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- Schemenner, R.W., Huber, J.C. and Cook, R.L. (1987), "Geographic Differences and the Location of New Manufacturing Facilities," Journal of Urban Economics, Vol. 21, No. 1, pp. 83-104.

CONFERENCE PAPERS

- Garg Sambhav (2011): "Business Ethics" Paper presented at the Annual International Conference for the All India Management Association, New Delhi, India, 19–22 June.

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ROLE OF USER FEES IN ETHIOPIA: A CASE STUDY OF JIMMA UNIVERSITY SPECIALIZED HOSPITAL, SOUTH WEST ETHIOPIA

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ABSTRACT

In response to reducing budgets and growing demand for health care many low and middle income countries have adopted formal user fees in government health facilities as a strategy to generate revenue for public health facilities. Ethiopia meanwhile has been practicing user fees in public health facilities since 60 years and only few studies conducted on this area and addressed the issues related to user fee system of this country. A Hospital based descriptive study both qualitative and quantitative research methods used. Data collected form secondary sources, in-depth interviews and exit interviews on outpatients. There is sharp decline in all out patients departments providing free services during the study period. The growth of user fees has increased from 2.2% [2085-09]-to 7.8% [2009-2010].But the percentage of user fees to total budget declined from 5.68% to 4.72%.Out of 401 exit interview respondents 60.8% paid for the service and 38.2% got free treatment from the facility. Monthly income, occupation, land ownership, residence, and source of income of the respondents turned out to be statistically significant. The health service utilization in this hospital is not depended on user fees only, but factors like availability of health professionals, drugs and other expenses are also affecting .The revenue from user fees is less than 5%,which is similar to the results of user fee studies in other SSA countries. Even if there are some leakages and under coverage for the identification of poor, most of the poor people are exempted from payment.

KEYWORDS

Health care financing, User fees, Sub-Saharan Africa.

BACKGROUND

Most of the African countries have had a tradition of free Public health services. But the declining budgets allocation and growing demand for health care many countries have forced to adopt formal user fees in public health facilities as a strategy to generate revenue [Bitran R&Giledeon.U, 2003]. At the time of tight budget constraints, it was hoped that user fee revenues would enhance quality improvements, such as improved drug availability, staff motivation and operating costs. In 1987, the governments of African countries meeting in Bamako with direct involvement of the UNICEF and WHO, proposed the introduction of user fees in Sub Saharan Africa to improve the under funded health care system. After years of commitment to free health care, the implementation of user fees in Sub-Saharan countries [SSA] are intend to supplement to governments' health spending less than $5 per capitae .The meeting decision later came to be known as Bamako initiative [BI]. By the end of mid 90s user fees were common in several developing countries particularly in Africa where in1995, 28 out of 37 countries studied the World Bank survey had introduced user fees in government health facilities(Arhin D, 2000)). In 1987 in its report the World Bank argued that user fees would:

- Raise substantial additional revenue for health sector which could be used to improve efficiency and equity in the health sector:
- Improve targeting of resources by reducing frivolous demand:
- Improve efficiency by encouraging people to use low cost primary health care services while protecting poor through exemptions [World Bank 1987].

ADDIS ABABA CONSENSUS ON USER FEES

Ethiopia meanwhile has been practicing some form of payments in public health facilities since 60 years back even before the introduction of user fee system in other Sub-Saharan economies [FMOH 2000]. In 1997 Addis Ababa [capital of Ethiopia] Consensus on principles of cost sharing in Education and Health in Sub-Saharan Africa provides two key principles that are sill relevant. First, cost sharing should only be considered after all other options have been thoroughly examined, including user revenue from taxation, and efforts to reduce costs by making services more efficient. Second, fees should be considered a stepping stone towards other financing options like insurance mechanisms (Addis Ababa Consensus 1997).

