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Ethiopia's Progress in Health Financing and the Contribution of the 1998 Health Care and Financing Strategy in Ethiopia

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Federal Democratic Republic of Ethiopia
Ministry of Health

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Acronyms

ANC	Antenatal Care
ARM	Annual Review Meeting
ART	Antiretroviral Treatment
BG	Benishangul-Gumuz
BIC	Breakthrough International Consultancy
BOFED	Bureau of Finance and Economic Development
BPR	Business Process Re-engineering
CBHI	Community Based Health Insurance
CDC	Center for Disease Control
CHAI	Clinton Health Access Initiative
CMAM	Community Management of Acute Malnutrition
CMH	Commission on Macroeconomics and Health
CSA	Central Statistical Agency
DP	Development Partner
DPT	Diphtheria Pertussis Tetanus
DRS	Developing Regional States
EBP	Evidence-Based Planning
EFY	Ethiopian Fiscal Year
EHIA	Ethiopian Health Insurance Agency
EHSP	Essential Health Service Package
EPHI	Ethiopian Public Health Institute
ETB	Ethiopian Birr
FGD	Focus Group Discussion
FGR	First Generation Reform
FMHACA	Food, Medicine and Health Care Administration and Control Agency
FMOH	Federal Ministry of Health
FRM	Financial Resource Mobilization Directorate (FMOH)
FWB	Fee Waiver Beneficiaries
GBS	General Budget Support
GDP	Gross Domestic Product
GF	Global Fund
GFATM	Global Fund to Fight AIDS, Tuberculosis, and Malaria
GGE	General Government Expenditure
GMU	Grants Management Unit (FMOH)
GNI	Gross National Income
GoE	Government of Ethiopia
GTP	Growth and Transformation Plan
HC	Health Center
HCF	Health Care Finance
HCF TWG	Health Care Finance Technical Working Group
HCFR	Health Care Financing Reform
HCFS	Health Care Financing Strategy
HEP	Health Extension Program
HEW	Health Extension Worker
HF	Health Facility
HFG/HSFR	Health Financing and Governance/Health Sector Financing Reform
HH	Household(s)
HHM	HSDP Harmonization Manual
HICES	Household Income Consumption and Expenditure Survey
HIT	Health Information Technology
HIV/AIDS	Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome
HLTF	Health Level Task Force
HMIS	Health Management Information System
HP	Health Post
HPF	Health Performance Fund
HPN	Health Partners Network
HRH	Human Resources for Health
HRIS	Human Resource Information System
HSDP	Health Sector Development Plan
HSPH	Harvard T.H. Chan School of Public Health
HSTP	Health Sector Transformation Plan
IBEX	Integrated Budget and Expenditure (System)
ICCM	Integrated Community Case Management
IP	Implementing Partners
JANS	Joint Assessment of National Health Strategies
JCCC	Joint Core Coordinating Committee
JCF	Joint Consultative Forum
JFA	Joint Financial Arrangement
JRM	Joint Review Mission
KII	Key Informant Interviews
MBB	Marginal Budgeting for Bottlenecks
MDG	Millennium Development Goal
MDG PF	MDG Performance Fund
MOFED	Ministry of Finance and Economic Development
MTR	Midterm Review
NHA	National Health Accounts
NMEI	New Medical Education Initiative
OOP	Out-of-pocket
OPD	Outpatient Department
P4R	Performance for Results
PBF	Performance-Based Financing
PBS	Promotion of Basic Services
PEPFAR	President's Emergency Plan for AIDS Relief
PFSA	Pharmaceutical Fund Supply Agency
PHC	Primary Health Care
PHCU	Primary Health Care Unit
PMTCT	Prevention of Mother-to-Child Transmission
PNC	Postnatal Care
PPD	Policy and Planning Directorate (FMOH)
PPP	Public Private Partnership
PW	Private Wing
RBF	Results-Based Financing
RDF	Revolving Drug Fund
RHB	Regional Health Bureau
RR&U	Revenue Retention and Utilization
RTM	Resource Tracking and Management
SCMS	Supply Chain Management System
SHI	Social Health Insurance
SNNPR	Southern Nations, Nationalities, and Peoples' Region
TA	Technical Assistance
TB	Tuberculosis
THE	Total Health Expenditure
UHC	Universal Health Coverage
UN	United Nations
USAID	United States Assistance for International Development
USG	United States Government
WHO	World Health Organization
WMS	Welfare Monitoring Survey
WoFED	Woreda Office of Finance and Economic Development
WorHO	Woreda Health Office

Executive Summary

In 1998, the Council of Ministers of the Government of Ethiopia (GoE) endorsed the Health Care and Financing Strategy for the country. The fourteen years since that approval have seen dramatic and positive changes in Ethiopia's health systems conditions and health outcomes. One positive example of this noted globally, was the announcement in 2014 that Ethiopia had achieved the 4th Millennium Development Goal of reducing child mortality by two-thirds from 1990 levels.

Today, Ethiopia's health system looks very different from that of 1998. Health expenditures per capita have increased from US$4 (1996) to US$21 (2011) and almost certainly higher in 2014, perhaps a six-fold increase in nominal dollar terms. Substantial financial support for health has been generated from international development partners, government, and retained fees. More than 38,000 health extension workers on government salary provide services in rural and urban kebeles throughout the country. Significant scale-up in training physicians and other health workers is underway. Preparations are advanced to launch social health insurance and expand community-based health insurance.

The 1998 Health Care and Financing Strategy envisioned and laid foundations that contributed to many of these changes. With development of the health ministry's visioning document for 2035, which aims at universal health coverage through primary care, and anticipating the next 20-year overall national Growth and Transformation Plan (GTP II) as well as the next five-year Health Sector Transformation Plan in 2015-20, the Federal Ministry of Health (FMOH) decided to review the experience in health care financing since 1998 with an eye to update and revise the Health Care and Financing Strategy. This report contributes to that review by generating evidence on what has worked as well as lessons learned from what has not worked as well as expected.

The 1998 document laid out a number of strategies — both general and specific. This report reviews progress along several broad dimensions of health care financing as well as a number of specific initiatives that the strategy helped launch. It draws on compilation and analysis of a number of studies and reports done over this period. It also reports on new data collection, in part through key informant interviews, on the actual implementation of important specific initiatives throughout the country. The report includes sections focusing on the following topics:

- The context of changes in Ethiopia related to economic growth and health systems development;
- The institutional and governance structures relevant to health care financing;
- The goals, principles, and strategies put forward in the 1998 Health Care and Financing Strategy;
- Progress and achievements in raising, organizing, and disbursing funds for health at national, regional, and woreda levels in Ethiopia and developments in the efficiency and equity of financing;
- Progress and achievements in key specific initiatives launched by the 1998 strategy including fee retention at health facilities, private wings, community-based health insurance, and social health insurance;
- New and persistent challenges facing Ethiopia today in continuing progress in health care financing; and
- Recommendations for areas that an updated Health Care and Financing Strategy could address.

