



# How Big is the Crowding-Out Effect of User Fees in the Rural Areas of Ethiopia? Implications for Equity and Resources Mobilization

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**Summary.** — Using a nested multinomial logit model, this study investigates the demand “reduction” and “diversion” effects of user fees in rural areas of Ethiopia. The results reveal that an increase in user fees of public clinics, which are the most widely used alternative, can have a significant demand reduction effect on the poorest of the poor. This implies that despite cost recovery has been advocated as an alternative means of health care financing in most of the developing world, increasing user fees may drive the poorest segment of the population out of the health care market unless some protective measures are taken.  
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*Key words* — Africa, Ethiopia, user fees, demand for health, demand reduction, demand diversion

## 1. INTRODUCTION

Following the Alma Ata declaration of “Health for All” in 1978, many governments in Africa were very enthusiastic to expand and provide free or highly subsidized primary (including maternal and childcare health—MCH) services to their population. But, the poor economic performance of the African countries in the 1980s and 1990s, and the associated budget crises reduced the ability of governments to participate actively in the financing of basic health services. The structural adjustment programs, which pressurized governments to work under austerity and tight budgets, made the task even more difficult. As a result, a new proposal known as “the Bamako Initiative” was launched by African Health Ministers, WHO, and UNICEF at Bamako, Mali

in September 1987. The basic aim of the initiative was to sustain and ensure the Alma Ata declaration by providing high-quality primary health care services through the introduction of user fees.

While there is a substantial literature on the health care demand behavior of households, few studies have been conducted to investigate the demand reduction and demand diversion effects of user fees. In addition to their limited

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methodological scope, most of the studies do not take user fees as an explanatory variable in determining both the demand for treatment (given illness/injury) and the provider choice (given the decision to obtain treatment) and do not investigate the impact of a rise in user fees on the poorest of the poor. As a result, very little is known about the "crowding out" effects of user fees, especially on the poorest of the poor in the rural areas of developing countries. This study, by rigorously analyzing the health care demand behavior of households in rural areas of Ethiopia, tries to investigate how poor households respond to changes in user fees at different health care providers.

Ethiopia is taken as a case study for the following reasons. First, Ethiopia is among the poorest countries of the world and thus affordable health care is of particular concern there. Second, very few studies on this topic have been conducted in the country. Most of these few studies also concentrate on factors that affect the incidence and duration of illness, determinants of health care utilization and provider choice (including maternity care), health care expenditure pattern, impact of farmer's health on their productivity, and the like.<sup>1</sup> As a result, their analysis on the impact of user fees on the health care demand behavior and provider choice of households is sketchy.<sup>2</sup>

Third, increasing user fees has been advocated as one source of finance to provide efficient and sustainable primary health services in the country. Especially after the recent health reform program, cost sharing has been considered as an important instrument for sustainable health care development in the country (Russell & Abdella, 2002). For instance, the health care and financing strategy of the Federal Democratic Republic of Ethiopia states that

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

Because of this and other market reform measures,<sup>3</sup> the price of health services has increased significantly in the country. For instance, during 1974–84, the price rise in the health care sector was 93.7% compared to a rise in the overall consumer price index of 147%. During 1984–94, however, the price rise in the health care sector was 232.6% compared to the general price rise of 130.5% (CSA).

Fourth, health insurance schemes, both formal and informal, hardly exist in the country. The major sources of health care finance in the country are still the government (through tax revenue), the private sector (through out-of-pocket payments), and foreign aid. According to the World Bank Social Sector Report (World Bank, 1997), the financial contribution of health insurance to the health sector of the country was only 0.2 and 0.5% in 1986 and 1996, respectively.

Therefore, given the current debate on increasing user fees in the country and given the absence of strong formal and informal health insurance schemes to protect the poor in the state of rampant poverty, Ethiopia is a good case study from which to draw lessons on the impact of user fees especially on the poorest of the poor.

## 2. USER FEES AS A HEALTH CARE FINANCING STRATEGY

Depending on their economic and social development, different countries have been adopting different health care financing strategies. Though it is quite difficult to make a clear distinction, the major financing strategies that have been adopted by most governments can be seen as tax based, user fees, external sources, and insurance. Usually these strategies have been used in combination to one another, based on the overall health policy and the level of development of the country. The specific strategies and the way each strategy has been implemented also vary from country to country and from time to time.

User fees have also been considered as one important source of finance for providing efficient and sustainable health care services in developing countries. The advocates of user fees anchor their arguments on the willingness and ability of individuals to pay for health services (Yoder, 1989). Based on health care demand studies, various researchers (Akin, Griffin, Guilkey, & Popkin, 1986; de Ferranti, 1985; Lavy, 1994; Sköld, 1998; WHO (Bamako Initiative), 1988) argue that health care demand in most developing countries is price inelastic, so that enough resources can be generated without significantly affecting the current demand patterns. Some researchers even argue that the negative impact of user fees can be outweighed if other factors that negatively affect health care demand, such as poor quality of services, un-

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