IMPACT OF USER FEES IN AFRICAN COUNTRIES

An overall assessment of the extensive literature on user fees over the last twenty three years giving a higher weighting to country wide data, shows that this policy has not fulfilled its objectives. Evidence from many low and middle income countries in Africa showed that overall utilization of public health services declined after introduction of user fees. In Zambia, for example after introduction of registration fees at health centers and treatment fees at hospitals in mid 1990s,overall attendance in public health facilities dropped by a third over two years followed a continued but slower decline(Blas E& Lambella M2001).A study conducted by save the children UK in Sudan reported that pregnancy follow up which used to be free of charge in Sudan, but when user charges introduced the visits of pregnant mothers declined significantly(Witter S et al 2005).In Tanzania it was found that people turned to traditional medicine after introduction of user fees in public health facilities because of payments are flexible and credit arrangements are possible in traditional and private practitioners.(Mula S.Moshi A &Ribera.J 2000).The rationale for user fees was set by World Bank in 1987 which argued that fees can raise substantial additional revenue for health sector which will leads to improved efficiency and equity. But in many African countries the fee raised very little revenue and it is less than 5% of total public health revenue and the fee levels have been sufficient to suppress the demand from poor people and exemption schemes are ineffective (Yates.R 2006).A survey conducted in 16 African found that user fees contributed 1-20% of recurrent health service expenditures and an average around 5%(Gilson L1997).Equity is the underlying principle of all major global health policies. If revenue from user charges is used to improve the quality of care at lower facilities, which typically are close to poor people, utilization by the poor as well as their health might improve. Alternatively if user charges dissuade richer sections from using public health facilities, they may help the poor to obtain better access to subsidized care (Mahal A2005).Most of the studies showed the evidence that after introduction of user fees it adversely affected the utilization by the poor, either they are not seeking care or shifting to traditional medicines.

In the first phase user fees were a new idea that the World Bank and other donor agencies felt would solve the acute health financing problems in developing countries. But after two decades of evidence from many countries which showed that user fees it self doesn't solve the health financing problems in developing countries. So a broad approach is needed from policy makers to solve problem. The appropriateness of user fees has been widely questioned even with in the World Bank. In September 2001 the World Bank issued a revised user fee policy, saying it "supports the provision of free basic health services to poor people and discourage user fees for immunization, MCH and efforts to targeting TB, HIV/AIDS and certain other disease. Now a debate is going on whether to retain or remove user fees especially in African countries. However user fees were still considered as necessary and the emphasis was on correcting their design and implementation to minimize the problems .By the early 2000s , the donors were focusing on pro-poor policies and had come to view user fees as undesirable. But most bilateral and multilateral donors continue to resent user fees as a "necessary evil". DFID, for example in its strategy paper "Making government work for poor people states that: "when government can afford it, poor people should have free access to basic heath services……. But poor countries cannot always afford free universal public service, and because formal charges levied by poorly paid and corrupt officials, government may do better to formalize fees at affordable level". Similarly the World Bank continues to insist that user fees are still relevant and appropriate. "Publicly subsidized care for all is not an affordable option for African governments" World Bank states in its handbook in 2001. Finally, the World Bank says "no blanket policy on user fees" outlined in the World Development report 2004 can be seen as a land mark on user fee policy.

HEALTH SECTOR REFORM AGENDA IN ETHIOPIA

Health services in Ethiopia are financed through four sources. These are :(1) government [both federal and regional],(2) bilateral donors [both grants and loans], (3)non-governmental organizations and (4)private contributions. The national health accounts exercise for financial year 2000/01 revealed that the major contribution is that of out of households [out of pocket] contribution is [46%], government [33%] and bilateral and multilateral donors [21%].Ethiopia had a national system of nominal fees for services provided at government facilities for a long time (NHA 2001). But there have been high rates of exemption and low rates of revenue collection. MCH services, Immunizations, TB, malaria, HIV/AIDS etc are exempted from user fees. In 1993 Ethiopian Federal Ministry of Health set out the principles and objectives of Health sector reform in Ethiopia. This made emphasis on Strengthening of cost recovery measures, Decentralization of health care delivery system and Promotion of private sector and NGO involvement in the financing and delivery of health care. Implementation followed in 1995, designed to strategic frame work for health sector reform over a period of 20 years. Reforming health care financing is one of the strategies of Health Sector Development Program [HSDP] and cost recovery is integral to this strategy. In 1998 a Health care financing [HCF] strategy was adopted by the council of Ministers and one of the core concepts of the HCF strategy is "Health Facility Revenue", a cash fund derived from user fees, revolving drug funds [RDFs], risk sharing schemes and donations that can be retained at facility, and which is additional to the government budget and to be used to improve the quality and quantity of health services (Health sector strategic plan 2005). Now HSDP111 phase is running and the main objective of health care financing section of this plan in to increase overall health expenditures percapita from 5.6US$to 9.6US$.The share of health as a proportion to total government budget should be double and 100% of retention and utilization of revenue generated from user fees at hospitals and health centers (HSDP111).