Development Context

Since 1998 Ethiopia has experienced rapid economic growth, averaging just shy of 10% real GDP growth annually from 1999-2012. Factoring in population growth, this equates to an average of 6% increase in real GDP per capita per year. Much of this growth has been channelled into investments and economic activities that contribute to improved health, beyond the direct effects of health services and programs. There have been improvements in transportation infrastructure, education, food production, water and sanitation and employment all of which provide some synergistic effects on improving health and health systems. These broader gains can also be associated with significant increases in the numbers of health personnel and health facilities. There has been a particular emphasis in Ethiopia during this period on strengthening primary health care delivery — most notably through the establishment of the kebele-level health posts and training of more than 38,000 health extension workers throughout the country beginning in the mid-2000's as well as the construction of more than 3000 health centers.

Institutional Environment for Health Care Financing

Ethiopia's institutional and governance environment for health financing is complex with multiple levels and actors. This complexity will need to be considered to achieve effective and timely monitoring of the situation as well as for developing reforms to improve financing and health system performance. At the national level, three distinct channels of financing with somewhat different management mechanisms make up the total health expenditures, channel 1 and 2 funds managed by various levels of government while channel three is managed by non-government implementing partners. Each of these channels has several subsidiary mechanisms and different sources of financing which include general government revenue, block transfers from development partners, and project financing from development partners both on and off budget. Positive movement of funds to more on-budget and accountable mechanisms has been achieved, but off-budget funding is still significant. Some channels of financing work through devolved mechanisms of allocation and responsibilities at region and woreda level, while others are more centralized and provide funds or in-kind inputs to the health care delivery system. An annual "resource mapping" process tracks flow of fund and other resource from development partner. Coverage and timeliness of reporting has improved over time but gaps still remain. Despite the emphasis on woreda-level planning, according to the many Joint Review Mission (JRM) and the Midterm Review (MTR) reports local authorities may not have the full and timely information about externally financed resource flows that they need to incorporate into their planning. Three out of six Regional Health Bureaus (RHBs) and 13 out of 18 woredas (districts) assessed reported that they do not try to collect information about resources from implementing partners and NGOs within regions and very few NGOs interviewed reported awareness of or involvement in resource mapping or evidence-based planning (EBP) at lower levels (Altman, Alebachew et al, 2012).

Current Health Care and Financing Strategy

The 1998 Health Care and Financing Strategy emphasized goals of increasing the financial resources for health through a pluralistic approach involving government, external, and private domestic contributions; increasing efficient use of resources linked to decentralized planning; strengthening sustainability of health financing; and improving service coverage and quality. It launched specific initiatives to strengthen the collection and use of user fees through fee retention at health facilities, programs of fee exemption for key services and those in need linked to public financing to compensate for delivery of free services; enhanced private sector contributions to health; and piloting of new community-based health insurance initiatives. Action was taken across all of these dimensions and notable progress in many of these is documented in this report.

Overall Development in Health Care Financing

From 1998-2014 Ethiopia achieved a substantial increase in total per capita health expenditures with the most recent documented figure being US$21 per capita in 2011. With rapid GDP growth, all sources of health spending increased substantially in nominal terms, but not to equal degrees. The government health budget financed with general revenue increased by 376% over this period (in nominal birr), but has been flat or declining throughout as a share of total government budget. It accounts for 22% of total health expenditure in the most recent accounts. Out-of-pocket spending is decreasing as a share of the total, accounting from 53% in the first to 34% in the most recent national health accounts (from 1995/96 to 2010/11), although also increasing in nominal terms. The most significant increase has been in external sources of financing from development partners. There has been a dramatic scale-up in external financing from the mid-2000s. This now makes up 50% of total health spending and an even larger share of about 55% of primary care expenditure. Significant external financing in Ethiopia in part reflects the country's relatively large population amongst African countries as well as a positive policy environment. Nonetheless, it is important that Ethiopia's success in increasing total health expenditure and focusing this increase on its primary health care priorities relied significantly on external resource flows whose growth may not continue at the same rate into the future.

While the health financing evidence reviewed here does not provide rigorous evidence of improving efficiency in resource use, complementary evidence on the development of health facilities and personnel and gains in basic health indicators linked to government programs suggest that increased financing was allocated efficiently. Stakeholders reported that evidence based planning has had a major impact on increasing the prioritization of high-impact interventions. National-level interviewees perceived that this has been the most important EBP impact so far at the woreda levels. Interviewees at all levels saw a strong link between EBP, the prioritization of high-impact interventions,

and the achievement of national health goals and Millennium Development Goals (MDGs) (Altman, Alebachew et al, 2012). The effects of these initiatives could not be evaluated rigorously with the evidence available.

In terms of equity, health gains also have reached the poorer sections of the income distribution as shown by findings of pro-poor impact. Fee-exempt services minimize the burden of user fees on households for key health services, and the fee waiver program also benefits the poor. However, limited evidence suggests that fee waiver schemes still may not reach a sizable population in need. For example, 1.4 million people nationally are reported as eligible with the appropriate certification as compared to the close to 24 million people who live below poverty line. This gap could be smaller if one considers the population accessing fee waiver benefit in the old fee waiver system (i.e. in regions that have not fully implemented health care financing reform such as in Somali, parts of Afar and Gambella regions). There are also problems of proper documentation of waiver beneficiaries at woreda levels. Evidence also suggests that fees for non-exempt services still pose a significant barrier to access to health care for the poor who are not covered by fee waiver.

Specific Initiatives Undertaken Since 1998

This review also reports new evidence on progress with specific initiatives launched as a result of the 1998 Health Care and Financing Strategy. Internally generated resources — largely user fees collected by health facilities — comprise a significant share of recurrent budget (average at 31% in health centers, varying from 18% to 41% and averaging at 50% in hospitals and varying between 21% and 79% in the sampled facilities).

Development and implementation of clear and consistent policies and procedures for fee retention and use by health facilities has been successful in incentivizing facility managers to collect and make good use of these resources. Key informant interviews confirm widespread awareness and use of these procedures but also identify important gaps that still need to be addressed for more effective implementation. Participatory governance mechanisms, in particular management boards at the level of individual health facilities, are functioning widely and involving community representatives.

Private wings have been established in a number of government hospitals along with additional compensation for physicians serving these wards. These policies do strengthen the financing of government hospitals and provide positive incentives to retain specialist physicians in government facilities.

The fee waiver program was introduced as measures to protect the poor from the negative effects of out-of-pocket payments and to protect equity in access. Despite the existence of inadequate recordkeeping in some regions, evidence compiled for this review suggests that coverage with fee waivers is still low in many regions and that implementation is uneven. Many woredas are reluctant to apply fee waivers to the full extent due to the implications for limited woreda budgets.

Ethiopia established an Essential or Minimum Health Service Package consisting of services of public health importance. Most of the services included in the package are exempt from user fee charges. Policies towards exempted services are being widely implemented, although recent data shows that there is some variation across regions as well as types of services. Providing exempted services imposes cost burdens on woredas, and more specifically on health facilities. Facilities are often not fully compensated by additional financing when new services are added, e.g. inclusion of deliveries at hospital level in the exempted service lists. This is exacerbated when there is no third party payer for costs. There is a need to review the basis of reimbursements for subsidized services as well as potentially to update and clarify the list of exempted services and strengthen implementation.

