BASICS SUPPORT TO THE ETHIOPIA HEALTH FINANCING STRATEGY

November 7-11, 1994

Dr. Daniel Kraushaar

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ACRONYMS

BASICS	Basic Support for Institutionalizing Child Survival Project
BI	Bamako Initiative
CMS	Central Medical Stores
ERCS	Ethiopian Red Cross Society
ERRP	Emergency Relief and Reconstruction Programme
ESHE	Essential Services for Health in Ethiopia
FP	Family Planning
GOE	Government of Ethiopia
HCF	Health Care Financing
HPN	Health, Population, and Nutrition
MIS	Management Information System
MOF	Ministry of Finance
MOH/E	Ministry of Health/Ethiopia
MSH	Management Sciences for Health
P/PHC	Primary and Preventive Health Care
REDSO	Regional Design and Support Office
RDF	Revolving Drug Fund
TA	Technical Assistance
TDY	Temporary Duty Assignment
TGE	Transitional Government of Ethiopia
USAID	United States Agency for International Development
USAID/E	USAID/Ethiopia
USAID/W	USAID/Washington

Purpose of Trip/Background

This consultancy was part of the USAID/REDSO collaborative effort designed to share health care financing-related experiences between countries in the Eastern and Southern Africa region. This effort is funded by the USAID regional office (REDSO) through a buy-in to BASICS in Washington and supported by the USAID Population and Health Office, USAID/Kenya.

This visit was a continuation of several previous contacts between the Ministries of Health in Ethiopia and Kenya and the USAID-funded Kenya Health Care Financing Project. In early 1994 Ethiopia's health financing study team visited Kenya to learn about Kenya's Health Financing Programme after which the head of the Health Care Financing Secretariat, MOH Kenya, Ibrahim Hussein, and Dan Kraushaar, Chief of Party, Kenya Health Care Financing Project visited Ethiopia to assist the study team in preparing their draft national health care financing strategy.

Following these initial visits, members of the Ethiopian study team returned to Kenya to attend Management Sciences for Health's financial management course in Nairobi. During this time Dan Kraushaar, Ibrahim Hussein and David Collins, MSH's Health Financing Program Director, provided additional assistance to the Ethiopian team on their HCF Strategy. It was during this meeting that the Ethiopian team requested a follow-up visit by Dan Kraushaar to Ethiopia.

The study team of Ethiopia's Ministry of Health has requested additional visits by Dan Kraushaar and Ibrahim Hussein up to the point that their Health Care Financing Strategy is adopted as national policy by the Government of Ethiopia. Scopes of Work and concurrences for additional visits will need to be developed in the next two months.

Scope of Work

The scope of work for the visit by Dan Kraushaar to Ethiopia was defined by Dr. Barbiero USAID/E in an e-mail to BASICS dated 11/03/94:

1. To follow-up on HCF Strategy document preparation with the Ethiopian HCF strategy development team.

2. To prepare a detailed review of the MOH draft HCF strategy statement, including issues and deficiencies, if any.

3. Further discuss options for conditionality with USAID/E/HPN office.

4. Review the HCF budget within the ESHE project, and provide more detail as required.

5. Set the timetable for future consultant visits.

6. Prepare a draft trip report.

In addition to the above, the Ethiopian Study Team and BASICS requested the following:

7. Develop a scope of work and budget for a national-level technical review of the draft HCF Strategy.

8. Develop a scope of work and tentative budget for a national policy-level review of the HCF Strategy.

9. Develop preliminary scopes of work for three studies:
   - Curative/quality gap study
   - Primary/preventive services gap study
   - Addis Ababa area study

10. Define the roles and functions, staffing and budget for the Ethiopian Health Care Financing Secretariat and technical assistance team.

Trip Activities

During the majority of time in Ethiopia, the consultant worked with three members of the Ethiopia study team: team leader Beletu Woldesenbet, Ato Gebre and Ato Mohammed. Discussions were held regarding the assignment with Dr. Victor Barbiero, Head USAID/E/HPN, Dr. Carmela Green-Abate of USAID/E, Ms. Margaret Neuse, USAID/W and Dr. Messeret Shiferaw, Head, Health Services and Training Department, MOH/E. A debriefing of USAID/E and Dr. Messeret occurred on Friday, November 11 at the Ministry of Health.

The consultant met daily with the team at the Ministry of Health, after which editing of the materials continued. The bulk of time was spent on the draft Health Care Financing Strategy following up on meetings held in Nairobi and comments made earlier. As requested, additional remaining time was devoted to work on the agenda and budgets for the technical and national reviews, and roles and functions of the HCF Secretariat.

The draft Health Financing Strategy is far from perfect. It is broader now as a result of discussions and will enable the Ministry of Health to be involved in a broader range of health financing activities than simply cost sharing. The study team recognizes these limitations but feels that sending out an official draft report will lead to the technical review (outlined in Appendix B). At that time the document can be further revised as needed.

(See appendices for additional outputs from trip).

Recommendations

In addition to the information contained in the appendices (which is self-explanatory), the following are general recommendations regarding the Ethiopian Health Financing Strategy:

HCF in the Ministry of Health

Health financing is considered by many to be simply the collection of user fees, their accountability and control. In reality, a properly defined and implemented health financing program cuts across all aspects of the functions of a ministry of health. Financing strategies, as defined in the attached draft document, are broadly defined and address the efficiency of health services delivery, allocation of GOE resources, manpower distribution, private sector involvement, user fees and so forth. Because of this broad scope, any constituted Health Financing Secretariat must be empowered to work directly with all levels of the Ministry of Health and regions. For this to work, the head of the Secretariat needs be positioned in the Ministry of Health in such a way that he/she can discuss policy and implementation issues directly with the Vice Minister.

Role and Longevity of the HCF Secretariat

The HCF Secretariat, given the extent of decentralization in Ethiopia, should be considered a temporary body assigned the task of implementing, with the regions, the core of a national health care financing reform program for a defined period of time (3-4 years) after which it could be disbanded as a unit. There may continue to be a need for central financing functions but keeping a full complement of staff indefinitely would be hard to justify.

Equity issues

Rich regions will collect more cost sharing revenue than poor regions. Rich regions also tend to absorb more health resources than poor regions. For this reason attention needs to be given to how to avoid equity problems in the implementation of the proposed user fee program. This can be done through MOH/E's retention policy or through a redistribution of GOE resources for health. This potential problem was not adequately addressed in the draft strategy.

Technical assistance team

The TA team proposed in the strategy is larger than envisioned by USAID. Experience in Kenya indicates that a well-qualified, experienced TA team at the national level is important for the successful implementation of a national program. Most of the strategies outlined in the document have core activities which need to be implemented nationwide but could allow for regional variability. If donors concentrate only on specific regions, national uniformity of key programs may suffer and, in the end, Ethiopia could be worse off. USAID/E should consider funding at least two of the central staff on the TA team. The two positions would be a local Ethiopian hospital specialist (see comments on Beletu below) and a financial management/chartered accountant-type specialist. The management specialist and the health services planner are necessary though not immediately so. Given the MOH emphasis in Project Year One on the cost

sharing program, combining the talents of a hospital person (local) with those of a financial management person would be most useful.

Beletu Woldesenbet

Mrs. Beletu has been head of the health financing study team and responsible for putting together the draft Ethiopian Health Financing Strategy. The rationale for recommending her for the position of hospital specialist on the technical assistance team has been forwarded with this report. Her experience and abilities would be very useful at the national level and for USAID/E in their work in the Southern People's Region.

Privatization

The Ministry of Health steadfastly refused to consider privatization of nationalized health facilities in their Health Financing Strategy. The MOH did, however, indicate that support for private sector development is their policy and will be maintained. Effort should be made to have the MOH/E consider privatization of previously nationalized facilities as one way of promoting movement towards greater private sector health care services.

Extent of cost recovery

The Ministry of Health has high expectations for the user fee program, thinking that it will recover a relatively large portion of the recurrent budget. Experience in Kenya and elsewhere indicates that the degree of cost recovery may be limited. If the revolving drug fund is to cover a large portion of the drug bill, then the balance of user fee revenue will be negligible (perhaps in the range of 5-10 percent of the recurrent budget).

