International Journal of Gynecology and Obstetrics 115 (2011) 310–315

Contents lists available at SciVerse ScienceDirect

International Journal of Gynecology and Obstetrics

journal homepage: www.elsevier.com/locate/ijgo

AVERTING MATERNAL DEATH AND DISABILITY

User fees and maternity services in Ethiopia

Luwei Pearson [a,*], Meena Gandhi [b], Keseteberhan Admasu [c], Emily B. Keyes [d]

[a] UNICEF, Ethiopia
[b] Save the Children UK, Ethiopia
[c] Federal Ministry of Health, Ethiopia
[d] FHI, Research Triangle Park, USA

ARTICLE INFO

Keywords:
Ethiopia
Low-resource country
Maternity services
Quality of care
User fees

ABSTRACT

Objectives: To examine user fees for maternity services and how they relate to provision, quality, and use of maternity services in Ethiopia. *Methods:* The national assessment of emergency obstetric and newborn care (EmONC) examined user fees for maternity services in 751 health facilities that provided childbirth services in 2008. *Results:* Overall, only about 6.6% of women gave birth in health facilities. Among facilities that provided delivery care, 68% charged a fee in cash or kind for normal delivery. Health centers should be providing maternity services free of charge (the healthcare financing proclamation), yet 65% still charge for some aspect of care, including drugs and supplies. The average cost for normal and cesarean delivery was US $7.70 and US $51.80, respectively. Nineteen percent of these facilities required payment in advance for treatment of an obstetric emergency. The health facilities that charged user fees had, on average, more delivery beds, deliveries (normal and cesarean), direct obstetric complications treated, and a higher ratio of skilled birth attendants per 1000 deliveries than those that did not charge. The case fatality rate was 3.8% and 7.1% in hospitals that did and did not charge user fees, respectively. *Conclusion:* Utilization of maternal health services is extremely low in Ethiopia and, although there is a government decree against charging for maternity service, 65% of health centers do charge for some aspects of maternal care. As health facilities are not reimbursed by the government for the costs of maternity services, this loss of revenue may account for the more and better services offered in facilities that continue to charge user fees. User fees are not the only factor that determines utilization in settings where the coverage of maternity services is extremely low. Additional factors include other out-of-pocket payments such as cost of transport and food and lodging for accompanying relatives. It is important to keep quality of care in mind when user fees are under discussion.

1. Introduction

User fees are an unaffordable burden for poor households and represent one facet of the social exclusion experienced by the poor. Out-of-pocket payments, which include user fees at public sector facilities, are regressive methods of financing health care, taking a higher proportion of income among poor households than wealthier ones [1]. One challenge to improving maternal health services is that of balancing the need to increase coverage and utilization, particularly among the poor, with the need to improve the quality and financial viability of the health system.

Factors related to uptake of health services are many and complex, and vary in countries with low and high coverage of skilled birth attendants (SBAs). A review of the literature on the role of user fees in healthcare services in 5 African countries showed that removing them generally has positive effects on utilization of services, but also highlighted issues of quality, workload, provider satisfaction, and implementation [2]. An evaluation of the national free delivery and cesarean policy in Senegal found that there were small increases in utilization for normal deliveries (from 40% to 44% of expected deliveries in the intervention areas from 2004–05) and in (population-based) cesarean rates, which increased from 4.2% to 5.6% [3]. A recent review analyzed 8 case studies using different methods to increase access to obstetric services, including the abolition of user fees, targeted waivers, conditional cash transfers, and insurance schemes. Although service utilization increased with most approaches, concerns remained about the quality of care and rich/poor and urban/ rural equity. There were also concerns about the financial sustainability of these strategies [4].

In Ethiopia, it is clear that the population in the lowest wealth quintile has significantly poorer access to basic health care [5]. A study on the perceptions of user fees for health services showed that fees presented a considerable psychological burden to a family, especially when dealing with unexpected major illnesses. Families usually did not save and were often forced to sell assets in these

* Corresponding author.
E-mail address: lpearson@unicef.org (L. Pearson).

0020-7292/$ – see front matter
doi:10.1016/j.ijgo.2011.09.007

situations [6]. A more recent study on vulnerable children showed that the cost of illness was a significant factor in tipping families from poverty into extreme vulnerability and exposure to several risks [7]. The fees charged are often not standard and the indirect costs of health care such as transport costs and lodging for the family and food were as much of a burden as the fees themselves. Similarly, the recent National Health Account (NHA) survey round IV found that 4 out of 10 people who had been sick within the 4 weeks preceding the survey did not seek care and by far the most common reason given was affordability. This survey also estimated the national out-of-pocket per capita health expenditure to be US $4.15 for outpatients, US $0.46 for inpatients, and US $0.94 for nonhealth expenditures (transport, accommodation, and food etc.). The indirect costs were higher for rural residents than urban. Half of clients walk almost 10 km to get to facilities [8].