Community-based health insurance (CBHI) has been implemented in 13 pilot woredas. Substantial development of administrative processes was completed as part of these pilots. Enrolments in pilot woredas averaged 48% ranging from 25 to 100% of the households. Scale-up of CBHI is now underway with a target of 190 woredas.

Preparation for the launch of social health insurance (SHI) is at an advanced stage. The Ethiopia Health Insurance Agency has established offices at national and regional level. SHI will initially cover government employees and their families as well as formal sector workers through a combination of employer and employee contributions.

Challenges and Recommendations

The report concludes with a discussion of key challenges and recommendations that could help advise the development of an updated Health Care and Financing Strategy. Overall, the experience since 1998 convincingly demonstrates the value of a national strategy of this kind in guiding policy and planning over an extended period. Our report notes that health financing in Ethiopia has evolved considerably over this time period along with the overall economy. Funding is greater and increasingly diverse in sources and uses.

Ethiopia should revise and update its strategy in keeping with these developments. A revised Health Care and Financing Strategy should be built on a sector-wide perspective and incorporate evidence and best practices from Ethiopia and other countries. Sound strategies will be essential to help Ethiopia navigate the significant transition it plans to middle-income country status, which will almost certainly be accompanied by a reduction in the share of external resources in national health financing and increases in government and non-government financing.

Some key findings of this report include:

- The importance of a comprehensive vision for the future development of health care financing in Ethiopia, aligned with broader development plans and plans for development of Ethiopia's health system, with clear roles and directions for government, non-government, and development partners.
- Clarifying and increasing the government's role in health care financing for the future, anticipating a likely slowdown in financing contributed by development partners and Ethiopia's positive growth trajectory. There is a need to explore the potential of innovative financing sources to mobilize additional resources in the country through government mechanisms and if found feasible get a government approval for its implementation.
- Clarifying, expanding government collaboration with the private sector in general, and non-government sector in particular to strengthen health care delivery.
- Redefining the expenditure assignment of exempted services especially commodities to ensure that the gains made in these services are maintained even if external resources decline in the coming years.
- Developing the strategic vision for the future role of contributory financing (SHI, CBHI, user fees) in a sustainable health financing strategy for Ethiopia. Proposing specific initiatives that will carry this forward during the next GTP period and beyond.
- Strengthening institutional structures and capacities in the FMOH, regions and woredas to plan, implement and monitor and manage financing in a diverse funding and institutional environment and to provide strategic policy guidance to the FMOH, and other national and regional government bodies in key areas of health care financing development.

1. Background and Objectives of the HCF Review

1.1 Background

Prior to 1998, Ethiopia did not have a health care finance policy or strategy, but user fees were in place for more than 50 years. During this time, various problems in health finance and overall service delivery was observed. There was low per capita government budget allocated for health— between US$1 and US$1.20 since the early 1980's up to the mid-1990's, far below the Sub-Saharan African per capita average of US$6.70 (FMOH, 1998). Within these limited resources, skewed allocation of resources occurred in favour of hospitals. The user fees charged in health facilities were not reflective of the cost of health care and all revenue collected was remitted to the government treasury, leaving little incentive for health facilities to collect user fees. In addition, there was little or no insurance coverage making it challenging for some households to pay for the health services needed. The poor were issued with a 'free certificate' to access care, but received only consultation service, as there were no medicines at the facility levels. Given the long history of socialism in the pre-1983 period, the involvement of the private sector in health also remained quite limited.

It is to address the above challenges that the Health Care and Financing Strategy[1] (HCFS) was endorsed by the Council of Ministers in 1998. It provided the overall guidance and direction on how to mobilise domestic and external resources and use it efficiently and effectively. The strategy provided greater autonomy to health care facilities and led to the improvement of revenue generation by introducing reforms such as the establishment of facility boards, retaining user fees, outsourcing non-clinical services, and opening private wings in public hospitals and revision of the fee waiver system with pre-identification of households and putting woredas as third party payers, etc.

Since the adoption of the HCFS, there have been several areas of progress in the sector. Per capita health expenditure quadrupled between 1995/96 and 2007/08 from US$4 to US$16; this has further increased to almost US$21 in 2010/11 (FMOH, 1996; FMOH, 2010a; FMOH, 2014a). During this period, the share distribution of health finance sources has changed. For example, the government's share in total health spending declined from 40% in 1995/96 to 22% in 2007/08 and 16% in 2010/11, largely due to the increase of other sources more rapidly than government. During the same period, share of household out-of-pocket (OOP) spending declined from 53% (1995/96) to 37% (2007/08) and again to about 34% in 2010/2011; while the share of external resources (donors/international NGOs) spiked from 1% to 39% in the same period with a further increase to almost 50% in 2010/2011 (FMOH, 1996; FMOH, 2010a; FMOH, 2014a).

Progress around the various HCFS components is documented in the 2013 Health Sector Annual Performance Report (FMOH, 2013). As of the 2014 (Ethiopian fiscal year (EFY) 2006), 2,558 health facilities (101 hospitals and 2,457 health centers) are retaining and utilizing internally generated revenues to improve the quantity and quality of health services, and have functional governing bodies. Forty-five public hospitals in the country have started providing private wing service. As of August 2012, 2.5 million fee waiver beneficiaries were screened for the service in the country and the government allocated a budget of Ethiopian birr (ETB) 25,527,418 to cover expenses incurred by health facilities for these beneficiaries. In the 13 community-based health insurance (CBHI) pilot woredas, 143,852 households registered for the insurance scheme in 2012 (EFY 2005[2]) with enrolment coverage of almost 48%. The total number of beneficiaries from these households has reached 608,675. Among the CBHI beneficiaries, per capita health utilization in 2012 was 0.7 visits as compared to the national average of 0.3 visits (HSFR, 2015). CBHI has also contributed to an increase in revenue generation whereby in EFY 2005 alone the 13 CBHI schemes reimbursed ETB 8 million to health facilities. Preparations are also underway to launch social health insurance (SHI) by the end of this fiscal year.

Since 1998, the financing landscape has changed both nationally and globally, and the HCFS does not fully reflect or address these changes. For example, the financial implications of changing disease burdens, the recent emergence of SHI and CBHI schemes, focus on universal health coverage (UHC), and the emergence of innovative health financing strategies is not fully captured in this strategy.

Given such a background, the Federal Ministry of Health (FMOH) seeks to revise the HCFS in order to reflect the changes in the current health financing landscape in the country and internationally. In order to do that, the FMOH would like

[1] Although the Strategy is entitled "Health Care and Financing Strategy", it does not address issues around health care. Similarly, this review solely focuses on progress around health care finance.
[2] Given that Ethiopia uses a different calendar, its fiscal year is 7 years behind the Gregorian (western) calendar (e.g., 2010 would be 2003 in the Ethiopian calendar), and is from July 8th – July 7th.

to document the successes, challenges, and lessons learned from health care finance (HCF) implementation to date. This document serves this purpose.

