative data were obtained by examining records of the health facilities, where available, to determine how many waivers and exemptions were granted and whether there is proper recording system for those who have got the waiver.

Qualitative information was obtained to supplement the quantitative data for which in-depth interviews with health institution administrators were held at each health facility.

The information gathered during the interviews included: the types of services provided, policy and procedure for granting waivers and exemptions, and the type of system in place for granting the waivers and exemption.

### *8.2 Patient Exit Interview Survey*

Exit interviews were made with 210 respondents. Using systematic sampling method, every fifth patient was included in the survey by following the card number of OPD visits during the 2 weeks period of data collection. As much as possible, efforts were made to interview every patient with privacy.

The exit interviews helped to substantiate how the system worked in practice and to assess the satisfaction of patients with the quality of services provided. It was also helpful to identify the socio-economic characteristics of patients attending the facilities.

### *8.3 Kebele (Village) level information*

There are two free treatment paper writers in each kebele, purposively all (two) free treatment paper writers from each selected kebele (village) and farmer associations that were included in the household survey were given the self administered questionnaires.

This was helpful to identify how the system for free treatment privilege operates and what types of screening mechanisms are used for providing the free treatment paper.

### *8.4 Household Surveys*

Sample size determination for household survey

$$n = \frac{Z_{\alpha/2}^2 * P(1-P)}{d^2}$$

$$\mathbf{n = 323}$$

Where:

P = the prevalence of free health care provision in the area (70%).

d = Marginal error between the sample and the population (5%).

$Z_{\alpha/2}$ = Critical value at 95% certainty (1.96)

n = The estimated minimum sample size

Multistage sampling method was used to get the study subjects (head of households). Here, the selection of the primary sampling units were, the selection of the kebeles for urban and the selection of farmer associations for the rural study area. Out of 17 kebeles of the urban and 38 farmer associations of the rural, five kebeles and five farmer associations were selected randomly using a lottery method.

The selection of the secondary sampling units was, the selection of the households. Using house numbers for the town and lists of heads of households for the rural study area, as a sampling frame, households were selected randomly using a table of random number, based on which 32 households were included as the study subjects from each selected kebeles.

Since the farmer associations are widely dispersed and due to resource constraints equal sample size were used for both urban and rural study areas.

Data from this level provided information about how the free service system was perceived and utilized by the community, and whether there were people who don't know about the existence and the mode of operation of the privilege.

## 9. Survey Procedure

The heads of the households were considered the best person to address, in cases where the head of the household or other responsible adult were not at home, interviewers were instructed to return at least three times to that particular household. If the house was empty after three attempts, the house immediate left of the predetermined one was included. If the alternative house was also empty, the interviewer was told to drop that interview.

The principal investigator reviewed every questionnaire for proper compilation and logical consistency before leaving each study area.

## 10. Data Analysis

The data was entered and processed using EPI-INFO Version 6 statistical package. After organizing and cleaning the data, frequencies and percentages were calculated on all variables that are related to the objectives of the study. Multivariate analysis was done by logistic regression model using STATA software to compare and see the effects of confounding factors on paying and free patients.

## 11. Definition of Key terms

Poor:- Those individuals whose monthly income is < 105 Birr/month for urban and those individuals who have no ox for rural.

**Waiver**:- Discretionary release from payment based up on inability to pay or income levels.

**Exemption:-** Provision of free or reduced priced benefits to people with certain attributes, regardless of income level which is aimed at ensuring they seek such services. e.g., immunization program.

**Under coverage** is where the poor do not receive the intended benefit because they are either erroneously categorized as non-poor or they must still pay the fee despite their waiver.

**Leakage**:- is where the non-poor receive benefit intended for the poor. Here the non-poor receive the designation of poor, though they are not, which allows them to receive the services at no or a reduced charge though the person has the ability to pay for the services.

**Cost recovery**:- Contributions to costs by users, in cash rather than in kind or labour, that can be made on an individual basis or by a group of users, and are not necessarily per unit of service delivered.

**User fees**:- Contributions to costs by individual users in the form of a charge per unit of service consumed, typically in the form of cash.

# Results

## I. Experience with targeting mechanism at the kebele (Farmer association) level:

Of those five urban kebeles and five farmer associations, a total of 20 free treatment paper writers (two from each kebele) were involved for the self-administered questionnaire. All respondents said that the free certificate was written by the committee and the guidelines to determine eligibility were: -

One has to be a resident of the kebele or farmers' association

One has to have a monthly income of 105 Birr or less in urban kebeles or should have no ox for rural kebeles.

This information will be verified by three individual witnesses. Except for one farmer association, all the rest said that the free paper had to be renewed every three months.

All the free certificate writers from the town and one of the farmer associations utilized special registration book to keep records on waivers granted. Those free certificate writers from rural kebeles which have no special registration books to grant the waiver could not answer properly the number of waivers granted.

All respondents claimed to have faced no problem in the process of free paper provision and all denied the presence of leakage and under coverage.

## II. Experiences with Targeting Mechanisms at Health Facilities Level

Out of the total patients seen in Felegehiwot Hospital in 1998, 66% were free patient, but the number of patients which received free services in the year 1998 in Bahir-dar Health Center and the three health stations were not documented.

All government health facilities which were included in the study exempted the poor from fees, based on free treatment papers brought. A free treatment certificate is considered valid only for three months.

Even though all health institutions have special registration books for those free patients, the pattern of documenting was poor. This was specially true for the health centers and health stations. This was said to be because of the lack of manpower to record such patients. Except the hospital administrator, all the others (health center and health station administrators) denied the presence of leakage and under-coverage.