The Government of Ethiopia introduced healthcare financing reforms in the most populous regions of the country beginning in 2005. The principles and implementation of the reforms vary from region to region but include user fee retention at facility level, user fee revision, social and community based health insurance schemes, a waiver system for the poorest (identified by fixed criteria), and a standardized list of exempted services that are to be delivered free of charge to everyone at point-of-use at health center and health post level. While expenses to healthcare providers on waiver-related services are reimbursed, those on exempted services are not. These last two components, however, are bold progressive moves toward achieving real equity in healthcare access [9].

The implementation manual for healthcare financing reforms of the Federal Ministry 2005 [9] states that prenatal, delivery, postnatal, and family planning services provided by primary healthcare units (health centers and health posts) should be exempt from payment for all people (regardless of ability to pay), along with tuberculosis treatment, immunization, voluntary counseling and testing (VCT) for HIV, prevention of mother-to-child transmission of HIV (PMTCT), leprosy, and epidemic related services. However, as stated above, the cost of these services is not reimbursed to health centers and must be covered by other revenues. Exemptions do not apply at hospital level.

Perceptions of quality of care also play a role in seeking care for maternity services. Studies in both Ethiopia and Tanzania show that a high proportion of people bypass their nearest primary care facilities to seek care in higher-level government facilities or private facilities. Perceived poor quality of care at nearby primary care facilities (as well as the patients' age, number of children, and use of maternity waiting homes) was significantly associated with bypassing in the Tanzania study [10]. A qualitative study in Ethiopia identified other key factors that affected utilization of maternity services, including a lack of education, low income, lack of awareness of services, distance from services, and health facility related factors [11].

Ethiopia has taken many steps to resolve some of the barriers facing women when seeking maternity services. These include the rapid expansion of health services, moves to quadruple the number of midwives trained and the inclusion of prenatal, delivery, and postnatal care on the list of free services. Indirect cost factors, transport, cultural barriers, and the perceived quality of care have not been sufficiently addressed.

1.1. Purpose

We examine the cost and types of user fees charged for maternity services in both government and private hospitals and health centers that offer maternity services in all regions of Ethiopia using data from the emergency obstetric and newborn care (EmONC) assessment in 2008. In addition, we compare the quality and utilization of maternity services between facilities that charged and those that did not.

2. Methods

The 2008 Ethiopian National EmONC Assessment has been described in detail elsewhere [12]. Briefly, it covered 797 health facilities (750 government, 27 private for profit, 12 NGO, and 8 mission facilities) (Table 1). A total of 751 health facilities provided maternity services (112 hospitals and 639 health centers). Data were collected between October 8, 2008 and January 15, 2009. A total of 84 data collectors, all health professionals, were recruited and trained, then worked in 4-person teams. Hand held GPS units were used to take the location of the health facilities surveyed. Data were reviewed for quality before entry and were double entered in CSPro software (US Census Bureau, Washington DC, USA). The assessment had 10 modules for various aspects of EmONC services, and this paper focuses on the module on user fees related to maternity and EmONC. In all health facilities surveyed, we asked staff about types and amounts of user fees for maternity services including card fees (registration fee required before consultation), consultation fees, charges for delivery services, lab services, and essential commodities for maternity service, such as drugs and supplies. We also asked if payment is required before a woman can receive treatment, including treatment for obstetric emergencies. We analyzed the data to identify differences in quantity and quality of maternity services between the facilities that charge user fees and those that do not.

3. Results

3.1. Costs of EmONC Services

3.1.1. Card fees and payment policies

In Ethiopia, 54% of health facilities report that they require a card fee prior to providing services. The average charge for the card was US $0.40 in government hospitals and US $2.80 in the nongovernment hospitals. Fees were lower in health centers/clinics. Fee schedules were posted and visible in 29% of facilities (data not shown).

Among facilities (private and government) providing delivery services, 68% (85% in hospitals and 66% in health centers) charged a fee for normal delivery or required women to buy supplies for a normal delivery. Percentages were slightly higher in nongovernment facilities than government facilities.

One-fifth of facilities with delivery services required payment in advance for an obstetric emergency. Three-quarters of nongovernment and 30% of government hospitals required payment in advance. About 1 in 5 health centers/clinics required payment before treatment for an emergency (Table 1).

Table 1
Percentage of facilities that require women to purchase supplies and that require payment before emergency among facilities that perform deliveries, Ethiopia, 2008.

	Charge fee or require woman to buy supplies for normal delivery, % [a]	Require payment prior to treatment for obs/gyn emergency, % [a]	Total number of facilities that perform deliveries
National	68	19	751
Facility type			
Hospital	85	38	112
Government	83	30	90
Other	91	73	22
Health center/clinic	66	16	639
Government	65	16	625
Other	71	21	14

[a] Two health centers did not answer and were excluded from denominators in these columns.