1.2 Objective of the assignment and scope

The overall objective of this assignment was to generate evidence on what has worked, and identify any gaps and best practices in providing accessible quality care for Ethiopia's population, particularly the poor since the launching of the strategy. This report will inform the revision of the strategy, and is intended as the first step to align the HCFS to better meet the emerging health care financing needs of the country, the revision of the health policy and the objective of universal access as envisioned for 2035. The Harvard T.H. Chan School of Public Health (HSPH) along with Breakthrough International Consulting PLC (BIC) has carried out this review with support from the FMOH under the Resource Tracking and Management (RTM) project. The funding for the RTM work was provided by BMGF. The rest of this document will refer to HSPH and BIC as the RTM team.

The scope of this assessment consists of the following main activities:

- Collect data/information on best practices and challenges for implementing the HCFS at lower levels, and identify any policy gaps at national level.
- Review the successes and challenges of traditional health finance reforms (management committees, user fees, outsourcing, protection of the poor, etc. in Ethiopia.
- Review the pilots and plans for demand-side financing (SHI and CBHI), and what is needed for national scale-up.
- Explore best practices from other countries, and provide evidence on successes and challenges in strengthening health finance.
- Review efforts made to enhance efficiency and effectiveness in resource use and potential improvements to be made in the HCFS.
- Review the types of essential health package services that are being offered compared to the 2005 essential health service package (EHSP) list.
- Explore the effectiveness and efficiency of different financing modes.

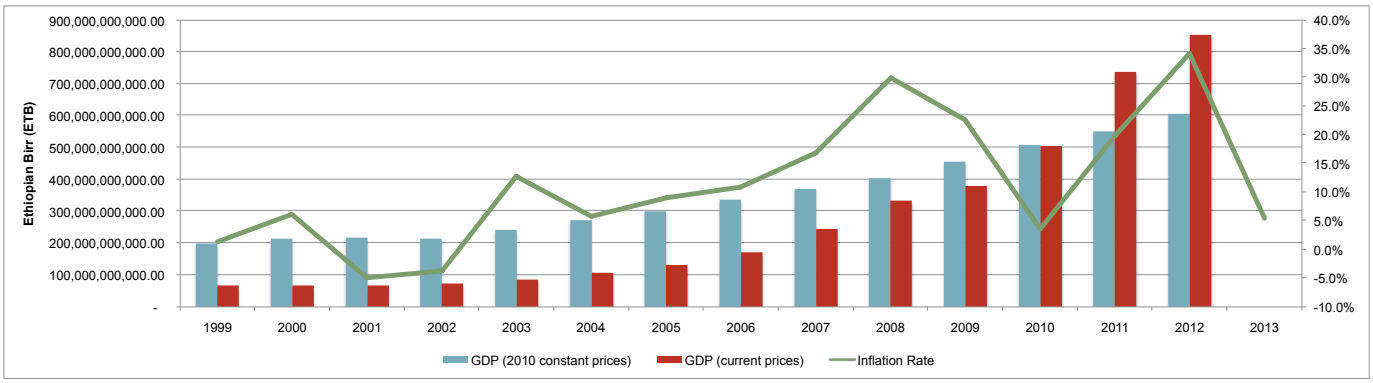
The rest of the report is organized as follows. Section two will give background to the study and its objectives. Section three presents the review methodology and framework. Section four gives an overview the health care and financing strategy. Section five presents an institutional analysis of HCFS implementation. Section six deals with overall achievements of HCFS. Section seven presents the specific achievements of the strategy. Section eight highlights the gaps in the overall HCF policy framework. Finally, section nine pulls out the implication of findings and best practices on the revision of HCF in Ethiopia.

2. Background on the Ethiopian Economy, Health System and Health Care Financing

2.1 Background on Ethiopian Economy

Ethiopia has seen rapid economic growth since the establishment of the HCFS in 1998. In 2012, Ethiopia was the 12th fastest growing economy, globally (World Bank, 2013a). The average real GDP growth from 1999 (1992 EFY) to 2012 (2005 EFY) was just shy of 10% (9.1%). This equates to an average real GDP per capita growth rate of 6% during the same time frame. Despite achievements in rapid economic growth, Ethiopia also experienced rapid inflation. The inflation rate (GDP deflator) during 1999-2012 was in the double digits for most of this period, with an average rate of 11.7% (see Figure 2.1). The inflation rate was at its highest, 34.2%, in 2012. The GoE recently implemented fiscal policies that have stabilized the inflation rate, where it has dropped down to single digits in 2013 (5.3%) and is projected to remain stable for the next two decades (average of about 9%) (IMF, 2014a).

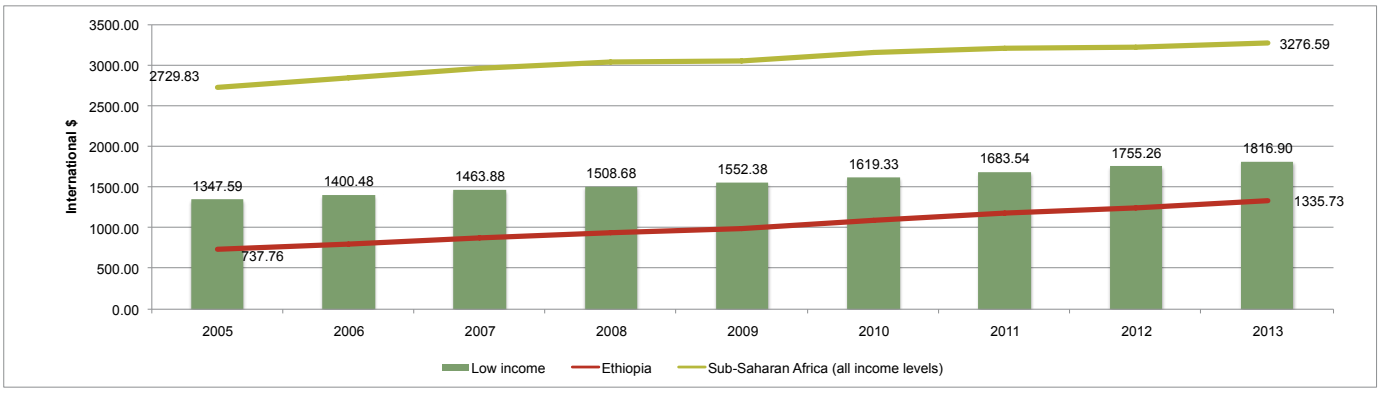
Figure 2.1: Trend in GDP and Inflation Rate



Source: Data from MOFED (2014a); IMF (2014a); and IMF (2014b)

Despite Ethiopia's rapid economic growth over the last decade, GDP per capita in PPP — purchasing power parity terms remains much lower than its peers in Sub-Saharan Africa as well as other low-income countries (see Figure 2.2). Ethiopia's population is the second highest in Sub-Saharan Africa at about 90 million people (GoE's latest estimate is 85.8 million; UN estimate is 94.1 million) (World Bank, 2014a). The GDP per capita in PPP terms in Ethiopia was $1336 in 2013 while the respective average figure was $1817 for low-income countries and $ 3277 for sub-Saharan Africa (see Figure 2.2). This shows that Ethiopia has a way to go before reaching overall sub Saharan African average or achieve middle-income status[3] to have a GNI per capita above US$1,045.