Emergency cases and people who do not have permanent residency in the area were reasons mentioned by the hospital administrator for leakage/under-coverage.

All government health facilities included in the study have certain types of patients or services that are automatically exempted from fees. These include tuberculosis, leprosy, family planning, and antenatal care. In addition, health workers were exempted from paying fees.

Eligibility for automatic exemption from fees for these services is determined at the health institutions and does not require any formal process. In the hospital and the health center, someone requesting an exemption due to an illness will pay the required fees until an investigation or test results confirm that the illness is one that deserves exemption.

All the health facility administrators claimed that, even though information on waivers and exemptions is provided by health facility staff, most of the patients have learned about the benefit from relatives and friends.

## III. Findings from patient exit interviews:

The study subjects for exit interviews (n=210) consisted of 95 (45%) male and 115 (55%) females. The ages of the study subjects ranged from 15-85 years. (Table 1). Most of the respondents (40.1%) were in the age group of 25-34 years. The educational status of the study subjects were 47.6% illiterate and 52.4% were literate. Out of the total 210 respondents 67(42%) of them in urban area and 18(35%) of those in rural areas were considered to be poor.

Out of the 210 respondents in government health institution, 60 were from the two selected health stations from rural areas, and samples of 77, 44 and 29 patients were selected from Bahir-dar Hospital, health center and health station, respectively.

Table 1 Socioeconomic characteristics of exit respondents, Bahir-dar Town and Bahir-dar Zuria woreda, Northern Ethiopia, 1999(n=210).

| Variable | n (%) of urban | n (%) of rural | rural & urban |
|---|---|---|---|
| Age categories | | | |
| 15-24 | 40 (26.6%) | 13 (21.7%) | 53 (25.3%) |
| 25-34 | 61 (40.6%) | 23 (38.3%) | 84 (40.1%) |
| 35-44 | 25 (16.6%) | 8 (13.3%) | 33 (15.9%) |
| 45-54 | 19 (12.6%) | 11 (18.3%) | 30 (14.4%) |
| ≥55 | 5 (3.3%) | 5 (8.4%) | 10 (4.9%) |
| Sex | | | |
| male | 75 (50%) | 20 (33.3%) | 95 (45.2%) |
| female | 75 (50%) | 40 (66.7%) | 115 (54.8%) |
| Occupation | | | |
| Gov.employee | 15 (10%) | 1 (1.7%) | 16 (7.6%) |
| Student | 19 (12.6%) | ----- | ------- |
| Merchant | 7 (4.6%) | ----- | ----- - |
| daily laborer | 4 (2.6%) | ----- | ------ |
| housewife | 39 (26%) | 17(28.3%) | 56 (26.7%) |
| farmer | 32 (21.3%) | 22 (36.7%) | 54 (25.7%) |
| other | 34 (22.6%) | 20 (33.4%) | 54 (25.7%) |
| Educational status | | | |
| illiterate | 67 (44.6%) | 33 (55%) | 100 (47.6%) |
| literate | 83 (55.3%) | 27(49%) | 110 (52.4%) |
| Family size | | | |
| ≤5 | 98 (65.3%) | 41 (68.3%) | 139 (66.5%) |
| >5 | 51 (34%) | 19 (31.7%) | 71 (33.5%) |
| Urban income | | | |
| ≤105 Birr | 52 (34.6%) | 15 (34.9%) | 67(42.1%) |
| >105 Birr | 64 (42.6%) | 28 (65.1%) | 143 (57.9%) |
| Rural income | | | |
| no ox | 16 (10.6%) | 2 (11.8%) | 18 (35.3%) |
| ≥ 1 ox | 18 (12%) | 15 (88.2%) | 192 (64.7%) |

Based on table 2, the income of those patients who got free treatment was compared with those who paid. Accordingly, out of the 210 respondents to the exit interviews at government facilities the reported prevalence of paying patients was 100 (47.6%) and the reported prevalence of free patients was 110 (52.4%). Of those free patients, 30 (27.3%) were exempted and 80 (72.7%) got waivers.

Out of the 150 urban respondents, 60 (40%) got waivers, 70 (46.6%) paid for the services while 20 (13.4%) were exempted.

Out of the 60 rural respondents, 20 (33%) got waivers, 30 (50%) paid for the services, and the rest 10 (17%) were exempted. Therefore, provision of free health care in this study represents more than half of the government health expenditure

TABLE: 2. REPORTED PREVALENCE OF PAYING AND FREE PATIENTS AT BOTH URBAN AND RURAL HEALTH FACILITIES, BAHIR-DAR TOWN AND BAHIR-DAR ZURIA WOREDA, NORTHERN ETHIOPIA, 1999.

| | Urban N (%) | Rural N (%) | Total |
|---|---|---|---|
| Paying | 70 (46.6%) | 30 (50%) | 100 (47.6%) |
| Non-paying | 80 (53.4%) | 30 (50%) | 110 (52.4%) |
| Exempted | 20 (13.4%) | 10 (17%) | 30 (27.7%) |
| Got waiver | 60 (40%) | 20 (33%) | 80 (72.7%) |
| Total | 150 (71%) | 60 (29%) | 210 (100%) |

Table 3 shows the results of the crude odds ratio for comparing those paying patients with those getting the services freely by their socio-economic characteristics. Table 4 depicts the adjusted effect of the socio-economic characteristics of free and paying patients, where under the column 'total', the result of adjusted odds ratio excludes the income status; under a column of 'urban', the result of adjusted odds ratio excludes the rural income; and the column of 'rural' excludes the urban income.

These were done to see whether the effect of the confounders act differently in urban and rural study area.