Revolving drug funds

The Ministry of Health is proposing revolving drug funds as a means of addressing chronic drug shortages in the system. The proposal is that revolving funds would cover 100 percent of the cost of the drugs. In order for this to happen drug charges would not only have to cover the cost of the drugs but also transportation and handling, in addition to the cost of drugs given out to exempt patients, the poor and to regions which have lower cost recovery potential. The Ministry of Health may need to lower their expectations on the extent to which revolving drug funds can address the drug financing on a national level.

The Southern People's Region as a pilot site

The Health Financing Strategy wisely proposes that the user fee program (and other interventions) occur in a phased way using Addis Ababa and one region as the first step. It makes good sense since USAID/E is planning to support the HCF Secretariat and the Regional Health Bureau in the Southern People's Region, that this region be the test site for many health financing interventions. It would also allow the one advisor Dr. Barbiero plans to place in MOH headquarters to be better integrated into the TA team which will be located in Awassa.

Follow-on TDY's

The Ministry of Health has requested support from Kraushaar and Ibrahim Hussein in implementing the technical review workshop as well as the national policy workshop to be held the latter part of January, 1995 and March, 1995 respectively. The timing and involvement are okay for both people (although USAID/Kenya approval is needed). Dr. Barbiero and Ken Heise of BASICS are also in agreement. Firm arrangements will have to be made in Ethiopia between Beletu and Barbiero. It remains to be seen whether additional collaboration after these two workshops would be needed.

Appendices

Outputs of the assignment are attached:

Appendix A Comments on the HCF Strategy
Appendix B Scope of Work, Technical Review of the Strategy
Appendix C Scope of Work, Curative/Quality Gap Study
Appendix D Scope of Work, Primary/Preventive Service Gap Study
Appendix E Scope of Work, Addis Ababa Area Study
Appendix F Outline of roles, functions and budget for HCF Secretariat

also completed:
Scope of Work, National Policy Review (see Health Care Financing Strategy)

APPENDICES

APPENDIX A

Appendix A.1

KENYA HEALTH CARE FINANCING PROJECT

Management Sciences for Health
Carr, Stanyer, Gitau and Co.
Box 41869, Nairobi, Kenya
Phone: 716761; FAX: 254-2-719308

TO: Mrs. Boletu Woldensebet
FROM: Dan Kraushaar
DATE: October 20, 1994

SUBJECT: Comments on Ethiopian Health Financing Strategy

Attached please find the combined comments of David Collins and myself for your review. We both congratulate you on the fine work you and your team have done. It's amazing to see the amount and quality of work done by you and your team given that this was all done in addition to your routine assignments with the Ethiopian Government.

We hope these comments are helpful.

I understand that Mr. Hussein will be giving you his comments directly.

APPENDIX A.1 (cont)

REVIEW AND COMMENTS
ETHIOPIAN HEALTH FINANCING STRATEGY
October 20, 1994

Our comments are not editorial in nature but pertain primarily to the scope of the strategy and broad content issues.

COMMENTS ON PART 1

Problem identification

A number of problems were outlined in Part I of the strategy. I've listed them below because, for each priority problem, you may want to develop a strategy for overcoming the problem. However, not all problems were addressed in the strategy. This list is in no priority order. Consideration should be given to make sure all priority problems addressed in the background section of Part 1 are addressed in the strategy either as long term objectives or shorter term objectives for more immediate action.

PROBLEM/ISSUE	ADDRESSED IN STRATEGY?
User charges not kept up with cost/inflation	yes
Decentralization	yes
Uneven distribution of facilities and general lack of infrastructure	no
Manpower 60% of recurrent budget	no
Manpower underutilized because of lack of supplies/equipment, etc	not directly
Low per capita spending on health	no
Collected revenue not retained	yes
Drugs supply inadequate	somewhat - revolving drug fund only
Mission/private facilities nationalized	no
Little insurance	yes
Low FP use but high population growth rate	no
Ignorance of population	no
Lack of management skills and supervisory structure	no
Free patients 30% to 85% of revenue lost	yes
Unqualified accounting staff	no
Revenues declining and low compared to need	yes
Inefficient revenue collection	yes
Addis Ababa consumes inappropriate amount of resources	no
Inefficient use of existing resources	yes
Fees not revised recently	yes

In addition to this you allude to lack of social and health insurance but there are no data to support this assumption.

Summary of ten year financing objectives

In summary, the 10-year strategies for addressing the above problems are outlined below. While nobody can argue with these objectives it may be useful to set specific measurable targets to be achieved. You have much of the information to identify a specific target in the background material but moving from review of data to financing strategies has left off any quantification of how much change you'd like to see in the future.

1. Improve government sector efficiency
   - allocative efficiency
   - operational efficiency
   - therapeutic efficiency
2. Generate new sources of revenue
   - increasing GOE allocations
   - expand and revise the user fee program
     - retention
     - control
     - staff incentives
     - no-year funds
   - revolving drug funds
3. Encourage private sector participation
4. Increase donor funding
5. Develop social and private health insurance
6. Expand private sector services in Addis Ababa
   - financed by health insurance
   - privatization of existing services
7. Revise GOE policies and laws

The 10-year strategies form the acceptable priority list of options upon which specific 5-year and 1-year objectives, targets and activities are based. If some area is not chosen for action reasons why they are not chosen should be stated.

COMMENTS ON PART 2: 5-YEAR IMPLEMENTATION PLAN

On page 53-54 you summarize the long range strategies. This list misses two of the strategies outlined in Part 1 namely (1) Overall development of social and private health insurance (insurance not specifically targeted to Addis Ababa) and (2) revision or changes to GOE policies, rules, regulations and laws to facilitate changes in the health care system and its financing.

In general, you may want to reorganize the 5-year section of your strategy in the following order to make it more readable:

item	current page numbers
10-year summary of strategies	pages 53-54
5-year summary of strategies	pages 55-57
5-year objectives and targets	pages 54-55

A summary table would be useful as illustrated below:

10-YEAR STRATEGY	5-YEAR STRATEGY	5-YEAR OBJECTIVES/TARGETS

I put together a table of 10-year strategies and 5-year strategies and objectives to illustrate that some 10-year strategies were ignored in the 5-year time horizon. Reasons for not addressing certain strategies should be given. (see table 1 below) Some 5-year objectives don't have strategies and some 5-year strategies don't have objectives and some objectives which, by definition should be quantified, aren't quantified and therefore are not measurable. For example,

TABLE 1

LIST OF LONG TERM FINANCING STRATEGIES AND CHOSEN FIVE-YEAR OBJECTIVES FOR HEALTH FINANCING

10-YEAR FINANCING STRATEGIES	FIVE-YEAR OBJECTIVES
Improve government sector efficiency . allocative efficiency . operational efficiency . therapeutic efficiency	1. Rationalize hospital care 2. Promote efficient use of GOE health resources 3. Develop mechanisms for rational use of drugs
Generate new sources of revenue . increasing GOE allocations . expand and revise the user fee program - retention - control - staff incentives - no-year funds . revolving drug funds	1. User fees at least 35% of GOE recurrent budget 2. Develop a policies and procedures manual for revolving drug funds and four (4) regions piloting revolving drug funds. 3. Develop other revenue generation schemes
Encourage private sector participation	
Increase donor funding	1. Increase by 50% in donor and NGO funding of curative, preventive health care
Develop social and private health insurance	1. Increase the population covered by insurance
Expand private sector services in Addis Ababa . financed by health insurance . privatization of existing services	1. Examine and test strategies for enhanced private sector participation in health in Addis Ababa
Revise GOE policies and laws	1. Alter laws on importation and distribution of drugs. 2. Change regulatory, licensure laws constraining private sector. 3. Removal of legal and regulatory barriers to private health care development

Five-year strategies which don't have 10-year strategies include:

1. Strengthen basic and or preventive services using money generated through curative service-giving institutions.

2. Establish a management system within the MOH to support health financing activities nationwide.

3. Create a cadre of professional managers capable of overseeing the recovery of the health system in Ethiopia.

COMMENTS ON PART III

This section would benefit from a statement of specific one-year objectives and tasks. This section is the longest, most specific and therefore most difficult to follow. A summary would be useful in the form of chosen five-year objectives compared to one-year objectives and tasks in the form below:

FIVE-YEAR OBJECTIVES	ONE-YEAR OBJECTIVES	ONE-YEAR TASKS

It seems that the only five-year objectives addressed in the first year of implementation are:

1. Develop and expand the user fee program.

2. Develop social and private health insurance.

3. Develop a policies and procedures manual for revolving drug funds and four (4) regions piloting revolving drug funds.

Is this adequate? Is there nothing that can be done during year one to make some movement towards addressing other problems in the system?