Figure 2.2: Trend in GDP per capita, PPP (constant 2011 international $) for Ethiopia, Sub-Saharan Africa, and Low Income Countries

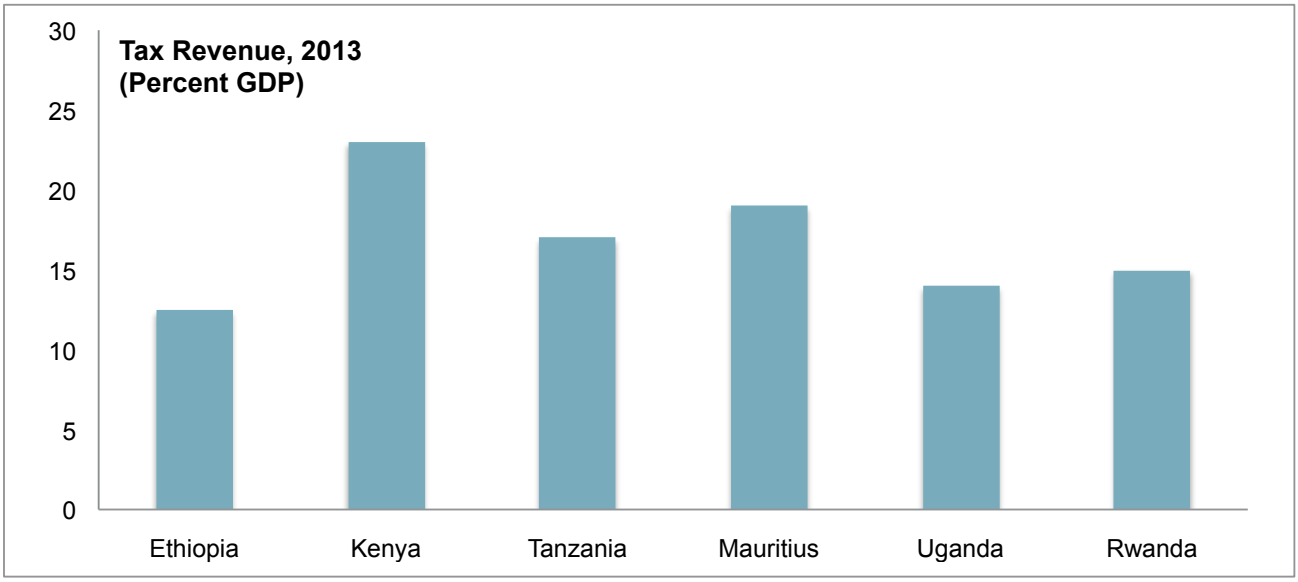


Source: Data from World Bank, 2014b

[3] According to the updated income classifications by the World Bank middle-income status is where a country's GNI per capita is more than US$1,045 and less than US$12,746.

Overall domestic revenue has been increasing but at a much slower rate than GDP growth. Tax revenue, as a percent of GDP, has remained quite low (12.5% in 2012/13), despite a slight up tick in the last few years (11.6% in 2011/12) (IMF, 2014a). Referring to Figure 2.3, Ethiopia's tax revenue as a % of GDP compared to its peers is significantly lower. This low domestic revenue base has implications on Ethiopia's general budget and expenditures across the different sectors.

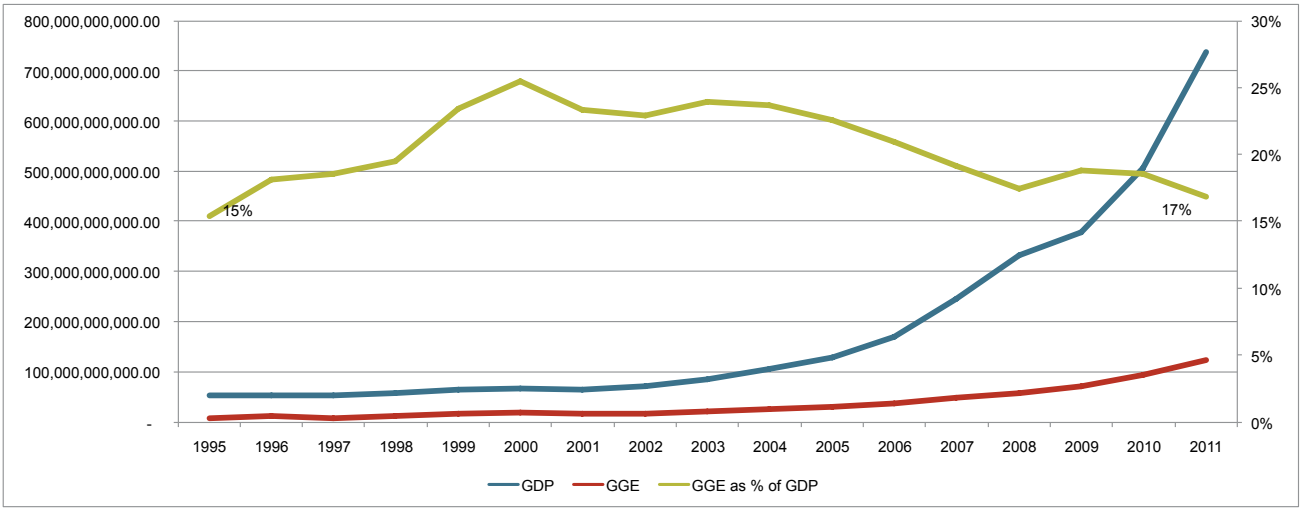
Figure 2.3: 2013 Tax Revenue (% of GDP) Compared to Peers



Source: IMF, 2014a

Figure 2.4 illustrates the trend in GDP and the general government expenditure (GGE) in nominal birr between 1995-2011. As Ethiopia started experiencing rapid economic growth, the GGE began to grow at a much slower rate. The highest point of GGE as a percent of GDP was in 2000 (26%). The GGE as a percent of GDP remained to be in the 20s until 2005, where a steady decline occurred as GDP rapidly increased.