The direction and the magnitude of association for crude and adjusted odds ratio are similar for all variables except for the variable educational status, where there is change in the magnitude and direction for both urban and rural results. The result of the crude odds ratio showed no statisticaly significant difference between illiterate and literate in the provision of free health care services.

The result of the adjusted odds ratio showed statistically significant difference for both urban and rural, where there is risk effect for the urban and protective effect for the rural.

When we see the result of the rural income, the odds of free health service for those low income in the rural area was 1.71 times higher than the odds of free health care services for those of better income. However, since the 95% confidence interval for the odds ratio includes unity, the difference between these groups was not statistically significant.

Contrary to the rural areas the urban finding showed a statistically significant result. The odds of utilizing free health care services for those low income in the urban area was 3.42 times higher than the odds of utilizing free health care services for those of better income with 95% confidence interval of 1.51 to 7.78.

In this study gender, family size, number of rooms, house ownership have no statistically significant association with getting free service privilege.

TABLE 3.COMPARISON OF SOCIOECONOMIC STATUS OF FEE WAIVERS (N=80) WITH PAYING PATIENTS(N=100), BAHIR-DAR TOWN AND BAHIR-DAR ZURIA WOREDA, NORTHERN ETHIOPIA, 1999.

| Variable | Got waiver (n=80) | Paid for services (n=100) |
|---|---|---|
| Rural income | | |
| no ox | 10 | 8 |
| ≥ oxen | 10 | 22 |
| OR (95% CI) | 1 | 2.75 (0.83,9.07) |
| Urban income | | |
| ≤ 105 Birr | 39 | 21 |
| > 105 Birr | 21 | 49 |
| OR (95% CI) | 1 | 4.33 (2.07,9.05)* |
| Education status. | | |
| illiterate | 45 | 44 |
| literate | 35 | 56 |
| OR (95% CI) | 1 | 1.63 (0.90,2.96) |
| Family size | | |
| ≤5 | 58 | 58 |
| >5 | 22 | 41 |
| OR (95% CI) | 1 | 1.86 (0.94,3.71) |
| House ownership | | |
| rented | 26 | 31 |
| owned | 54 | 69 |
| OR (95% CI) | 1 | 1.07 (0.57,2.01) |
| Number of rooms | | |
| 1 | 49 | 48 |
| ≥2 | 31 | 52 |
| OR (95% CI) | 1 | 1.71 (0.94,3.11) |
| Gender | | |
| male | 45 | 45 |
| female | 35 | 55 |
| OR | 1 | 1.57 (0.83,2.99) |

where * is when p-value < 0.05

TABLE 4. ADJUSTED EFFECT OF SOCIOECONOMIC STATUS IN WAIVER (N=80) AND PAYING PATIENTS (N=100), BAHIR-DAR TOWN AND BAHIR-DAR ZURIA WOREDA, NORTHERN ETHIOPIA, 1999.

| Variable | Free | Paying | Total OR(95%CI) | Urban OR(95%CI) | Rural OR(95%CI) |
|---|---|---|---|---|---|
| Sex | | | | | |
| Male | 45 | 45 | 1 | 1 | 1 |
| Female | 35 | 55 | 1.59(0.86,2.98) | 1.77(0.78,3.99) | 3.43(0.74,16.04) |
| Family size | | | | | |
| ≤ 5 | 58 | 59 | 1 | 1 | 1 |
| > 5 | 22 | 41 | 1.63(0.81,3.28) | 1.41(0.54,3.71) | 1.10(0.28,4.23) |
| Education | | | | | |
| Illiterate | 45 | 44 | 1 | 1 | 1 |
| Literate | 35 | 56 | 1.65(0.88,3.09) | 2.85(1.26,6.48)* | 0.19(0.41,0.94)* |
| House ownership | | | | | |
| Rented | 26 | 31 | 1 | 1 | 1 |
| Owned | 54 | 69 | 1.02(0.51,2.04) | 0.73(0.31,1.71) | 0.29(0.52,1.52) |
| Number of rooms | | | | | |
| 1 | 49 | 48 | 1 | 1 | 1 |
| ≥2 | 31 | 52 | 1.29(0.67,2.48) | 1.04(0.42,2.58) | 5.29(0.72,39.21) |
| Rural income | | | | | |
| No ox | 10 | 8 | 1 | 1 | 1 |
| ≥ one ox | 10 | 22 | ---------- | ---------- | 1.71(0.44,6.73) |
| Urban income | | | | | |
| ≤ 105 Birr | 39 | 21 | 1 | 1 | 1 |
| > 105 Birr | 21 | 49 | ---------- | 3.42(1.51,7.78)* | ---------- |

where * is when p-value <0.05.

As indicated in table 5, exit respondents were asked why they preferred to get health care at government health institutions, the most important reason mentioned in most cases(68% in rural areas and in 27% cases in urban areas) was distance followed by monetry cost (18.3% in rural and 27.3% in uran areas).

TABLE 5: REASONS FOR SEEKING CARE AT GOVERNMENT HEALTH INSTITUTION, BAHIR-DAR TOWN AND BAHIR-DAR ZURIA WOREDA, NORTHERN ETHIOPIA, 1999.

| Reason for preference | Urban n (%) | Rural n (%) |
|---|---|---|
| Since this is nearby | 40 (26.7%) | 41 (68.3%) |
| Not expensive | 41 (27.3%) | 11 (18.3%) |
| Referred from other institution | 8 (5.3%) | 1 (1.7%) |
| Not too crowded | 2 (1.3%) | ------ |
| Believed to be efficacious | 33 (22%) | 7 (11.7%) |
| All other means attempted & failed | 12 (8%) | ------ |
| No reason | 14 (9.3%) | ------ |

To determine whether the public was familiar with the existence and policy on waiver, respondents were asked whether they know about the fact that poor patients are eligible for waiver from paying health facility fees. Most of the urban (93%) as well as the rural (91%) exiting respondents knew this fact. Of those people who were aware of waiver, 81.7% of the urban and 60.7% of rural respondents learned from word of mouth followed by discussion with health institution staff (see table 6 below).