SPECIFIC COMMENTS ON THE USER FEE PORTION OF THE PLAN

1. Provincial authorities should be able to set fee levels and to approve plans for spending cost sharing funds.

2. Fee levels and cost recovery targets: The cost recovery target of 35% of total MOH recurrent budget (page 54) is unrealistically high. There will probably be a high level of waivers and exemptions. For the remaining patients to cover such a 35% of total costs including preventive and administrative. services, the fee level will probably be more than cost and will not be affordable. The higher the fee levels, the higher the number of waivers. A target of 5% is probably realistic in the first two years, and 10% may be possible after that. A simple fee setting model should be used to determine fee levels and overall cost recovery targets. Someone should do a spreadsheet model for you to have in Ethiopia which would require basic information such as a detailed summary of MOH/E budget, volumes of services per facility, numbers and types of facilities, and suggested fees.

3. The policy of charging for public health services in urban areas and not in rural areas is not equitable. Why should the urban poor have to pay for services when better off people in rural areas get it free?

4. The following basic policies must be adopted by the program. You may want to talk to Victor Barbiero to see that you have support for them in his conditionalities for non-project assistance. They are:

- no-year funds
- additive to treasury allocations (missing from your document)
- local retention
- local control
- list of areas for which cost sharing revenue is acceptable to be used

In your document you did not mention **additivity** which is really a very basic policy which you would want. Agreement should be reached with MOF so that the MOH budget is not reduced in real terms. If that is not attainable, then at least the MOH should agree that funding to the MOH should not be reduced as a proportion of overall GOE budget. If it is currently 6% of the overall budget in 1993/94, it should not fall below that in future years.

The proportion of funds to be retained by the facility should be standard across provinces and types of facilities. To have a uniform policy such as 75% facility and 25% public health is simple, and the proportion can always be adjusted in later years. The MOH should have the power to decide the proportions used. The "public health" funds should be used at the level of the catchment area of the population. Revenues from a provincial hospital should be used for provincial level activities, or should be able to be redistributed to poorer districts for equity reasons.

5. Retention of funds should be 100% and no less. Need is far greater than available resources even with additional cost sharing revenue.

6. If you want to penalize self referrals at hospitals, you must ensure that the lower level services are accessible.

7. Exemptions: There should be a standard exemptions policy for the country. For example, children under 5 years should be exempt everywhere.

8. Budget allocation for poorer areas: The allocation of the central budget should compensate for lack of cost sharing potential in poorer areas in a way which does not remove the incentive to collect revenue. For example, revenue targets should be set for each region and the balance between the defined regional "need" and the cost sharing revenue target should be covered by the budget allocation. If a region collects less than the target, they should not be compensated for the shortfall, and if they collect more, they should be allowed to keep the extra.

9. Phasing of implementation: Implementation should be on a phased basis in order to test fees and systems, exemption and waiver policies, and to spread out the enormous task of developing operations manuals, training staff, etc. Implementation nationally all at once is politically and administratively very risky and is also a massive undertaking.

We recommend starting at a national referral hospital within Addis ababa and with Addis' urban area health centers if they are under the MOH. We would then recommend moving, after 3-6 months, to regional hospitals and later to regional health centres. Then you could use the national hospitals as the basis for training regions and regions as the basis for training health centres. It is very unlikely that good systems can be developed without proper testing in real life situations. The testing of systems and operations manuals in Addis Ababa will avoid possibly having to change them after implementing them nationally if problems occur.

10. Treatment fee vs consultation (door) fee: You are recommending a door or consultation fee. Our experience in situations where basic supplies and drugs are not routinely available is that collecting fees for no perceived service will lead to problems. Until at least the drug supply problem is solved you may want to move in the same direction as we did in Kenya and charge for services only when they are available. Otherwise the consultation is free.

11. Charging for P/PHC services which are public goods: You may want to consider not charging for P/PHC services for which demand is very price sensitive. You want to expand P/PHC services and so reducing all barriers to these services, including the cost barrier, is important.

12. Simplicity is a key word. Make sure all systems, fees and methods are as simple as possible. For example your fees on referral (see page 63) are a bit complex. Administering them, controlling them and implementing standards for supervision will be difficult.

13. Summary of exemptions. You should make a table of exemptions so it is easy to see who/what is exempt.

14. Organizational structure (page 74): An accountant would be appropriate to have on the regional hospital committee.

15. Zonal health management committee (page 76): This level should include the job of "executing the retained money"--spending funds accumulating at this level.

16. Don't forget that a revolving drug fund will reduce cost sharing revenue by a very large amount. If drug funds are only for drug purchases then cost sharing revenue will be almost insignificant.

17. The work of the HCF Secretariat (page 89) should include:
    - Developing standard policies and procedures for CS including manuals.
    - Implementing standard training for appropriate staff at all levels.
    - Monitoring and evaluation of the national program.
    - Systems development
    - Pilot testing interventions
    - Replication of interventions as appropriate
    - Work with the TA team

    The purpose of the HCF Secretariat should be clearly laid out in this section.

18. Budget for the HCF Secretariat: This is a first year budget and should be expanded to include both capital and recurrent budget needs over a 3 year period. You will need more than 3 computers, possibly 6.

Appendix A.2

SUMMARY OF PROBLEMS AND
WHERE THEY WERE ADDRESSED IN STRATEGY

FINANCING PROBLEM	ADDRESSED IN 10-YEAR STRATEGY?	ADDRESSED IN 5-YEAR OBJECTIVES?	ADDRESSED IN 1-YEAR PLAN?
EFFICIENCY			
Productive Infrastructure poor/broken Lack of basic supplies/drugs Management ability of GOE poor			
Allocative Uneven dist of facilities Uneven dist of staff Personnel 60% of rec budget Concentration resources in Addi_			
Therapeutic			
LACK OF RESOURCES			
User fee program Cost recovery low Fees revert to treasury			
Government allocations Gov't allocations to health low P/PHC under financed Concentration on curative care Major health probs preventable			
Drug supply Drugs under supplied Drug budget too low Drug management poor			
LACK PRIVATE SECTOR INVOLVEMENT Facilities nationalized Private sector uncontrolled			

LACK OF (SOCIAL) INSURANCE Health insurance undeveloped Insurance poorly understood			
LIMITED DONOR FUNDING Missions/NGO's sent away			

Appendix A.3

SUMMARY OF TEN-YEAR STRATEGIES
FIVE-YEAR OBJECTIVES
ONE YEAR TARGETS

ETHIOPIAN HEALTH FINANCING STRATEGY
November 7, 1994

10-YEAR STRATEGIES	5-YEAR OBJECTIVES	1-YEAR TARGETS
IMPROVE GOVERNMENT SECTOR EFFICIENCY Allocation of resource	Use cost sharing revenue to promote P/PHC services	
Operational efficiency	Adopt ways to strengthen referral system Evaluate, draft and review laws on importation and distribution of drugs Create a cadre of professional managers Develop a more motivated work force	Use cost sharing fee levels to influence patient use of curative care facilities.
Therapeutic efficiency	Develop mechanisms for rational use of drugs	
GENERATING NEW SOURCES OF REVENUE Government allocations	Continue GOE allocations to health	Continue GOE allocations to health Implement two studies: 1. P/PHC gap study 2. Curative/quality gap study

Expanded user fee program	User fee revenue at least 10% of GOE total recurrent budget for health Pilot new revised fee and retention policies Phased implementation of new program Changed rules on exemptions and waivers Develop private/high class wards Develop a Health Financing Secretariat	Conduct technical review of HCF strategy. Conduct national policy review of HCF strategy. Revise fee levels Revise exemption and waiver policies Revise revenue retention policies Develop MIS for managing the cost sharing program Develop expenditure guidelines Develop roles and responsibilities of all parties involved in cost sharing program Create and staff HCF Secretariat Develop revised cost sharing management and accounting systems. Train implementors of revised systems. Implement public awareness campaign
Revolving drug funds	Develop policies and procedures manuals Pilot implementation in four regions	Study and develop implementation design for revolving drug scheme. Develop proposed sales scheme operational procedures Identify pilot implementation sites and field test systems.
ENCOURAGE PRIVATE SECTOR PARTICIPATION	NGO/donor financial input increased by 50% Removal of legal and regulatory barriers to private health care Assess laws and recommend alterations	Assess role of private sector and demand for health insurance in Addis Ababa
DEVELOPMENT OF SOCIAL AND PRIVATE SECTOR INSURANCE	Increase population covered by insurance	Assess role of private sector and demand for health insurance in Addis Ababa

INCREASE DONOR FUNDING		
ADDIS ABABA AS SPECIAL FINANCING AREA	Increase population covered by insurance	Implement Addis Ababa area study.