In Ethiopia the practice of charging user fee is not new, and has existed for more than 60 years. Users being charged for registration, laboratory tests, investigation and diagnostic methods and drugs. There is an exemption policy for the poor who can not afford to pay. The actual capacity of the population to pay for public health services is uncertain. In 1995 WHO estimates that 30-38% of the patients were exempted from user fees. In contrast a study conducted by Oxford university in Amhara and Southern regions in 1996 suggests that the percentage of free or exempt patients were only about 10%.Clinics in highly impoverished areas of Northern Shewa reported only 3-4% of exemptions. A study conducted in 2002 on free healthcare provision in Northern Ethiopia find out that 59.5% of the patients had been served as free.

The criteria for granting free health care services in Ethiopia is mainly based on the real monthly income of the individual and setting the minimum wage for civil servents.In1967, for example anyone with a monthly income less than 50 Birr [US$ 25] was eligible for free health services (Endale L, Damian H 2002).In 1997 the monthly income for eligible was revised and changed to 105 Birr [US$52] and presently it was fixed as 324Birr which is the basic salary of a government servant. As to the 1981 proclamation the eligibility criteria of an applicant was determined by the Keble administration. A committee of people from the Kebele administration would examine the means of livelihood and grand a certificate that allows the individual to get free treatment from public health facilities. The eligibility certificate would usually be valuable up to one year. But many times the exemption polices are biased and under utilization and leakages are common. Although there are guidelines for implementing the user fee system and granting waivers and exemption mechanisms in the public health sector only few studies have been conducted on this issue. Therefore this study will try to provide some insights on the role of user fees as a health care financing strategy in Ethiopia.

RESEARCH METHODOLOGY

Study area: the study was carried out in Jimma University specialized hospital. The hospital is located in Jimma town, about 335 Km south west away of Addis Ababa. The town has one hospital, one health centre and one MCH clinic as public health facilities. Now the hospital has 450 beds and 12 main departments and serving about 15,000,000 people living in the south west region of Ethiopia including South Sudanese refuges. This is a teaching hospital and the only referral hospital in Oromia region attached to Jimma University and governed by Federal Ministry of Education.

Study design: A hospital based descriptive study both qualitative and quantitative research methods were employed to study the outlined above. Information was gathered by three methods: (1) Secondary data; (2) In depth interviews with 10 key persons, [3] Exit interview on 401 out patients.

Data collection and analysis: We obtained the secondary data from records of jimma university hospital, Federal Ministry of education, Federal Ministry of Health and Oromia Health Bureau. Relevant research studies and reports also were reviewed. An exit interview was conducted on out patients of jimma university hospital for the supportive evidence of free health care provision. A total of 401 people were interviewed. Respondents were selected from all out patient department excluding the services providing free. The sample size was determined with the help of Epi Info software based on previous year's outpatient's number. A systematic random sampling technique was used for selection of respondents. First respondent was selected as random followed by every tenth patient was selected for exit interview. Structured questionnaire was used for data collection. The data entered in SPSS16 and analyzed. For qualitative data collection purposively selected10 key persons from Jimma University specialized hospital and Federal Ministry of Education, Federal Ministry of Health ,Oromia Health Bureau, Jimma Kebele administration were interviewed. An interview guideline was used for data collection. In depth interviews were tape recorded, transcribed and analyzed thematically.

Ethical approval: Ethical clearance obtained from Jimma University Ethical committee and Jimma University hospital administration. Informed consent obtained from respondents before in depth interviews and exit interview.