TABLE 6: AWARNESS OF EXIT RESPONDENTS ON SOURCES OF INFORMATION ABOUT WAIVER AND EXEMPTION, BAHIR-DAR TOWN AND BAHIR-DAR ZURIA WOREDA, NORTHERN ETHIOPIA, 1999.

| Source of information | Urban<br>n (%) | Rural<br>n (%) |
|---|---|---|
| Word of mouth | 49 (81.7%) | 91 (60.7%) |
| Health institution staff | 9 (15%) | 41 (27.3%) |
| Sign posted at health facility | 2 (3.3%) | 18 (12%) |

Of the 210 interviewees, 87.6% claimed that there was no difficulty to obtain a free certificate, though the process was time consuming. It was also not uncommon for someone to have obtained free papers under false pretenses while being able to pay fees. This was found out by asking the respondents whether they know of someone who has got the free privilege while the individual can afford to pay. Based on this response, the reported prevalence of leakage was 8% for the urban and 6.7% for the rural and the reported prevalence of under-coverage was 20% for urban and 15% for the rural areas ( table 7).

TABLE 7. RESPONDENTS WHO REPORTED CASES OF LEAKAGE AND UNDER COVERAGE, BAHIR-DAR TOWN AND BAHIR-DAR ZURIA WEREDA, NORTHERN ETHIOPIA, 1999.

| Variable | Urban | Rural | Total |
|---|---|---|---|
| Leakage | 12 (8%) | 4 (6.7%) | 16 (7.6%) |
| Under coverage | 30 (20%) | 9 (15%) | 39 (18.6%) |

## IV. Findings From Household Surveys

The household survey was conducted since it would give better picture of the situation than the exit interview. This is because respondents at health facilities are usually self-selected segments of the population and it would be difficult to generalize findings to the larger community based on health facility exit surveys.

Of the total calculated sample size of 323 households, 300 (92.8%) were interviewed. Out of these, 150 respondents were from the rural and the other half were from the rural areas. Table 8, below, shows the socio-economic characteristics fo the household survey respondents.

TABLE 8 SOCIOECONOMIC CHARACTERISTICS OF HOUSEHOLDS, BAHIR-DAR TOWN AND BAHIR-DAR ZURIA WOREDA, NORTHERN ETHIOPIA, 1999 (N=300).

| Variable | Urban N (%) | Rural N (%) |
|---|---|---|
| Age categories | | |
| 15-24 | 14 (9.3%) | 26 (16.4%) |
| 25-34 | 32 (21.4%) | 44 (29.4%) |
| 35-44 | 37 (24.7%) | 30 (20%) |
| 45-54 | 34 (22.7%) | 33 (22.1%) |
| ≥55 | 33 (22.2%) | 17 (11:4%) |
| Sex | | |
| male | 51 (34%) | 99 (66%) |
| female | 99 (66%) | 51 (34%) |
| Occupation | | |
| Gov. Employee | 26 (17.3%) | 1 (0.7%) |
| student | 3 (2%) | ------ |
| Merchant | 8 (5.3%) | ----- |
| daily labourer | 12 (8%) | 2 (1.3%) |
| housewife | 63 (42%) | 29 (19.3%) |
| farmer | --------- | 118 (78.7%) |
| other | 38 (25%) | ------- |
| Educational status | | |
| illiterate | 64 (42.7%) | 118 (78.7%) |
| literate | 86 (57.3%) | 32 (21.3%) |
| Family size | | |
| ≤5 | 77 (51.3%) | 96 (64%) |
| >5 | 73 (48.7%) | 54 (36%) |
| Urban income | | |
| ≤105 Birr | 62 (41.3%) | ------- |
| >105 Birr | 88 (58.7%) | ------ |
| Rural income | | |
| no ox | -------- | 11 (7.3%) |
| ≥ 1 ox | ------- | 139 (92.7%) |

Eighty nine (60%) of the rural and seventy six (51%) of the urban respondents reported as experiencing at least one episode of illness in the last month preceding the study period. Of those households who reported sickness in the last month, 78% of the rural and 96% of the urban respondents sought care when they were sick. Of these later, 42.2% of the rural respondents sought care at government health stations, while 42.9% of the urban interviewees sought care at medical doctors (M.D.) private clinocs ( Table 9).

TABLE:9 HOUSEHOLD RESPONDENTS CHOICE OF HEALTH CARE FACILITIES, BAHIR-DAR TOWN AND BAHIR-DAR ZURIA WOREDA NORTHERN ETHIOPIA, 1999.

| Respondents chose | Urban n (%) | Rural n (%) |
|---|---|---|
| Government Hospital | 23 (29.9%) | 3 (3.3%) |
| Government Health center | 9 (11.7%) | 2 (2.2%) |
| Government Health station | 3 (3.9%) | 38 (42.2%) |
| M.D. private clinic | 33 (42.9%) | 2 (2.2%) |
| Non M.D. private clinic | 2 (2.6%) | 10 (11.1%) |
| Rural drug vender | 3 (3.9%) | 14 (15.6%) |
| Did nothing | 3 (3.9%) | 20 (22.2%) |

Where, M.D. is medical doctor

Of those households who chose not to go to government health care facilities, 40% of the rural and 57% the urban respondents did so because of incomplete health services provision at the government health facilities, and 34% of the rural and 2% of urban cited lack of money. Seventeen percent of the rural and 7% of the urban respondents, did not go because of dissatisfaction with previous experience (see Table 10).