APPENDIX B

APPENDIX B

PROPOSAL

TECHNICAL REVIEW OF ETHIOPIAN HEALTH CARE FINANCING STRATEGY

November 8, 1994

BACKGROUND

In 1993 the Transitional Government of Ethiopia set a restructuring and adjustment program in line with the new economic policy directives. Similarly the Ministry of Health took steps to set a new health policy which emphasized strengthening of national self-reliance by mobilizing and utilizing available internal and external resources.

Health care in Ethiopia is inadequately financed partly due to the long war that took place in the country and partly due to poverty. Realizing this fact, TGE committed itself to look for additional health care financing options, a task force which was organized at the MOH to explore the options came up with a recommendation of user fee retention and utilization in health facilities.

Directives by the P.M.O. were given to the MOH to further study and develop the issue. Following it, a Study Committee composed of Hospital Services Division Head, High Expert of Health Services, Division Head of Budget and Accounting, Division Head of personnel Administration, and pharmacist, expert, Department of Pharmacy was established at the support by His Excellency Dr. Abdi Aden Mohammed, Vice Minister of Health Services Main Department.

The draft Health Care Financing Strategy has been developed by the Study Committee. The Study Committee, however, wishes to have the Strategy technically evaluated by specialists in the fields covered by the Strategy. For this reason a technical review is planned prior to having the document formally presented for adoption by the Ministry of Health.

PURPOSE

The purpose of the technical review is to refine the Health Care Financing Strategy. During the technical review there will be:

1. debate on the problem definitions
2. debate and alteration of the 10-year strategies to address the problems
3. debate and alteration of the 5-year objectives to be achieved in implementing the 10-year strategies
4. refinement of the 1-year implementation plan
5. recommendations of resource requirements.

METHOD

It is proposed that a group of specialists in specific fields as defined in the draft Health Care Financing Strategy be convened to review the strategy and make recommendations for changing it if necessary. For each topic area background material will be prepared including a summary of the problem, summary of the 10-year strategies, 5-year objectives and 1-year targets to addressing the financing problem. This material will come primarily from the draft HCF Strategy document but may include other materials as appropriate. These materials, together with the Executive Summary of the HCF Strategy, will be provided to each of the people to be invited to the technical review for each topic they will address.

All specialists invited will be asked to participate in one or more of the working groups on specific topics. These working groups will be meeting concurrently during the workshop and will be staffed by members of the Study Committee.

Most of the technical review will be completed during the first two days with the exception of review of the portion of the draft HCF Strategy which relates to the special case of Addis Ababa. This final review will be completed in the morning of the third day.

Day four in the morning will be a review of the strategy with donors.

It is hoped that by the end of day five the draft HCF Strategy will have been revised in preparation for its submission to the Cabinet for approval.

CHOICE OF WORKSHOP PARTICIPANTS

People will be invited to the workshop based on whether the person has:

1. specific technical capability in a particular topic
2. influence over policy decisions which may affect implementation
3. control over resources required to implement recommendations
4. a current or future work assignment in a specific topic

EXPECTED OUTCOMES

It is expected that each group working on a specific topic will recommend changes to the existing draft HCF Strategy document, which will be incorporated into the draft HCF Strategy immediately following the workshop. A revised draft HCF Strategy should be prepared within one week following the technical review.

WORKSHOP FACILITATORS

The HCF Study Team will be the facilitators of the workshop. The workshop, it is proposed, will be opened by the Vice Minister for Health. Special support may be forthcoming from the Kenya Ministry of Health, Health Care Financing Secretariat and the Kenya Health Care

Financing Project with support from the regional office of USAID in Nairobi and financial assistance from the BASICS Project.

PREPARATION FOR EACH TECHNICAL WORKING GROUP

The lead person responsible for each technical working group will prepare a packet of materials which would include:

1. Background to the HCF Strategy

2. Background and technical information on the technical topic

3. Relevant excerpts from the draft HCF Strategy pertinent to the technical topic

4. Strategic questions to be addressed by each group

5. Blank forms to be completed by each group

For an example of the type of materials to be presented to each group, one set of materials was developed for the Revolving Drug Fund group and is attached to this proposal.

APPENDIX B (cont) WORKSHOP PARTICIPANTS
TECHNICAL REVIEW: DRAFT HCF STRATEGY

Working groups:

1. GOE efficiency: productive & allocative
2. GOE efficiency: therapeutic
3. Expanded user fee program
4. Revolving drug fund
5. Private/NGO sector development
6. Social Insurance/private health insurance development
7. Special case of Addis Ababa
8. Donor support

	TECHNICAL WORKING GROUP ASSIGNMENTS							
PERSON(S) INVITED	1	2	3	4	5	6	7	8
Medical Director: Central Referral hospital								
MOH Services and Training Department								
Ministry of Finance								
Ministry of Trade								
Ministry of Planning & Development								
MOH Pharmacist								
MOH Public Health Expert								
Public pharmacy								
Red Cross Pharmacy								
UNICEF: Bamako Initiative								
Team Leader: Arusha workshop								
Private pharmacist								
Private medical doctor								
Private nurse								
Medical director: regional hospital								
Large employer								

Ethiopia Insurance Corporation								
Head, Central Medical Stores								
Univ of AA: Economist								
Univ of AA: Law Professor								
MOH Medico Legal Services								
Ministry of Justice								
MOH Planning Department								
Addis Ababa City Council								
Medical Director: Zewditu Hospital								
USAID/Kenya								
FINNIDA								
World Bank								
SIDA								
DANNIDA								
Ministry of Finance								
MOH Deputy Minister								
MEEC								
MOH PPD								

AGENDA: Technical Review - draft HCF Strategy

The week-long technical review workshop will be implemented as follows:

Day 1
AM Background and summary of draft HCF Strategy by topic area

PM Concurrent small group working sessions:
- a. GOE Health sector efficiency: allocative and productive efficiency
- b. GOE Health sector efficiency: therapeutic efficiency
- c. Expanded user fee program

Day 2
AM Concurrent small group working sessions:
- a. Revolving drug fund
- b. Private sector (non-governmental) development
- c. Social and health insurance

PM Working group presentations

Day 3
AM Small group session on Addis Ababa as a special financing problem

PM Development of summary and begin editing of final draft HCF Strategy

Day 4
AM Briefing of donors on draft strategy discussing level of donor support and collaboration

PM Continue editing final draft HCF Strategy

Day 5

AM Continue editing final draft HCF Strategy

PM Completion of edit.

BUDGET: Technical Review - draft HCF Strategy

The budget is broken into two alternatives. The first, and least desirable, alternative is to have the technical review in Addis Ababa. This is least desirable because people may be pulled out occasionally for their routine work. Their full concentration on the task of reviewing the document is unlikely.

The second budget alternative is to have the meeting located in Debre Zeit about 40 km outside Addis. This alternative is strongly recommended because it would allow participants to fully participate in the review without distraction. The full group would stay two nights and two days. A selected few would remain for the morning of the third day to discuss the special financing case of Addis Ababa and return to Addis in the afternoon. On the third day selected donors would be invited for a briefing on donor implications of the draft.