Limitations of the study: Documentation system in the hospital is not function well, so there is chance of variations in the health service utilization data. Inpatients were not included in the data collection on free health service provision.

RESULTS

This study assessed the role of user fees as a health care financing mechanism in jimma university hospital Ethiopia. Through this study we attempted to examine the health service utilization, revenue from user fees, and utilization pattern of revenue from user fees and practice of free health care provision [waivers and exemption schemes] in this hospital.

TABLE 1: ANALYSIS OF HEALTH SERVICE UTILIZATION JIMMA UNIVERSITY SPECIALIZED HOSPITAL [2005-08]

No	Services	2007-08	2008-09	2009-2010
1	New OPD Cases	60,472	41,107(-32%)	71,793(74.65%)
2	Admissions (Inpatients)	7,873	8068 [2.48%]	9,051[12.18%]
3	Operations major	728	1,364	1749
4	Operations minor	1,736	2087	2838
5	Deliveries	2,206	2,813	2,753
6	Laboratory	183,311	227,668	12,48741
7	X-ray	12,131	8407	14,157
8	Ultrasound	1,993	1,289	2,367
9	Free services Family planning	2,221	3,256 [46.6%]	853 [[-73%]
10	Vaccination	6,288	6,476 [2.9%]	5,266 [-18%]
11	TB clinic	7766	3960	1001
12	ART	732	1026	449
13	PMTCT	1409	1112	1003

The study analyzed three consecutive years' secondary data. The results showed that, health service utilization in various out patients departments of this hospital decreased significantly in the year of 2008-09, but this decline in utilization is not due to user fees. There are other reasons like, lack of trained professionals and availability of medicines in many departments during that period affected the service utilization. But in 2009-10 the health service utilization has increased, because now many departments have the facility of specialists and departments are equipped with modern diagnostic and therapeutic instruments. But there is a steady increase in admissions in all departments through out the study period. Very interestingly there is a sharp decline in all departments providing free services in 2009-10.

TABLE 2: THE SHARE OF USER FEES TO TOTAL BUDGET TO JIMMA UNIVERSITY SPECIALIZED HOSPITAL BUDGET [2005-08]

Year	2007-08[Birr]	2008-09[Birr]	2009--10[Birr]
Total budget	12,136,434	14,795,827 [2.19%]	15,491,100 [4.7%]
Revenue from user fees	689,004.47	704,281.32 [2.2%]	731,028.37 [7.8%]
Percentage of user fees	5.68%	4.76%	4.72%

The study results show that there is steady increase in public health budget allocated to this hospital. There is 2.19% increase noticed in 2008-09 and again it is increasing up to 4.7%in 2009-2010 periods. The growth of revenue from user fees has increased from 2.2% in 2008-09to 7.8% in 2009-2010 and revenue from user fees and total budget allocated and used by the hospital are increasing every year but when the revenue from user fees compared to public health budget is declined form 5-68% in 2007-08 to 4.72% in 2009-2010.

TABLE 3: SOCIO-DEMOGRAPHIC CHARACTERISTICS OF EXIT INTERVIEW RESPONDENTS

No	Socio-demographic Variables	Total [n]	Percentage
1	Sex Male	224	57%
	Female	171	43%
2	Residence Urban	157	39.3%
	Rural	242	69.7%
3	Age 18-24	118	34%
	25-34	96	27.6%
	35-44	58	16.7%
	45-54	40	11.5%
	<55	35	10.5%
4	Education <Grade 1	84	26.2%
	Grade 1-6	79	24.9%
	Grade 7-10	74	23.7%
	Grade 10-12	36	11.2%
	>Grade 1	45	14.0%
5	Occupation Government employees	31	7.8%
	Merchants	46	11.8%
	Farmers	137	34.3%
	Housewife	42	10.5%
	Students	108	27.6%
	Other workers	21	5.3%
	Unemployed	10	2.8%
6	Monthly income <300Birr	185	47.0%
	300-500 Birr	122	31.7%
	500-1000 Birr	60	15.5%
	>1000 Birr	23	5.8%
7	Marital status Married	192	47.9%
	Never married	187	47.6%
	Separated	5	1.2%
	Divorced	3	2.0%
	Widowed	5	1.2%
8	Land ownership Yes No	259 137	65.4% 34.6%
9	House ownership Rented from kebele	18	4.5%
	Rented private	51	12.7%
	Own house	321	81.0%
	Free	6	1.5%
	Others	1	.2%
10	Family size 1-2	34	5.2%
	3-5	159	38.3%
	>5	203	56.2%