TABLE: 10 REASONS FOR SEEKING ALTERNATIVE HEALTH CARE PROVIDER, BAHIR-DAR TOWN AND BAHIR-DAR ZURIA WOREDA, NORTHERN ETHIOPIA, 1999.

| Reasons | Urban n (%) | Rural n (%) |
|---|---|---|
| Incomplete health services provision | 24 (57%) | 19 (40.4%) |
| Lack of money | 1 (2.4%) | 16 (34%) |
| Dissatisfaction | 3 (7.1%) | 8 (17%) |
| Difficulty in registration | 4 (9.5%) | 1 (2.1%) |
| Inconvenience of location | 3 (7.1%) | 1 (2.1%) |

To determine whether the household was familiar with the existence and policy on waivers, the respondents were asked if they knew that the poor could obtain waivers from paying service charges. 82.7% of rural respondents and 94% of urban respondents knew that the poor does not have to pay. Of those households who were aware of the waiver policy, they were asked how they knew about the existence of the waiver policy. As depicted in Table 11, most households (64.7% for urban and 63.3% for the rural) learned about the policy from words of mouth, followed by discussion with health institution staff (13.3% of the urban 19.3% of the rural respondents).

TABLE 11.SOURCES OF INFORMATION ABOUT WAIVERS OF HOUSEHOLD, BAHIR-DAR TOWN AND BAHIR-DAR ZURIA WEREDA, NORTHERN ETHIOPIA, 1999.

| Information from | Rural residence | Urban residence |
|---|---|---|
| Words of mouth | 95 (63.3%) | 97(64.3%) |
| Health institution staff | 29 (19.3%) | 20 (13.3%) |
| Learned from other patients | 5 (3.3%) | 9 (6%) |
| Learned from kebele | | |
| Free paper writers | ------- | 9(6%) |
| Posted at Health facility | 5 (3.3%) | 8 (5.3%) |
| Didn't know | 16 (10.7%) | 6 (4%) |
| Learned as a witness | ------ | 1 (0.7%) |

To assess knowledge about exemption, households were asked if they knew that certain categories of patients or people with specific diseases were exempted from paying for health services. As depicted in table 12, the proportion of those aware about exemption policy is more in the urban than the rural areas.

TABLE 12.HOUSEHOLD KNOWING ABOUT EXEMPTED DISEASE CATEGORIES, BAHIR- DAR TOWN AND BAHIR-DAR ZURIA WEREDA, NORTHERN ETHIOPIA, 1999.

| Disease category | % of respondents having knowledge | |
|---|---|---|
| | Urban | Rural |
| | n (%) | n (%) |
| Children under five | 38 (25.3%) | 25 (16.7%) |
| Tuberculosis | 31 (14%) | 21 (14%) |
| Leprosy | 18 (29.7%) | 5 (3.3%) |
| AIDS | 16 (10.7%) | 15 (10%) |
| Family Planing | 19 (12%) | 18 (12%) |

Thirty nine percent of the urban households and 10% of the rural households reported that there are problems to get free certificates. These problems included: giving unnecessary appointment (29%), people who have no permanent residency (56.9%), and not participating in environmental campaigns (14.1%) (see Table 13).

TABLE 13. RESPONDENTS REASONS FOR UNDER-COVERAGE AND PROBLEMS TO GET FREE CERTIFICATES, BAHIR-DAR TOWN AND BAHIR-DAR ZURIA WEREDA, NORTHERN ETHIOPIA, 1999.

| Reason | n (%) problem to get free paper | n (%) under-coverage |
|---|---|---|
| Unnecessary appointments | 17 (29%) | 4 (16%) |
| No permanent residency | 33 (56.9%) | 12 (48%) |
| No participate in environmental campaign | 8 (13.7%) | 7 (28%) |

Household respondents were also asked whether they know anyone who got free paper when they should not. 4.7% of the urban and 2% of the rural respondents claimed that they knew of such a situation (see table 14). The reasons given for such occurrences included being relatives to free paper writers (70%) and presenting false witnesses (30%).

Households were also asked whether they know of anybody who couldn't go to the health institution because they could not pay. 16.7% of the urban and 1.3% of the rural respondents agreed with the presence of such situations (see table 14). The main reason (in 48% of cases) for this was reported to be inability to get witnesses if one is a newcomer to the area. Kebeles were also said to refuse to give free papers if one does not participate in environmental health campaigns.

TABLE 14. RESPONDENTS WHO REPORTED AS KNOWING CASES OF LEAKAGE AND UNDER COVERAGE, BAHIR-DAR TOWN AND BAHIR-DAR ZURIA WEREDA, NORTHERN ETHIOPIA, 1999 (N=300)

| Variable | Urban | Rural | Total |
|---|---|---|---|
| Leakage | 7 (4.7%) | 2 (2%) | 9 (3%) |
| Under coverage | 25 (16.7%) | 1 (1.3%) | 26 (8.6%) |

## Discussion

This cross sectional study has compared the characteristics of free patients with those paying in the Northern part of Ethiopia.

Since the reference population (Northern Ethiopia) is large and widely scattered, multistage sampling method was appropriate to get the study subjects (households) in both urban and rural study area. Systematic sampling method for exit interview and purposive sampling for Kebele free treatment paper writers and health institution administrators were applied to get the respective study subjects.