	Addis Venue	Debre Zeit
lunches		
Birr 50/day for 2 days x 50 people	13,500	13,500
Birr 50/day for 1 day x 15 people	750	750
Birr 50/day for 3 days x 7 people	1,050	1,050
hotel		
Birr 250/day for 2 days x 50 people		25,000
Birr 250/day for 1 day x 15 people		3,750
Birr 250/day for 3 days x 7 people		5,250
Birr 250/day for 3 days x 10 people	7,500	
Conference room rent		
Birr 7.7/day x 50 people x 2 days	770	750
Birr 7.7/day x 15 people x 1 day	1,150	1,150
Birr 7.7/day x 7 people x 2 days	1,078	1,078
Coffee		
Birr 15/day x 50 people x 2 days	1,500	1,500
Birr 15/day x 15 people x 1 day	225	225
Birr 15/day x 7 people x 2 days	210	210
Fuel for vehicles	300	690
Stationery	1,500	1,500
	29,533	56,403
Contingency (10%)	2,950	5,640
GRAND TOTAL Birr	32,483	62,043
GRAND TOTAL US $	$5,282	$10,089

exchange rate used: $1.00 = Birr 6.15

ASSIGNMENTS: Technical Review - draft HCF Strategy

TECHNICAL WORKING GROUP	INDIVIDUAL WITH LEAD RESPONSIBILITY
Efficiency: Productive & Allocative	
Efficiency: Therapeutic	
Expanded user fee program	
Revolving Drug Fund	
Private/NGO sector development	
Social/Health insurance	
Special case of Addis Ababa	
Donors	

DRAFT

EXAMPLE OF HANDOUT TO TECHNICAL WORKING GROUP REVOLVING DRUG FUND

INTRODUCTION

In 1993 the Transitional Government of Ethiopia set a restructuring and adjustment program in line with the new economic policy directives. Similarly Ministry of Health took steps to set a new health policy which emphasized strengthening of national self-reliance by mobilizing and utilizing both available internal and external resources.

Health care in Ethiopia is inadequately financed partly due to the long standing war that took place in the country and partly due to poverty. Realizing this fact, TGE committed itself to look for additional option to health care financing and a task force which was organized at the MOH to explore the options came up with a recommendation of user fee retention and utilization in health facilities.

Directives by the P.M.O. were given to the MOH to further study and develop the issue. Following it, a Study Committee composed of Hospital Services Division Head, High Expert of Health Services, Division Head of Budget and Accounting, Division Head of personnel Administration, and pharmacist, expert, Department of Pharmacy was established at the support by His Excellency Dr. Abdi Aden Mohammed, Vice Minister of Health Services Main Department.

The health system of a country, like all other social services is a reflection of the overall socio-economic situation and the types and styles of the foregone political superstructures.

Virtually in every country, there is a sense that health needs are not met sufficiently. The situation in less developed countries is much more serious and below expectation even to satisfy the basic health needs.

In Ethiopia as well, the situation is more conflicting.

The health needs are rising faster than the national resources; public expectations are growing tremendously cost of medical equipments and materials, being governed by the international market, is ever increasing;

Lack of proper planning, the emergence of new communicable diseases, disease of deficiencies, poor housing conditions and unhygienic environment have worsened the condition;

- The meager resources of the country were drained by the long standing war that took place over the last 30 years. Also as a

result of the war, the great majority of the rural population was left without any form of health service.

- Even in the so called urban areas, the inadequate financial inputs, expressed by the shortage of drugs, poorly maintained equipments and buildings, improper bedding, inadequate and poor quality patient foods, shortage of reagents and other diagnostic materials, lack of appropriate personnel incentives, etc results in low staff morale and serious decline of medical care.

- Worst of all, the Derge regime nationalized the majority of the health facilities which had been run by NGOs including Missions. According to the 1990 statistics 83.2% of the hospitals, 96% of the health centres and 78.8% of the health stations were put in the hands of the government. Further exacerbating the situation, the 17 year reign of the Derge regime created mistrust and a lack of confidence and good will in the relation between the government and the private sector. Moreover, privately practicing individuals, if not totally prohibited, were tightly restricted. Thus medical service provision relied completely on the government.

- These disastrous conditions, combined with continued high population pressure and the growing need for modern health care, have led to a widening gap between the demand for care and the financial resources available to satisfy these needs.

- The provision of better health service at different levels is very much dependent on the availability and allocation of adequate funds These adequate funds cannot grow from government treasury because government expenditures, financed through general tax revenue, tend to decline from time to time due to a slow growth rate in the economy.

- The situation, therefore, has called for a need for assessing alternative methods of financing the health care systems.

- This can be achieved by inviting the collaboration of private organizations who are working either for-profit or not for-profit, the public and the government as well.

BACKGROUND INFORMATION ON THE TOPIC

Drug Problems

Although the drug supply system shows positive aspect, there are problems that should be solved before a sustainable drug availability in all health facilities is obtained. Some of the major problems in drug supply are:

- An insufficient drug budget of MOH health facilities such that only a certain proportion of the annual requirements are covered;
- Frequent shortage of life-saving and basic essential drugs at central and peripheral levels;
- Inadequate storage at health facilities;

- Irrational prescribing and inappropriate use of drugs by consumers;
- Weak stock control resulting in pillage and loss...etc

Shifting resources to P/PHC is not fundamentally a budgeting exercise. It requires controlling the Ministry's curative care expenditure (esp. facility, staff, drugs) and building constituency for PHC. Ministries need: RULES TO SAY NO BY, particularly to control curative care expenditures.

allocative efficiency --- Placing the right resources in the right places.

Curative vs. preventive services
Facilities -- types, number, location
Staff -- types, numbers, location
Drugs & Supplies -- selection, quantification, distribution

The drug system is in need of improvement. The current system does not place drugs where there is greatest need and forces facilities and therefore patients into paying higher prices than necessary. Actions which could alleviate these problems include elimination of duties and administrative import restrictions, freeing up foreign exchange allocations, elimination of mark up and price controls and easing the restrictions on retail sales. Staff incentives for improved efficiency should also be explored as well as the provision of productivity and cost information to decision makers so that resource allocation decisions can be made using objective information.

Drug supply

Drug procurement

Drug procurement in Ethiopia encompasses three major sectors: the public, the private and NGOs. The three sectors get drugs from three channels i.e. drug importation, local production and donation.

The main drug procurement agency is the Pharmaceutical Import and Wholesale Enterprise (formerly know as EPHARMECOR). The Enterprise imports finished products through open tender and other methods and distributes both for the public sector and other private and NGO drug outlets and health facilities. Of the total value distributed by the Enterprise the Ministry of Health receives only 27% by value.

The private sector imports drugs from expertise foreign manufacturers and distributes (sale) to public & private pharmacies.

Drug and medical supplies donations are imported both by governmental and non-governmental organizations and delivered to health facilities under MOH and NGOs. In the past 2 years, drugs and medical supplies worth 3-4 times the MOH drug budget of 1992/93 were purchased and distributed to all health facilities under MOH through the Emergency Relief and Reconstruction Programme. The supply of drug & medical

supplies under ERRP has contributed significantly to alleviating the chronic shortage that prevailed in government health facilities.

Drug Distribution

Drug distribution in the country is mainly handled by the Enterprise through the Central Medical Stores in Addis Ababa and other Zonal Distribution Centres.

Drug & medical supplies are distributed to health facilities under the ministry both from the CMS and Zonal Distribution Centres based on their drug budget allocated every year by the government. The drug budget of the majority of health facilities is insufficient to cover the whole year. Due to insufficient drug budget most of the health facilities run out of stock of the most needed essential and life saving drugs.

Drug price

Health facilities under the Ministry dispense drugs to patients on prescription. The drug price, in all the health facilities, only covers the actual cost of the drugs set by the distribution center. The delivery and other operational costs are not involved. On the other hand wholesalers are allowed to add a mark-up of 15% and retailers 25%. In actual practice private drug retail outlets never adhere to the profit margin and sometimes the price goes as high as 100 times the permitted price.

Drug financing

No cost recovery system exists in the public health facilities. Revenues collected from the sale of drugs, which at present is very minimal as a large portion of drugs are issued to free patients, goes to government treasury.

In the country there are some indications for cost recovery through a Revolving Drug Fund scheme as observed in pharmacies run under Urban Dwellers Association and recently the Ethiopian Red Cross Society.

Recently the country has started implementation of the Bamako Initiative in selected Woredas/Districts by establishing the Bamako Initiative pharmacies. These pharmacies have been provided with seed drugs given by UNICEF.