Figure 2.4: Trends in GDP and General Government Expenditures (GGE) in Nominal Birr



Source: MOFED (2014b)

2.2 Evolution of the health system

The Ethiopian health system has undergone huge transformations since the mid-1990s across all health system building blocks:

- Health Service Delivery: The health system now has an enhanced primary health care (PHC) system with heath posts (HP) providing preventive and promotive services at the rural and urban kebele level as well as health centers (HC) providing basic curative care and prevention services. Furthermore, access to care has dramatically increased through accelerated expansion of health facilities with special attention to primary care.
- Human Resources for Health: There is now an established and functional primary heath care unit due to the training and deployment of 38,000 health extension workers. An astronomic expansion of training institutions (from 3 universities in 2005 to more than 23 colleges in 2012) to meet the growing demand for health professionals has occurred.
- Health Financing: Per capita spending on health grew five-fold from US$4.07 in 1995/96 to US$21 in 2010/11 largely due to the aggressive efforts to mobilize international funding supported by the implementation of the reforms under the Health Care and Financing Strategy (HCFS) in the country. The HCFS aims to increase health resources, protect the poor, and introduce equitable financing mechanisms. The reforms are now being implemented in the majority of the regions that have more than 80% of health facility coverage.An astronomic expansion of training institutions (from 3 universities in 2005 to more than 23 colleges in 2012) to meet the growing demand for health professionals has occurred.
- Medical Products, Technologies: Ensuring that health facilities have essential medicines has been an area of focus. Initiatives around this include the development of an essential drug list, the revolving drug fund (RDF) within health facilities, improvements to the supply chain management, and ensuring quality control.
- Information and Research: The introduction and scale-up of the health management information system (HMIS), and community health information system (CHIS) at health post level, allows health facilities to keep track of health coverage and outcome data. This is routinely used in the annual woreda based core plans as well as to measure performance.
- Leadership and Governance: After the fall of the Derg (a communist regime) in 1991, the democratic government has shown strong commitment and dedicated leadership to transform the health system. This is reflective in ensuring the implementation of strategies and policies throughout the country that have led to the accomplishments highlighted above.

All the achievements mentioned have contributed to many improvements in health outcomes, and especially to the significant reduction in infant and child mortality that led to the achievement of the 4th Millennium Development Goal (MDG) (reducing under-5 child mortality by two-thirds from the 1990 estimates). A summary of the evolution of the Ethiopian health system on each health system building blocks over the last fifteen years is presented in Figure 2.5.

Figure 2.5: Evolution of Ethiopia's health system over the last 15 years

	Early to Mid-1990s	Mid-1990s to 2000	2001-2004	2005-2011	2011-2014
Health Service Delivery	Provided to few urban centers; 3-levels of care (hospitals, HCs, and clinics) focusing on curative services	Concept of expanding health posts as community outreach places started	Limited expansion of health facilities; PHCU concept evolved	Rapid expansion of PHCUs under HEP and more access to HCs; Structures of service delivery moved from 4-tier to 3-tier system; Decentralization of services (e.g., CMAM, ICCM) to community level	Focus on improving quality of health services; Ethiopian Hospital Reform Initiative
Human Resources			Development of HEWs and their supervisors' curriculum and training program	Development of HRH strategic plan; Expansion of medical colleges; More focus on accelerated training for HEWs, health officers, midwives, and obstetricians	Training of new cadre of health professionals: emergency professionals, biomedical experts, HITs, etc.
Health Information System		Institutionalization of annual sector reviews	Continuing with annual, midterm, and final sector reviews	Development HSDP Harmonization Manual (HHM) and HMIS tools, and pilot of new system; Scaling-up of system to 70-80% facilities in country; Introduction of family folder and community level information system	
Essential Medicine	Development of the Drugs Policy, and essential drug list	Establishment of Special Pharmacies (RDFs)	Expansion of RDFs; assessment of pharmaceutical sector	Development of pharmaceutical master plan; PFSA and hubs established; Revision of essential drug list; FMHACA established	
Financing	No financing strategy for health sector; financing either donor driven or highly dependent on OOPs	Health financing strategy adopted by GoE; Financing still donor driven or OOP dependent; Introduction NHA; Background studies conducted to inform HCF implementation	Piloting of HCF reforms (retention, waivers, exemptions, outsourcing and facility governance) in few regions; GoE and DPs start financing exempted services and some regions begin providing waivers to poor	Traditional finance reforms scaled-up to rest of country and risk pooling mechanism being piloted in few woredas	Preparation to scale-up CBHI and launch SHI
Leadership & Governance	Health Policy and Essential Medicine Policy	Redefining role of different tiers of gov't on health service delivery; Introduction of sector wide approach to health; Joint governance of health sector; Development of standard designs for HCs and hospitals	Introduction of HEP concept	Scale-up HEP; Introduction of accelerated expansion of PHC services through PHCUs; Training of health officers, nurses, HEWs; Introduction of evidence-based planning; More focus implementation on MDG-related interventions	

Despite all of the achievements that Ethiopia has made, the health system still faces challenges. Such as:

1. Not all established health facilities are furnished and equipped as per health facility readiness criteria, despite progress made in increasing access. Many facilities still do not have utilities such as water, and power and hence are not well prepared to provide the quality of services expected. According to the most recent Service Provision Assessment Plus (SPA+), only 57% of health centers surveyed have regular electricity[4] and only 44% of them have piped water[5] (EPHI, FMOH, and ICF International, 2014). Only 29% of health posts have regular electricity and only 3% of them have piped water (EPHI, FMOH, and ICF International, 2014).
2. While most have started providing service with deployment of minimum level of staff, it will take some time to staff all health centers as per standard. There continue to be issues around health worker motivation and retention.
3. Health facilities in all regions face shortage of drugs, medical supplies and other laboratory inputs. The retention of fees at facility level has increased the ability of the health facilities to procure medicines and medical supplies at their level. However, challenges exist around accessing these commodities at the right time, with the right quantities in PFSA hubs. This is because of factors dealing gaps in logistic management system on the part of Health facilities and supply shortage at the main government supplier (PFSA).
4. Limited investment in preventive maintenance of medical and laboratory equipment, hence areas where equipment is "out-of-order" implying inefficient use of existing resources.
5. Since the focus of the investment was on creating access at primary level, strengthening quality of care was not given the priority that it deserves. As a result, the referral system especially at primary and secondary hospitals is limited (FMOH, 2010b), and this may lead to inefficiencies within the system. Furthermore, per capita utilization of services has not grown in tandem with the increased potential access.
6. Social, financial and transportation barriers still exist and diminish the supply-side efforts by the Government to increase utilization rates.
7. Completeness, timeliness and reliability of health management information collected remain not reliable in comparison with the population based survey results. This has limited the ability of the system to provide evidence-based information to enhance efficiency both within the system (the ability of the system to capture necessary service delivery related information for management action) and without.