SOCIO-DEMOGRAPHIC CHARACTERISTICS OF THE EXIT INTERVIEW RESPONDENTS

The study covered a total of 401 facility exit respondents. Out of the total respondents, 227[56.6%] were found to be males and 242[60.3%] are from rural areas. One hundred and thirty seven [34.3%] of the respondents are farmers followed by one hundred and eight [27.6] are students. Thirty one [7.8%] is government employees and forty two [10.5%] are housewives. One hundred eighty five [47%] of the respondents had a monthly income less than 300 birr [US$ 10] per month. Only twenty three [5.8%] had the income above 1000 birr per month. The main source of income for two hundred and twenty eight [57%] respondents are from farming followed by eighty three [20.8%] from employment. Of the total respondents two hundred, and thirty five [58.6%] can read and write. Eighty four [26.2] respondents had the education below 1 grade and only forty five [14%] completed grade 12th. Two hundred and fifty nine respondents [65.4%] had their own land, and three hundred and twenty five [81%] living in their own house. One hundred and eighty four [46.2%] of the respondents had electricity facility, three hundred and three [75.8%] had the facility of separate kitchen and toilet.

TABLE 4: COMPARISON OF SOCIO-DEMOGRAPHIC VARIABLES WITH WAIVERS GRANTED AND PAY CATEGORIES OF SERVICES AT JIMMA UNIVERSITY SPECIALIZED HOSPITAL, SOUTH WEST ETHIOPIA (MAY 2009)

No	Socio-Demographic Variables	Paid	Granted free/wavier	Total	p-value
1	Sex				
	Male	136 [61%]	88 [39%]	224	0.836
	Female	105 [62%]	65[38%]	170	
2	Residence				
	Urban	111[71%]	45 [29%]	156	0.002
	Rural	132 [55%]	107[45%]	239	
3	Age				
	18-24	73 [61%]	45 [39%]	118	
	25-34	75[78%]	21 [22%]	96	0.582
	35-44	28[48%]	30[52%]	58	
	45-54	66[73%]	24 [27%]	90	
	>55	21[60%]	14[40%]	35	
4	Occupation Government employees				
	Merchants	26 [83%]	5 [17%]	31	
	Farmers	35 [76%]	11 [24%]	46	
	Housewife	72 [53%]	65 [47%]	137	0.003
	Students	29 [69%]	13 [31%]	42	
	Other workers	65[60%]	43 [40%]	108	
	Unemployed	11[52%]	10 [48%]	21	
		4 [40%]	6 [60%]	10	
5	Monthly income				
	<300 Birr	106 [57%]	79 [43%]	185	
	300-500 Birr	65 [53%]	58 [47%]	122	<0.001
	>500 Birr	69 [77%]	14 [23%]	83	
6	House ownership				
	Rented from kebele	10 [55%]	8 [45%]	18	
	Rented private	34 [67%]	17[33%]	51	0.767
	Own house	196[61%]	125 [39%]	321	
	Free	3 [50%]	3[50%]	6	
	Others	1 [100%]	0	1	
7	Education				
	<Grade 1	41 [48%]	43[52%]	84	
	Grade 1-6	50 [63%]	29[37%]	79	0.370
	Grade 7-10	48 [65%]	26 [35%]	74	
	Grade 10-12	28[78%]	8 [22%]	36	
	>Grade 12	28 [62%]	17 [38%]	45	
8	Main source of income				
	Employment				
	Farming	62[75%]	21[25%]	83	0.000
	Business	116[51%]	110[49%]	226	
	Others	63[80%]	16[20%]	79	
		3 [37%]	5 [63%]	8	
9	Land ownership				
	Yes	140[55%]	116[45%]	256	0.000
	No	101[74%]	35 [26%]	136	
10	Family size				
	1-2	22[64%]	12[36%]	34	0.628
	3-5	100[63%]	59 [57%]	159	
	>5	12160%]	82[40%]	203	
11	Self assed poverty level				
	Very poor	29[49%]	30 [51%]	59	
	Moderately poor	152[59%]	104 [41%	256	0.001
	Not poor	51[80%]	13[20%]	64	