These pharmacies will operate on a revolving fund and are expected to generate funds for assisting other PHC activities at district level.

The limited experience of Urban Dwellers, ERCS and lately the BI pharmacies can be adopted to public health facilities and included as one of the health care financing options.

EXCERPTS FROM THE HCF STRATEGY RELATED TO DRUG FINANCING

Developing Revolving Drug Funds

A revolving drug fund's main features are: (1) purchase of an initial stock of pharmaceuticals donated by a Government; Donor or Community; (2) sale of drugs to those who need them; (3) pricing for full recovery of drug supply costs with or without a mark up; (4) use of sales revenue to replace the original stock and for financing other operating and distribution costs. Such funds have been in operation in Ethiopia in a few limited locations and their expansion should help alleviate the common and chronic shortages of drugs in government facilities.

Drug sales are made by two types of organizations with many different goals. The private sector's objective is to maximize profit at each level of distribution, while the public sector's objective is to maximize coverage of the otherwise under-served population.

A drug sales program is a relatively easy mechanism for raising the public contribution to curative care. Public sector drug sales often use a revolving fund scheme as a mechanism to improve the supply and distribution of drugs.

Drug sales programs in which consumer contribution covers the partial or whole cost of drugs only or the cost of drugs plus other operating expenses are well known as revolving drug fund schemes.

Revolving drug fund schemes have a number of advantages:

- They improve the supply of drugs and thereby reduce rationing-by-scarcity found in many systems including Ethiopia's.
- They enhance efficiency of drug procurement and use and further improve revenue possibilities.
- When carefully designed they can improve the use of drugs through incentives for rational prescribing.

In Ethiopia, a Revolving Drug Fund scheme can be fully employed in government health facilities because:

- The public is already accustomed to paying for drugs both in the government and private sector.
- Significant increase in patient attendance has been observed in government health facilities when drugs are available.
- Drug procurement and distribution is being given due emphasis by the TGE to improve the efficiency of the drug supply system.
- Through bulk procurement of drugs by generic name, the price of drugs can be kept far below that of the private sector enabling substantial savings to patients....etc.

It is therefore timely to institute a RDF scheme in the government health facilities for the overall improvement of the drug supply and as an additional source of revenue for health care financing.

In capable government health facilities, selling pharmacies that operate on the RDF scheme can be introduced:

- to make drugs available as near to the facility as possible at a reasonable price and at the disposal of the facility's management.
- to protect the consumers, as much as possible, from being exposed to the private pharmacies whose prices are sky high.
- to make marginal profits so that the selling pharmacy's fund can revolve by itself.

Any medical care cannot be complete without a good supply of drugs. Therefore, selling pharmacies shall play a complementary role to the facility's pharmacy run by government budget.

Major points of considerations are given below.

Selling pharmacies, more than anything else, need seed money to have them started and good management procedures and systems. Otherwise the scheme will fail.

In the Ethiopian context specially, if we examine the cause of the unavailability or shortage of many vital and life saving drugs, is the poor national drug market and not mostly shortage of money. Patients most of the time have the money but the drug is not available in the local market for sale. Therefore selling pharmacies should have the mechanism for solving these problems to an acceptable level.

In this document it is recommended that selling pharmacies at facility level shall be treated as one component of services (packages) to make user fee meaningful option. Therefore the in-dept study shall remain to the responsibility of the HCF secretariat in the Ministry of Health for implementation or trial in the first 5-year period covered by this strategy.

DESIGN AND IMPLEMENT A REVOLVING DRUG FUND

Cost recovery

The fundamental principle of a RDF is that expenses should equal receipts from sales that all funds should be recovered. At present it may not be possible to recover all the expenses (costs) i.e. drug costs, operating costs or a capital cost of drugs, and a portion of operating costs can be covered by adding a fixed percentage mark-up on the basic cost of drugs.

Therefore, the cost recovery objective of the health facilities should aim at recovering the base cost of drugs plus a certain proportion of delivery cost and other administrative overheads.

Drug pricing

The price of drugs involves the base cost of drugs and an agreed percentage mark-up. The fee for drugs dispensed shall be a variable fee per item issued.

Pricing by level of importance of each item category of drugs shall be exercised in the future as the RDF scheme strengthens both technically and managerially.

The base cost of the drugs is the cost at the Central Distribution or Zonal Distribution Center depending on the center from which the facility receives the drugs.

Proposed drug sales scheme operational procedures

Existing drugs budget of health facilities should be given as seed money for the purchase and sale of drugs.

Any revenue from sale of drugs shall be kept separately at the facility level and used for the purchase of drugs.

All drug purchases by the facilities shall be done on cost-effective basis. Purchases will be done from Public Procurement and Distribution Center.

Only 30% of the revenue collected from sales of drugs will be used for the purchase of drugs from private sources in the year.

All transactions regarding the sale of drugs, and free issues drugs records shall be kept separately and updated.

No facility is allowed to exceed the maximum percentage mark-up permitted to set price, however

Location of implementation sites

The implementation site will be chosen in consultation with the Regional Health Bureaus and evaluated thoroughly. Lessons learned will be provided to other Regions during a seminar to be conducted in the latter part of the year.

QUESTIONS TO BE ADDRESSED

1. Are revolving drug funds a practical solution to the drug problem facing GOE facilities?

2. Who should be responsible for implementation of a revolving drug fund?

3. What systems are necessary to assure financial sustainability of such a program?

4. If implemented on a national level what monitoring and supervision would be necessary? Who would be responsible for this?

5. Where should initial drug stocks come from? Who would finance initial stocks?

6. How should drug purchases be done? Should purchases be centralized for better pricing or decentralized for better control?

7. etc .

APPENDIX C

APPENDIX C

STUDY SCOPE OF WORK
CURATIVE SERVICES AND QUALITY OF CARE FINANCING GAP STUDY IN ETHIOPIA

November 7, 1994

BACKGROUND

The Ministry of Health's draft National Health Financing Strategy document addresses short and long range financing problems in health care. The draft plan describes the state of Ethiopia's health care system and outlines issues which could be addressed through improvements in health financing. The Strategy also sets objectives for Ministry of Health allocative, productive and therapeutic efficiency as well as generation of revenue through an improved user fee program, expansion of private sector social and health insurance and others.

One unresolved issue for the Government of Ethiopia (GOE) for the long term development of the health system is the total financing gap between existing resources and needed resources for health care. For Primary and Preventive health care services, a study is proposed to measure the gap between the need for those services and the resources dedicated to them. That study will look at retention of user fee revenue to fill this gap. A second study, of curative health services, is needed to complete the picture.

The gap between resources dedicated to curative health services and the services needed also must be addressed with the National Health Financing Strategy outlining ways and means of addressing this resource gap. In the Ethiopian context, where a great deal of reconstruction will be necessary, one of the most critical factors influencing both the quality and quantity of health care services to be delivered is the planning of where and what type of facility should be renovated or newly constructed to meet the health care needs of the population. Capital investments in Ethiopia will drive, for some time to come, recurrent expenditures and availability and access to health services. Careful planning of these capital projects is necessary and should address the curative gap as it exists now.

PURPOSE OF THE STUDY

The purpose of the Curative Service Gap Study is to estimate the resources required to provide reasonable quality curative and ancillary services to the Ethiopian population. An estimate of the gap between resources available and needed will be made with recommendations given for a realistic retention policy.

STUDY COMPONENTS

This study will consist of several components:

1. ***Estimating need for curative services*** using available epidemiological and service data. This analysis would be done by Region if possible.

2. ***Estimating existing service capacity*** including location and type of facility, number and type of staff and their knowledge, staff capacity, availability of supplies, drugs, materials. Data for this evaluation will come from primary and secondary sources but would form an updated inventory available to the MOH.

3. ***Estimating "standard" unit costs and quality*** of providing a reasonable quality of curative care in different types of facilities.

4. ***Estimating the curative care financing gap*** nationally between resources needed to provide reasonable care and the number and types of facilities, staff and financial resources by Region.

5. ***Analysis of the cause of the curative gap*** and the contribution to poor quality and quantity of curative services resulting from lack of resources.