According to the study findings, the criterion to grant free health care services was mainly based on the direct monthly income of the individual, that is, less than or equal to 105 birr per month for urban. Since this criterion could not clearly address the rural areas that consider households who have no ox as poor, a clear guideline has to be established at a policy level for the rural community in the provision of free certificates so that leakage could be controlled.

The practice of record keeping for waivers granted varied widely between urban and rural kebeles and among health facilities visited. However, there was a distinct difference between urban and rural areas and the hospital and other lower health institutions in what was actually being practised. Record keeping was poorly practised by rural free treatment writers, health centers and health stations than urban free certificate writers and the hospital. Similarly, record keeping was poorly handled in government health institutions than mission hospitals for waivers granted in a Tanzanian case study[10]. This lack of records might make it difficult to evaluate the exemption system for the

poor. The effectiveness and the cost of the exemption system cannot be known without such information.

The study found that most of the rural (68.3%) and urban (27%) respondents preferred a particular health institution because it is nearby and followed by it's cost. Similarly, Studies on health care utilization in different developing countries showed that, the demand for and use of health services are initiated by perceived morbidity and further affected by factors such as distance to the nearest health care unit[11,12,13] the cost and organization of the health services[11,14,15,16]. Moreover, a study on utilization of selected hospital, health center and health stations in central, southern and western Ethiopia(1990) has shown that nearness, good service and free treatment as being the three major reasons for seeking care by respondents[17].

The study, on whether households were familiar with the existence and policy of waivers, showed that 82.7% of rural and 94% of urban respondents knew about the existence of the privilege. Likewise a Kenyan study has shown urban residents as being more aware about waivers[2].

For households that responded as knowing about waivers, the sources of information were words of mouth, health staff and sign posted in health institutions. Yet, in the Kenyan study information from health staff accounted for the majority followed by word of mouth and signs posted[2]. Contrary to a Tanzanian case study [11], more people know an overall waiver policy than exemption in this study. Therefore, health workers should take an active role in providing the correct information about the waiver and exemption policy.

Provision of free care represented more than half (52.4%) of health institution expenditure in this study. A similar finding was reported in a study on the feasibility of community-based health insurance in Ethiopia[19]. When services are free, there is a tendency to consume a greater quantity, which will affect the overall cost of care, the budget requirement for the facility, and financial viability.

More than half of the urban and 40% of rural respondents chose alternative health providers. This was claimed to be because there is an incomplete health provision at the government health institutions. This might indicate issues of policy importance for cost sharing and improved quality of service. The implication is that, given improved services, patients seem to have willingness and ability to pay.

With regard to problems in getting free papers, 87.6% of the exit respondents claimed as having no difficulty in obtaining the certificate though the process was time consuming. A similar finding was reported in another study in the urban areas of Ethiopia [19]. On the other hand, 39% of the respondents in the household survey have reported as having problem to get a free certificate. This shows that more people in the household survey have reported as having problems in getting free treatment papers compared to exit respondents. This might be due to the fact that the exit interview was done only on those patients who were able to come to the institution which did not include patients who could not come to the institution. Therefore, the finding at the household level should be considered as being more representative than the exit interview finding.

The reported prevalence of under-coverage, in this study, was 20% in the urban and 15% in the rural government health institutions. With regard to leakage, it was 8% for urban and 6.7% for rural health institutions. Study results of country experiences with targeting mechanisms have found minimizing under-coverage as being poorly handled than preventing leakage in Guinea, Kenya and Tanzania[19]. In addition, the results of the household survey revealed that there was 16% reported prevalence of under-coverage, and 4.7% leakage in the urban; and 1.3% under-coverage and 2% leakage in the rural areas.

There is a slight discrepancy in the findings of reported leakage and under-coverage between the health institution exit survey and the household survey. This might be explained by the fact that respondents at the exit polls of the health institutions were not asked about their place of residence, and thus could confidentially respond for the questions; while household respondents were interrogated in their place of residence which could create precedence, and they could also be cautious in what they respond so that they do not want to lose their social ties.

Comparison of average income of those patients who have got wavier with those who paid for the rural government health institutions showed that there was no statistically significant association between low income and free health services utilization. This finding is supported by an earlier study in central Ethiopia that indicated no significant difference between the income levels of paying patients and those who got services for free[18].

However, in the case of urban exit respondents those who got waivers had a statistically significantly lower average income than those who were paying. This may be due to the following reasons: -

- Since there were many urban (Bahir-dar) private clinics, those who can afford to pay might have preferred to go to these institutions.
- The town being the capital of the Amhara Region, there are lots of public officers (regional, zonal, and wereda levels) that might strictly enforce the rules and regulations in the provision of free paper.
- In addition, the responses of the urban free treatment writers to the self-administered questionnaire were more consistent than the rural ones. This might suggest that the urban writers may be more strict in applying the rules.
- Proper registration and recording of the free treatment provision in urban areas might have helped in reducing the occurrence of leakage.
- The absence of clear guideline in the rural area might create a difficulty in controlling the occurrence of leakage.

In general, targeted intervention (waiver and exemption) in developing countries have been compromised by a variety of difficulties, including excessive leakage, too subjective exemption criteria, informal identification and verification procedures and excessive costs. Most of the reasons for under-coverage and leakage can be improved by avoiding unnecessary bureaucratic management system at the free treatment writers level and utilizing proper recording and registration system for those who are granted the waiver. In addition, the prevalence of under-coverage could also be controlled by providing public education on waiver policy through health staff and mass media.

# Conclusions and Recommendations

## Strength and Limitation of the study

### Strengths

1 No formal assessment was done up to now whether the free health care operates efficiently or not. Therefore, this study can give a clue on the efficiency of the free health care services in the country.