WAIVERS AND EXEMPTIONS RECEIVED BY RESPONDENTS

Out of total 401 exit interview respondents two hundred and forty four [60.8%] paid for the services and one hundred and fifty three [38.2%] claimed that they got free treatment from the facility. The proportion of respondents aware of free health care for poor was 97% and 92.3 % for urban and rural respectively. Out of these respondents 26.9% got this information about free health care provision from their kebele and only 4.5 % from facility level. One hundred and forty three [35.7%] of respondents claimed that they are facing problems to get free treatment card from kebele. One hundred and eighty eight (46.9%) of the respondents reported that they know many people who did not get free treatment letter, even if they were deserved. Two hundred and one (50.1%) claimed that they personally know people who are not going to health facilities because of their inability to pay. Two hundred and eight (51.9%) reported they know people who are rich are getting free card from kebele. Three hundred and three respondents [76.1%] believed that the cost of health care is high so there is a need for pro-poor health care financing system while three hundred and ninety three (98%) respondents heard about health insurance schemes. two hundred and sixty four respondents had the awareness on private insurance and ninety nine (24.7%) had membership in community based insurance schemes. Comparing the pay categories of respondents with their socio-demographic characteristics: monthly income, occupation, land ownership, and residence, source of income and self assessed poverty level of the respondents turned out to be statistically significant, while, age, sex, house ownerships marital status, education level, family size etc are not significantly associated.

RESULTS OF IN-DEPTH INTERVIEWS

We present below the opinions expressed by various stakeholders at facility level through in-depth interviews. The vice president for health services expressed the opinion that "*The user fees settled in our hospital is very low compared to the hospitals run by federal Ministry of health .So we are planning to revise the fee this year itself. But there should be a window for poor people. I don't think that user fees will produce a big problem for the people because majority is getting either free treatment or exempted from the payment".* The administrator expressed his dissatisfaction about the selection criteria for the poor. He told "*I know that many people who do not deserve are getting benefits of free card but the selection done by kebele level. Government should take necessary steps to avoid this kind of leakages."* One official from ministry pointed out the positive aspects of user fees. *"We have very good examples in our country that user fee system is working in good manner. Many hospitals run by ministry of Health are collecting significant amount of money and utilizing for the development of hospitals. Such a mechanism is needed for teaching hospitals also."*

DISCUSSION

This study assessed the role of user fees as a health care financing mechanism in Jimma university hospital. Through this study we attempted to examine the health service utilization, revenue from user fees, utilization of revenue from user fees, assessment of free health care services etc. This hospital is governed by the Ministry of Education as a teaching hospital in the country. Total four teaching hospitals in the country under the direct control of Federal Ministry of Education. The user fee levels fixed by the Ministry of Education is less compared to the fees charged in other hospitals run by Federal Ministry of Health. Another feature of the user fee system in these hospitals is revenue from user fees is not permitted to retain and utilize at facility level for the expansion of services. The amount should be remitted to Ministry of Finance and Development. So the development of the hospital is mainly depends upon the annual budget allocated by the government and some external aids. The results of the study showed that health service utilization decreased significantly in the year of 2006-07, but this decline in utilization is not due to user fees. In depth interview with hospital authorities reveled that there are other reasons for this phenomenon. There was severe shortage of trained professionals and availability of medicines in many departments during that period. This may be the reason why health service utilization declined in that period. But again in 2007-08 the health service utilization has increased, because now many departments have the facility of residents and specialists and have the facility of modern diagnostic and therapeutic equipments. This is well noticed in the areas of dentistry and surgery. But ther is a sharp decline in utilization of out patients departments providing free services. The exact reason behind this is not clear, but a community health center which is functioning in Jimma town is retaining user fees at facility level and functioning well. The access for free health services like immunization, ART,TB and MCH services are available in this facility also.