SPECIFIC ACTIVITIES

1. ***Estimating need for curative services***

Existing service statistics, available epidemiologic data and other information will be collected to estimate morbidity and mortality trends for Ethiopia. These trends will be translated into service needs which are geographic (region-specific) to the extent possible.

2. ***Estimating existing service capacity***

An inventory of numbers and types of staff and facilities by region will be carried out. This would include staffing patterns, availability of supplies, drugs and materials. Data will be collected from existing secondary sources (e.g. from MOH files) and also through interviews and surveys of existing facilities.

This part of the study will include several steps:

- design a system of facility classification
- expand and/or update the facility inventory for all GOE, mission and private health facilities in Ethiopia
- estimate levels of coverage
- develop technical and political criteria for the construction, rehabilitation, expansion or redesign of fixed health facilities.
- develop a plan for future location of new or rehabilitated fixed health facilities.

3. ***Estimating "standard" unit costs and quality***

A standard quality of service will be defined and costed to obtain an estimated unit cost of providing a reasonable curative care service. If possible existing facilities at different levels in the system will be assessed to see whether an existing facility could be the "standard". If no facility is deemed adequate, a standard will be constructed hypothetically.
This component will attempt to characterize the cost of delivering a reasonable quality of services and the patterns of resource allocation necessary to deliver this level of care. Interviews and primary data collection will be necessary at this stage.

Quality will be measured primarily on inputs to the system and the process by which services are delivered. The likely criteria to be used include:

- existence and operational status of services and equipment
- existence and operational status of support services
- staffing levels and patterns
- availability of drugs and other essential supplies
- patient satisfaction

4. ***Estimating the curative care gap***

The need for quality services will be compared against existing capacity to determine the gap. The gap will be identified in terms of: (a) needed facilities by Region; (b) needed staff by type by Region by facility; (c) needed drugs, supplies, materials by type by Region by facility. The cost of these resources will be estimated.

OUTPUTS OF THE ANALYSES

There are four outputs of this study:

1. Curative care staff and facilities inventory report.
2. Curative care unit cost and quality assessment report.
3. Facility and staff rationalization report.
4. Gap report outlining the financial and other resources needed compared to those available in order to deliver an acceptable quality of care.

TIMELINE

The results of this study are needed early in the initial stages of implementing a revised user fee program. Because of this it is expected that the study would be completed by mid 1995.

APPENDIX D

APPENDIX D

STUDY SCOPE OF WORK

PRIMARY AND PREVENTIVE CARE GAP STUDY in Ethiopia

November 7, 1994

BACKGROUND

The Ministry of Health's draft National Health Financing Strategy document addresses short and long range financing problems in health care. The draft plan describes the state of Ethiopia's health care system and outlines issues which could be addressed through improvements in health financing. The Strategy also sets objectives for Ministry of Health allocative, operational and therapeutic efficiency as well as generation of revenue through an improved user fee program, expansion of private sector social and health insurance and others.

One policy issue which was addressed in this draft strategy is that of the level of retention of user fee revenue. Ethiopia's user fee retention policy should based on the degree to which currently available resources are able to finance the need for services. The gap between available resources and needed resources could be filled in full or in part by revenue from user charges.

PURPOSE OF THE STUDY

The P/PHC Resources Gap Study will estimate available health-related resources, compare available resources to the need for primary/preventive health services and quantify the resource gap between the two. In analyzing this financing gap, recommendations are given for a realistic retention policy.

STUDY COMPONENTS

This study will consist of several components:

1. ***Estimating current P/PHC system capacity*** in terms of personnel, facilities, materials, methods including estimating the amount of unused capacity for delivering P/PHC services.

2. ***Estimating the cost of provision of P/PHC services*** at different levels in the system.

3. ***Determining the actual allocation of funds to P/PHC*** at MOH/E Headquarters and Regions including the relationship between allocation to P/PHC services and curative services.

4. ***Determining the need for P/PHC Services*** in the country.

5. ***Estimating the gap*** between available P/PHC services and the need for services. The gap will outline the gap in terms of financing but will also include staffing, facilities, materials and supplies. This gap will be measured nationally and by region as well as by level of facility, which is the base from which most P/PHC services are delivered.

6. ***Estimating revenue generation potential of user fees*** and comparing this revenue against the financing need.

SPECIFIC ACTIVITIES

1. ***Estimating current P/PHC system capacity***

This initial phase will estimate existing physical and staffing capacity for offering P/PHC services in Ethiopia. This will include an inventory of facilities and personnel, level of training of each staff type, time available for service delivery. Standards will be developed. Data will be collected from primary and secondary sources.

2. ***Estimating the cost of provision of P/PHC services***

This second phase will develop a norm for service delivery and make a comparison between the norm and currently available facilities where P/PHC services are being offered. If possible an existing site will be selected as the norm for estimating the costs of service provision. If no site is considered suitable, a "standard" service package and site will be constructed. From this "standard", costs will be derived for service provision to be compared against existing services.

3. ***Determining the actual allocation of funds to P/PHC***

The current actual amount of type of resources committed to P/PHC services will be estimated through desegregating MOH/E Headquarters budgets and Regional budgets into their respective components. In addition, a sample of sites will be selected at which observations will be made as to actual use of resources and proportion of resources dedicated to P/PHC services. The amount of under-funding will be estimated at these sites.

4. ***Determining the need for P/PHC Services***

Using available epidemiological data, morbidity patterns, Health Information System reports, published studies and reports an estimate of the need, both geographical and epidemiological, will be made. Epidemiological need will be translated into service and resource needs based on standards established through step #2 above. Aggregated regionally and nationally, these data will represent the ideal picture of resources needed nationally and regionally to provide a high quality P/PHC service package. This package can be tailored to each Region's needs.

5. ***Estimating the gap***

The gap between current resources dedicated to P/PHC services and their cost and the P/PHC need estimated in step #4 will be identified. This gap will be outlined in terms of manpower, facilities, supplies and then converted into financial resources needed.

6. ***Estimating revenue generation potential of user fees***

The gap will be compared regionally against the revenue generation potential of user charges. The result of the comparison between fee revenue and financing gap for P/PHC services will be an input into the policy debate about the user fee retention policy.

OUTPUTS OF THE ANALYSES

These analyses will result in:

1. an estimate of available health facilities, staffing patterns, service patterns;

2. an estimate of existing service capacity for P/PHC services;

3. an estimate of the allocation of existing resources to P/PHC and other services;

4. estimates of unused system capacity if any;

5. an outline of service norms and costs;

6. estimates of P/PHC service needs nationally, by Region and by type of facility;

7. a final report on the gap between need and available resources. This report would include recommendations on a fee retention policy; and

8. areas requiring further study.

TIMELINE

The results of this study are required during the initial stages of implementing a revised user fee program. For this reason this study should be completed before the middle of calendar year 1995.

APPENDIX E

APPENDIX E: **STUDY SCOPE OF WORK**

ADDIS ABABA AREA STUDY
Ethiopia
November 7, 1994

BACKGROUND

The draft Ethiopian Health Care Financing Strategy indicates areas where health care resources are lacking or inappropriately distributed and where policy and programmatic action is needed. One of the issues outlined in the draft Strategy relates to the number and type of resources committed to Addis Ababa, the capital of Ethiopia.

According to the draft Strategy, 35% of the hospital beds in Ethiopia are in Addis Ababa where only 5.5% of the population lives. The GOE budget parallels this distribution. The general geographic concentration of MOH resources in Addis Ababa exacerbates other financing problems of the MOH. Sixty percent (60%) of Ethiopia's doctors, 16% of the nurses and 15% of the health assistants work in Addis Ababa. This highly skewed budgeting limits the resources available to the Regions. In addition, the orientation of the health system to facility-based, curative care may compound the problem.

The Curative Services and Primary/Preventive Gap Studies will address the gap between resources needed for curative and P/PHC services and available resources. They will not, however, go into sufficient detail to fully understand the situation in Addis Ababa. For Ethiopia to improve the financing of its health services it must address the problem of Addis Ababa.

Addis Ababa, as the capital of Ethiopia, also has many of the private sector resources of the country. Many factories, large employers, and government workers reside in the Addis. Together with good access to health facilities, this situation may lend itself to the development of privately provided health care as well as various forms of health insurance.