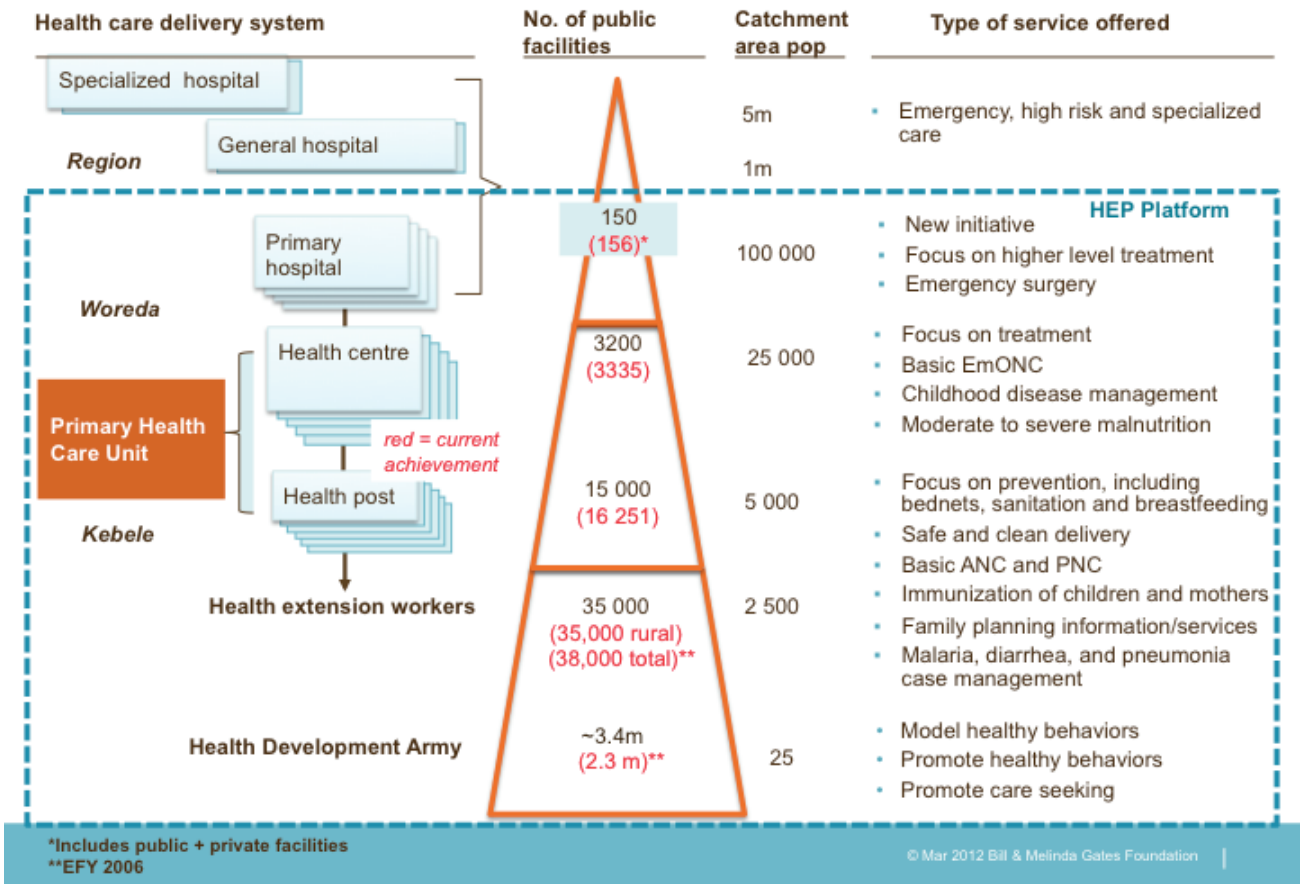
2.3 Service Delivery Landscape

Although Ethiopia is still a low-income country with a per capita GNI of US$ 629 (MOFED, 2014b), the proportion of people living below the local poverty line has declined by roughly a third over the past decade. It still remains high at 28 percent (CSA, 2012). Private final consumption on health is estimated at three percent of the GDP (MOFED, 2013). The country is federally structured with three tiers of government (federal, regional and woreda) that allocate resources to the health sector.

[4] Facility is connected to a central power grid and there has not been an interruption in power supply lasting for more than two hours at a time during normal working hours in the seven days before the survey, or facility has a functioning generator or invertor with fuel available on the day of the survey, or else facility has back-up solar power.

[5] Water is piped into facility or piped onto facility grounds or bottled water is used, or else water from a public tap or standpipe, a tube well or borehole, a protected dug well, protected spring, or rain water, and the outlet from this source is within 500 meters of the facility.

Figure 2.6: Health Care Delivery Landscape in Ethiopia



Source: Adapted from BMGF (2012)

Primary care has three points of service points as shown in Figure 2.6: health posts (HPs), health centers (HCs) and primary hospitals. A primary health care unit (PHCU) comprises of four health centres, five health posts within each health center, and a referral primary hospital and that serves roughly 100,000 people. The PHCU also engages community members through the Health Development Army.

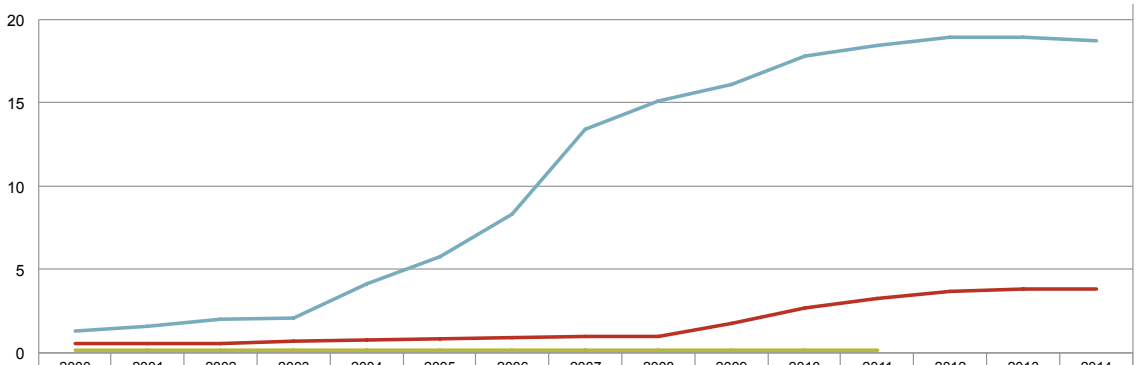
Each HP is staffed with two health extension workers (HEWs), and is responsible for a population of 3,000-5,000 persons. A HC has an average of 20 staff and provides both preventive and curative services. It also serves as a referral center and practical training institution for HEWs. HCs also have an inpatient capacity of 11 beds, where 10 beds is the set standard for emergency and delivery services (ESA, n.d.). Rural HCs serve populations up to 25,000 persons, while urban HCs serve up to 40,000 persons. A primary hospital provides inpatient and ambulatory services to an average population of 100,000. In addition to what a HC can provide, a primary hospital provides emergency surgical services, including caesarean section and gives access to blood transfusion service. It also serves as a referral center for HCs under its catchment areas, and is a practical training center for nurses and other paramedical health professionals. A primary hospital has an inpatient capacity of 35 beds. On average, a primary hospital has a staff of 53 persons.

The secondary level of care is comprised of general hospitals. A general hospital provides inpatient and ambulatory services to an average of 1,000,000 people. It is staffed with roughly 234 professionals and serves as a referral center for primary hospitals. General hospitals have an inpatient capacity of 50 beds and act as training centers for health officers, nurses and emergency surgeons, among other health professionals.

The tertiary level of care is comprised of federally-ran, specialized hospitals and university hospitals. A specialized hospital serves an average of five million people. The staffing pattern and bed capacity varies from hospital to hospital.