2. The fact that multivariate analysis using logistic regression model was utilized for the comparison of socio-economic status of those paying with those getting the service freely gives more strength to the statistical associations found in the study.

### Limitations

1. The sample size utilized for government exit interviews for the comparison of socioeconomic characteristics of free and paying respondents were relatively small.

2. There may be an under reporting of income status of the respondents since measurement was based on self reports.

3. Equal sample size was utilized for urban and rural house hold survey, eventhought the rural population is higher than the urban population.

## Conclusions

According to the findings of the present study, the criteria to grant free health care services is based on the direct monthly income of the individual, that is ≤ 105 birr/month and no ox for rural.

Proper registration with utilization of a special registration book was used by all the urban free treatment writers while this practice was non-existent in almost all the studied farmer associations. Even though all the health institutions have special registration books for free patients, most were not properly recording the waiver granted. This is specially true for health centers and the health stations which were included in the study.

The exemption system appears to work relatively quite well contrary to the waiver system. This may be because identifying patients with given disease characteristics is easier than knowing ones level of income.

Though the level of awareness about exemption was higher in urban areas, overall most respondents were aware of this fact. Most people learned this from words of mouth followed by discussion with health institution staff.

The problems of under-coverage and leakage were observed in the study even though it was not as high as it is seen in areas reviewed in the literature.

No statistically significant association was observed between low income and free health services utilization at the rural government health institutions.

## Recommendations

Based on the findings of the present study, the following recommendations are forwarded

1. Improved record keeping and monitoring of waivers and exemptions both at the kebele and health facilities level should be emphasized.
2. Periodic field evaluations by district administrators and health officials are needed to monitor the proper functioning of the system.
3. Validity of the free certificate period has to be lengthened so that the prevalence of under-coverage will be reduced.
4. A clear guideline has to be established for the rural community for the provision of free certificate so that leakage could be controlled.
5. Public education on waiver policy through health workers has to be initiated
6. Conducting a survey with a large sample size is recommended in order to evaluate further the problems of leakage and under-coverage.

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# ANNEXES

## QUESTIONNAIRE ON PATIENT EXIT INTERVIEW

1. Place of interview:-

   1.Hospital 2.Health center 3.Health station

2. Status of attendance:-

   1.Out patient 2.In patient

3. How old are you?_____

4. Sex _____

   1.male

   2.female

5. Occupation (specify) _____

6. Marital status:-

   1.Single 2.married 3. Separated 4. Divorced 5.widowed

7. Educational status:-

   1.Illiterate 2.Read and write 3.Elementary

   4. Secondary 5. College and above

8. Family size _____

9. Combined income(average):

| Urban | Rural |
|---|---|
| 1. ≤ 105 Birr | 1.No ox |
| 2. 105-250 Birr | 2.one ox |
| 3. 251-500 Birr | 3.two oxen |
| 4. 500-1000 Birr | 4.>two oxen |
| 5. > 1000 Birr | |

10. Type of house

1.corrugated

2.thatched

3.other (specify) _____

11. Number of rooms _____

12. Status of house ownership

1. Rented

2. Owned

3. Cohabitant

13. What means of transport did you use to come here?

1. On foot 2.on animal 3. Vehicle 4.being carried by people

14. Why did you choose the institution?

1. since these were accessible [nearby]

2. since these were not expensive

3. referred from other institution

4. since these were not too crowded

5. since these were believed to be efficacious

6. since all other means were attempted and failed

7. other reason [specify] _____

8. no response

15. How long did you wait before getting the service?

1. less than six hours

2. six to twelve hours

3. one to two days

4. three to seven days

5. more than one week

16. Was the hospital registration or reception process smooth and timely?

1. strongly agree 2. agree 3. neutral

4. disagree 5. strongly disagree

17. How was the approach of the staff towards you?

1. very good 2. good 3. poor

18. Were you able to get all the drugs prescribed?

1. Yes, all 2. Partial 3. Not at all 4.Not prescribed

19. If yes, did you pay?

1.Total amount 2. Partial amount

20. Did you pay for the services today?

1. Yes 2. No

21. If No, why not?

1. Exempted 2. Waiver 3. other

If waiver,

22. Is there any problem to get the free treatment paper?

1. Yes 2. No

23. If yes, Do you know any one who could not get the free paper when they should be given?

1. Yes 2. No

24. Do you know anyone who got free paper when they should not get?

1. Yes 2. No

25. Do the poor have to pay for care at this facility?

1.Yes 2. No 3. Partially

26. If not, what do, they do?_____

27. Do you have to pay for care at this facility, if you are or have:

| | |
|---|---|
| 1.children under five | 5.Family planning |
| 2.TB | 6.ANC |
| 3.Leprosy | 7.Civil service |
| 4.AIDS | 8.Health worker |

28. How did you learn that the free service privileges for the poor is practised?

1.Sign posted at the facility

2.Information provided by health facility staff

3.Learned from relatives or friends

4.Others

29. Do you know of anybody who could not go to heath center or hospital because they could not pay?

1.yes 2.no

If, yes

30. Why did not they go?

| | |
|---|---|
| 1.could not pay | 2.went to traditional healer |
| 3.No drugs available | 4.long distance |