PURPOSE OF THE STUDY

The purpose of this study is to define the need for curative and P/PHC services in Addis Ababa and assess ways to meet those needs using existing resources. Where possible, recommendations will be made for: (a) more efficient and effective use of existing resources; and (b) how to redistribute resources which could be freed up as a result of improved efficiencies.

STUDY COMPONENTS

This study will address several areas:

1. ***Estimating current patterns of service provision and use*** in Addis Ababa.

2. ***Estimating service efficiency*** by type of service and facility.

3. ***Assessing Addis Ababa's current financing patterns*** including financing from GOE, mission, private and donor resources and the degree to which the resources are coordinated.

4. ***Assessing the demand for insurance*** to support the development of the Government and private sector provision of health care.

5. ***Recommending financing changes*** necessary to better use existing and planned resources and the extent to which resources could be freed up for allocation to other parts of Ethiopia.

SPECIFIC ACTIVITIES

1. ***Estimating current patterns of service provision and use***

This phase of the study will describe the existing service delivery system, available facilities and staff, sponsorship, location, mix of services, volume of services and service utilization. Referral patterns, user charges, access questions will be addressed. This step will be completed using mostly secondary data sources.

2. ***Estimating service efficiency*** by type of service and facility.

Resource utilization and cost will be analyzed. Productivity measures will be developed to assess efficiency and compared against sampled facilities. Both public, mission and private facilities, to the extent that they exist, will be assessed. Both ambulatory, P/PHC and curative services will be studied. Data for this stage will be from records, interviews, direct observation.

3. ***Assessing Addis Ababa's current financing patterns***

The degree of public vs private financing will be studied. Availability of insurance, donor support, employer financing of health care, Treasury and MOH/E allocations for health services will be measured. The type and level of user charges, estimates of future user fee revenue and other alternative strategies for financing will be explored.

4. ***Assessing the demand for insurance***

Companies, Government and non-governmental institutions, large employers, private providers and the Ethiopian Insurance Corporation will be visited to assess the extent to which health insurance in all

forms exists in Addis Ababa and the extent to which risk sharing arrangements are understood and wanted by these groups.

5. ***Recommending financing changes***

Based on the study, suggestions and recommendations will be made regarding the financing of health care in Addis and the extent to which, if at all, existing services could be financed by development of the private sector and risk sharing pools. Implications for redistributing GOE allocations for health outside of Addis will be discussed.

OUTPUTS OF THE ANALYSES

This study will result in a series of options and recommendations for policy makers for improving system capacity, efficiency and effectiveness to meet the health care needs of Addis Ababa. An analysis dealing with the current financing of health care and assessment of the over- or under-financing, relative to other parts of Ethiopia, will be carried out. Economic, fiscal and managerial implications of the financing options will be written as the basis for decision making with the MOH/E.

The final report will also outline findings on current private sector provision of health care and availability and demand for health insurance.

TIMELINE

The results of this study are needed before mid 1995.

APPENDIX F

APPENDIX F:

PROPOSAL

COMPOSITION, FUNCTION AND BUDGET OF THE HEALTH CARE FINANCING SECRETARIAT AND TECHNICAL ASSISTANCE TEAM

HEALTH CARE FINANCING Program
MINISTRY OF HEALTH, ETHIOPIA
November 7, 1994

Health Care Financing Secretariat

The Health Care Financing Secretariat would be made up of competent professionals appointed by the Vice Minister for Health. Its head would be chairman of the Implementation Board and its staff would be the staff of the Board. The head of the Secretariat would report directly to the Vice Minister for Health.

Initially the Secretariat would be responsible for developing the national health financing strategy and carrying out initial implementation activities. Its prime purpose would be to outline a reform agenda, develop national implementation strategies and, if necessary, to assist in field testing interventions. Secondly, the HCF Secretariat would assist the Implementation Board, which would be held responsible for nationwide implementation of core programs such as the user fee program expansion. By core programs we mean the essential components which are to be implemented nationwide. Variations of the basic theme would be allowed regionally. Once health financing reforms are in place, the role and functions of the Secretariat may be reduced.

The Health Care Financing Secretariat, which should be based at the Ministry headquarters, should be adequately staffed and financed to effectively supervise, support and monitor the health care financing program. The specific function of the Secretariat, which should be highly placed within the structure of the MOH, should be:

1. To liaise with the regions for routine information on performance of the program,

2. To ensure that regions follow the core requirement of the program and develop standards for implementation,

3. To advise the Vice Minister on any policy changes of the program,

4. To implement training of Region personnel to assure consistent nationwide implementation of the core program and to provide a back-up support on region-specific training and supervision,

5. To design and develop systems appropriate for the program,

6. To coordinate donor support for the program,

7. To conduct studies and surveys necessary to improve the general management of the program and to assure proper monitoring and evaluation of the program and its impact,

8. To liaise with central Treasury and other organs of the TGE in order to improve the general management of the program,

9. To prepare an annual report of the program,

10. To act as staff to the Implementation Board,

11. To assist with piloting interventions if appropriate, and

12. Any other function as may be assigned by the Vice Minister.

Technical Assistance Team

A donor-funded technical assistance team would be established to support the functions of the HCF Secretariat and to assist in implementing the national Health Care Financing agenda. This team would be made up of a combination of Ethiopian and expatriate technical specialists.

The Technical Assistance Team, headed by an expatriate, would:

- Advise on the issues of HCF as requested by the Secretariat,
- Support the implementation of the scheme financially, materially and technically,
- Look for the sources of funding and material support to develop the scheme at all levels,
- Provide financial support to the HCF Secretariat until funding could be institutionalized within the MOH HQ budget,
- Assist in development of training methods and materials for implementation of the core program, and
- Provide short term technical assistance in areas related to implementation of the HCF reform agenda. Areas of technical assistance may be insurance, drug management, training, etc..

Staffing of the Health Care Financing Secretariat and TA Team

Secretariat staffing

Head of the secretariat	1
Public Health Physician	1
Senior nurse/matron.....	1
Health Planner	1
Senior Accountant	1
Pharmacist.....	1
Administrator	1
Senior Secretary	1
Clerks	2
Typists	2
Office Messenger	1
Drivers	2

Staffing of the Technical Assistance Team

The TA team must have expertise in those areas which are critical to the implementation of the health financing agenda. Specifically, expertise in implementation issues related to the user fee program and Ministry of Health efficiency improvements are necessary.

Team leader/management specialist.....	1	
Health services planner..... (Ethiopian)		1
CPA or chartered accountant.....	1	
Hospital administration..... (Ethiopian)		1

Illustrative list of short term technical assistance

Insurance expert
Accounting/financial management expert
Economist
Evaluation research specialist
Survey specialist
Training specialist
Drug management specialist
Manpower planner

Budget for the Health Care Financing Secretariat (see note below)

INITIAL FIRST YEAR SET-UP COSTS

	Items	Quantity	Unit Price in US	Total Price in US
1.	Vehicles, 4WD Land Cruiser	2	30000	60,000
2.	Computer + printers+ UPS	2	6000	12,000
3.	Lab top computer	3	2500	7,500
4.	Photocopier (heavy duty)	1	25000	25,000
5.	Typewriter, English	2	1599	3,198
6.	" Amharic	1	1600	1,600
7.	Calculators, Electric	3	205	615
8.	Double Pedsan 1.60x80	5	202	1,010
9.	New type swivel chair	5	131	655
10.	Guest chair with arms	30	63	1,890
11.	Easy chairs with arms	15	35	525
12.	Model 276 bookshelf	5	111	555
13.	Senior conference	1	178	178
14.	Tables ordinary type	5	96	480
15.	4-drawer filing cabinet	5	232	1,160
16.	Office stationery			5,000
			subtotal: US	$121,366

FIRST YEAR RUNNING COSTS

. Travel and Accommodation	15,000
. Fuel and Maintenance of vehicles	20,000
. Maintenance of equipment	5,000
. Telephone and postal	5,000
. Printing manuals and other documents	50,000
. Additional workshops and training	100,000
subtotal: US	$195,000

note: This budget does not include the costs associated with special studies, the setting up and equipping of a TA team project office, nor salaries and benefits of TA or Secretariat staff members. Some of the administrative support staff would be shared between the TA team and the Secretariat.