The study shows that the total budget allocated and used by the hospital is increasing but it is not enough to cater to the health care demand of the growing population in the area. In-depth interview with the officials of Jimma University Hospital revealed that many times they are in financial crisis and facing difficulties for purchasing medicines and maintenance of bio-medical equipments. The results reveal that revenue from user fees is increasing significantly compared the other countries of Sub-Saharan average. But when compared to the percentage of total budget allocated to the hospital the revenue from user fees is declining. Leakages and under coverage is common phenomena, because the criteria for exemption from user fees is decided at kebele level. Hospital authorities don't have any direct control on this matter.

Another factor is the revenue from user fees is not utilized for the quality improvements of the hospital. There is no updated guideline or training for the staff. No incentives for encouraging staff to collect more money, so they are less motivated and accountable for the collection of money from patients. Proper recording system is also needed to improve the situation. Though all key informants appreciated the role importance of user fees in public health facilities, most have reinforced the need to grant free health care for poorer sections of the society. However, as it has been seen in other studies in other countries the problem lies on the absence of clearly stated criteria and means testing while grant fee waivers.

This particular study examined the free health care provision in Jimma University Hospital through an exit interview among 401 respondents. Out of the total exit interview respondents two hundred and forty four [60.8%] paid for the services and one hundred and fifty three [38.2%] claimed that they got free treatment from the facility. The proportion of respondents who are aware of free health care for poor was 97% and 92.3 % for urban and rural respectively. The sources of information for majority are from their kebele and only 4.5 % are from facility level. One hundred and forty three [35.7%] of respondents claimed that they are facing problems to get free treatment card from kebele. Forty six.9% of the respondents reported the possibility of the under coverage while 52% claimed a possible leakage in the free health care system. This could imply the failure of equity goals, which are the primary aims of exemption policies. This problem could possibly be alleviated by setting up a transparent and organized free health care provision. Three hundred and three respondents [76.1%] believed that the cost of health care is high so there is a need for health care financing system while two hundred and sixty four respondents had awareness on private insurance and ninety nine known about community based insurance schemes. Expanding community health insurance mechanism [Edir] is one of the strategies of health care financing in Ethiopia, so the awareness on this issue can be seen as a great achievement of government policy. In this study the socio-demographic variables such as income, occupation, landownership, source of income etc are found to be associated statistically significant with free treatment and waivers. Very interestingly self assessed poverty level show highly significant association with free treatment. This may show that despite the absence of clear guidelines for selection criteria, people who deserve have got the service.

CONCLUSION

The results of the study thrown light on the finding that neither theory nor analysis offers any clear evidence of the impact of user fees on service utilization. This could also be attributed to deficiency in data sets that we used. There is no evidence on the impact of user fees on health service utilization. However other factors like the availability of health professionals and medicines are affecting the health service utilization. Although the fees structure was remained unchanged for many years, the cost of health services remains an important reason for low level of utilization of health services in Ethiopia. The study shows the clear evidence that the revenue from user charges is increasing continuously. There is 7.8% increase in thee revenue from user fees in the year of 2008, but the public health budget has increased this period while a 4.7% increase was witnessed in 2008.This is the reason behind the decline in percentage of user charges to the allocated budget of the hospital. If the revenue is allowed to utilize for the expansion of services one can expect the quality of services to improve and along with improve health services utilization. But before setting an optimal strategy on user fees there are certain key areas which should be considered. *First* the identification of beneficiaries for free services and exemptions schemes .If potential beneficiaries are identified and considered, the equity part of user fees will be taken care. *Secondly* the protection of households against financial risk associated with illnesses requires attention. Some health insurance mechanism in the form of social or community insurance is needed to address the risk related to catastrophic illness of the poor and certainly help to improve the health care utilization. Now the government of Ethiopia is planning to increase the user fees in public health facilities. A significant increase in user fees may reduce the demand for health care or place an additional burden for household budgets. While restructuring of user fee system will be appropriate only if accompanied by other efforts simultaneously increase the demand for health care services and level of utilization of public health facilities.

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