5.poor quality /unhappy previous experience

***

# QUESTIONNAIRE FOR HOUSEHOLD SURVEY

1. How old are you?_____

2. Sex 1.male 2.female

3. Occupation (specify) _____

4. Marital status:-

   1. Single 2.married 3. Separated 4. Divorced 5.widowed

5. Educational status:-

   1. Illiterate 2. Read and write 3. Elementary

   4. Secondary 5. College and above

6. Family size: _____

7. Type of house:

   1. corrugated 2. thatched 3. other(specify) _____

8. Number of rooms _____

9. Property owned:

   1. land in hectare 2. Number of cattle 3. Amount of crops 4. other(specify)_____

10. Average income/month:

| A. URBAN | B .Rural |
|---|---|
| 1. ≤ 105 Birr | 1. No ox |
| 2. 105-250 Birr | 2. one ox |
| 3. 251-500 Birr | 3. two oxen |
| 4. 500-1000 Birr | 4. >two oxen |
| 5. > 1000 Birr | |

11. Did anyone in your household experience an illness in the last month?

    1. Yes 2. no

12. Where did you go for health care?

| | |
|---|---|
| 1. Did nothing | 2. Self treatment |
| 3. Neighbour/friend | 4. Traditional healers |
| 5. Rural drug vendor | 6. Non-MD private |
| 7. MD private | 8. Health post |
| 9. Health station (government) | 10. Health station(mission) |
| 11. H/center (gov.) | 12. H/center(mission) |
| 13. Hospital (gov.) | 14. Hospital(mission) |
| 15. Other | |

13. Why did not you go to a government facility?

1. lack of money
2. inconvenience of location
3. health facility not open
4. unsatisfied with previous experience
5. 1 and 4
6. less expensive than government facility
7. other

14. Do the poor have to pay for government health facility?

1. yes 2. no

15. If not, what do they do so?

16. Do you have to pay for health care at this facility, if you are or have:

| | |
|---|---|
| 1. Children under five | 5. Family planning |
| 2. TB | 6. ANC |
| 3.Leprosy | 7.'Civil service |
| 4.AIDS | 8. Health worker |

17. How did you learn that these people or the poor do not have to pay?

1. sign posted at facility

2. information provided by health facility staff

3. learned from relatives/friends

4. did not know/never heard of waivers

18. Do you know of anybody who could not go to the health institution because they could not pay?

1. yes 2. no

19. Do you know of anybody who did not go to the institution for other reasons?

1. yes 2. no

If waiver,

20. Is there any problem to get the free treatment paper?

1. yes 2. no

21. If yes, Do you know any one who could not get the free paper when they should be given?

1. Yes 2. No

If yes, what were the reason?

22. Do you know anyone who got free paper when they should not get?

1. Yes 2. No

If yes, how could they get?

23. Is the area where the interview is conducted?

1.urban 2.rural

# HEALTH FACILITY INFORMATION

## In-depth interview for health facility administrators

1. Are the poor exempted from fees?

   1.yes 2.no

If yes,

2. Who is considered poor? _____

3. Who determines eligibility as poor? _____

4. How do they determine eligibility? (Criteria)_____

5. What information is required to determine eligibility?

6. When and where is eligibility determined?

7. How long is a waiver valid for?

8. Are records kept on waivers granted?

9. How many waivers were granted last month?

Do you think:

10. That there are people who didn't get free paper while they should get?

    1. Yes 2. No

If yes,

11. How could you identify those who don't get the free paper while they deserve?

    1] Rumour 2) Documented evidence based on S.E.S. 3] Based on observation

    4) Other(specify)_____

12. That there are people who are given free paper while they do not deserve to get?

    1. Yes 2. No

If yes,

13. How could you identify those who don't deserve the free paper?

1] Rumour 2] Documented evidence based on S.E.S.

3] Based on observation 4] Other (specify)_____

14. Are certain types of patients or services automatically exempted from fees?

15. If yes, for what type of patients or services?

1. Children under five 5. Family planning

2. TB 6. ANC

3. Leprosy 7. Civil service

4. AIDS 8. Health worker

16. Who determines eligibility for an exemption?

17. What information is required to determine eligibility?

18. When and where is eligibility determined?

19. Are records kept on waivers granted?

20. How many exemptions were granted last month?

21. Are patients informed that they are eligible for waivers or exemptions?

1.yes 2.no 3.I do not know

22. If yes, how?

1. sign posted at facility

2. information provided by health facility staff

3. learned from relatives/friends

4. did not know/never heard of waivers

5. others

_____ *** _____

# SELF ADMINISTERED QUESTIONNAIRE FOR KEBELE (FARMER) ASSOCIATION LEADERS

1. Woreda _____ Kebele/Farmer _____

   Position in your Kebele _____

2. Who will write the free treatment letter?

   1. The chairman 2. The committee

   3. Anybody member of the kebele staff

3. How is eligibility determined (locally)/What are the guidelines? _____

4. When is eligibility determined?

   i. Is card issued by the kebele before care is sought?

   ii. Is it made when the patient came and ask the kebele?

5. What information is required to determine eligibility?

6. How long is weaver valid for?

   1.< one month 2. 1-3 months 3. 3-6 months

   4.> six months

7. What records do you keep on waiver granted?

   1.Have special registration book

   2.No record keeping system

8. How many waivers were granted last month?_____

9. Do you think there is a problem in the provision of free paper?

   1. Yes 2. No

If yes,

10. What are the problems?_____

_____ *** _____

## DECLARATION

I, the undersigned, declare that this thesis is my original work and that all resources of material used for this thesis have been duly acknowledged.

Name: **Endale Engida, MD**

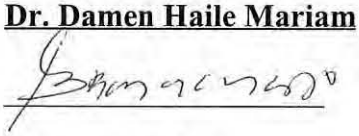
Signature: 

Place: Addis Ababa

Date of submission: February 03, 2000

This thesis has been submitted for examination with my approval as a university advisor.

Name: **Dr. Damen Haile Mariam**

Signature: 

Date: February 07, 2000