Over the past two decades, the government has given high priority to expand the primary health care (PHCU) system and services provided at this level of care (Figure 2.7). The health sector saw an unprecedented expansion of PHCUs, with all kebeles having their own HPs with HEWs and having more access to HCs. In addition, PHCUs are getting stronger with a linkage to primary hospitals. The primary health service coverage increased from 45% in 1996/97 (at the start of HSDP I) to 93.6% in 2012/13 (FMOH, 2011a; FMOH, 2012a, FMOH, 2013). As of last year, there were 16,251 HPs compared to only 76 in 1996/97. Over the same period, HCs increased from 412 to 3,335 (whereby 3,315 (99.4%) were functional and additional 211 were under construction) while hospitals increased from 87 to 156 out of which 150 (96.2%) were functional with 123 more under construction (FMOH, 2014c). This shift in focus towards primary care is in line with the prescription in the HCF strategy towards delivering cost-effective services that respond to the burden of disease and community's needs. This shows clear prioritization and consideration of value for money in the investment made.

Figure 2.7: Trends of health infrastructure per 100,000 people

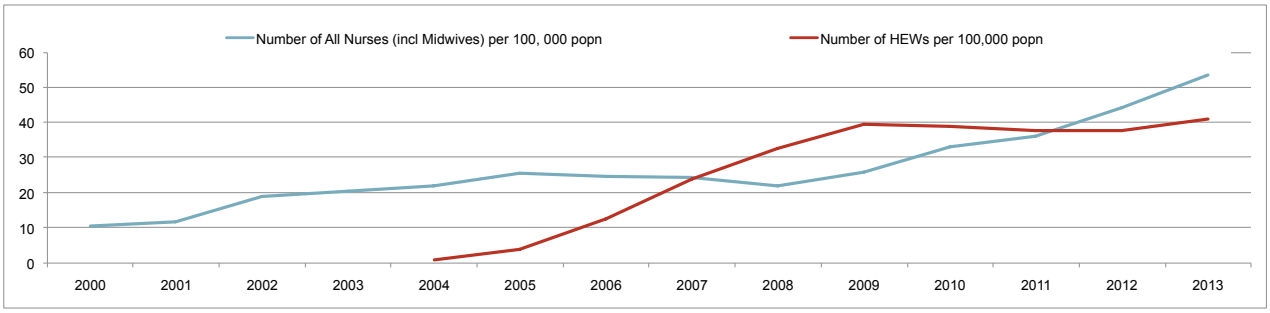


	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014
Number of HPs per 100,000 poptn	1.31	1.57	1.95	2.07	4.08	5.77	8.26	13.41	15.09	16.05	17.78	18.43	18.95	18.92	18.68
Number of HCs per 100,000 poptn	0.56	0.58	0.61	0.65	0.73	0.82	0.88	0.93	0.97	1.77	2.68	3.25	3.63	3.83	3.83
Number of hospitals per 100,000 poptn	0.16	0.17	0.17	0.17	0.18	0.18	0.19	0.19	0.20	0.25	0.25	0.25			

Source: Data from FMOH (2001); FMOH (2002); FMOH (2003); FMOH (2004); FMOH (2005a); FMOH (2006); FMOH (2007a); FMOH (2008a); FMOH (2009a); FMOH (2010c); FMOH (2011a); FMOH 2012a); and FMOH (2014c)

The investment in health infrastructure was also supported by investment on human resources for health (see Figure 2.8 and 2.9). Here again the emphasis has been on appropriate cadres of human resource for PHC. Figures 2.8 and 2.9 show that the number of health workers per 100,000 people increased significantly from 2000 to 2013, especially health extension workers and nurses. The trend of human resources required at hospital level (physicians) remained unchanged over the last 10 years (Figure 2.9) but is expected to significantly change to the better when the 11,291 students in training joined the labour market.

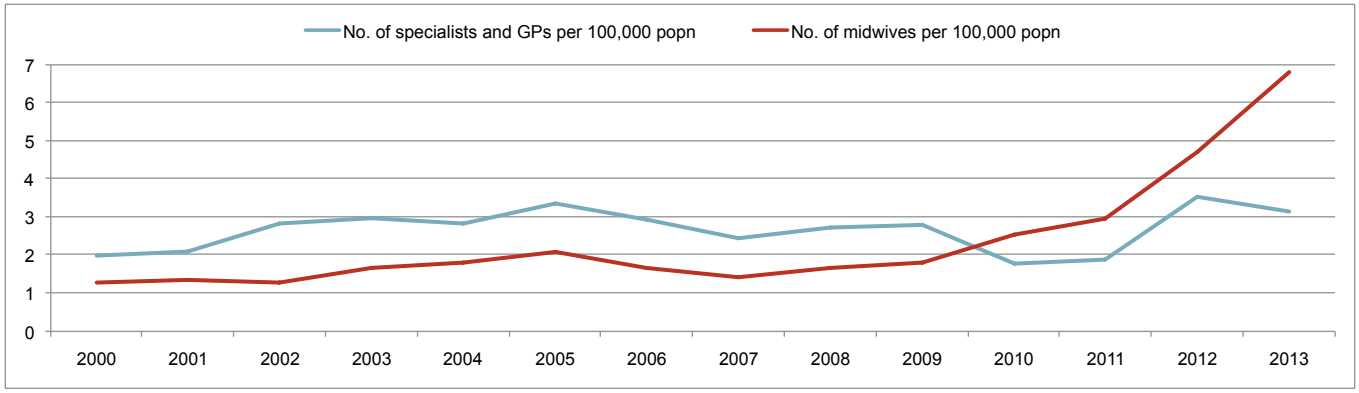
Figure 2.8: Trend of health extension workers and nurses (all types) per 100,000 people



Source: Data from FMOH (2004); FMOH (2005a); FMOH (2006); FMOH (2007a); FMOH (2008a); FMOH (2009a); FMOH (2010c); FMOH (2011a); FMOH 2012a); and FMOH (2014c)

Although Figure 2.9 clearly shows lower midwife numbers, this has changed in recent times. Utmost priority is given to reduce maternal mortality. Accelerated midwifery training program and the plan to staff each HC with two midwives is one such initiative to facilitate in the reduction of maternal mortality. Out of the planned 4,676, a total of 4,409 (94.3%) graduates were deployed in the past three years (FMOH, 2014c).

Figure 2.9: Trend of physicians and midwives per 100,000 people



Source: Data from FMOH (2001); FMOH (2002); FMOH (2003); FMOH (2004); FMOH (2005a); FMOH (2006); FMOH (2007a); FMOH (2008a); FMOH (2009a); FMOH (2010c); FMOH (2011a); FMOH 2012a); and FMOH (2014c)

2.4 Ethiopia's Policy for Achieving Universal Health Coverage

Ethiopia has recently undertaken a visioning exercise that lays out key directions on its path towards universal health coverage (UHC), a goal for the country's health sector transformation. The visioning document is still at draft stage but has been widely circulated for consultation. UHC has been defined as "guaranteeing access to all necessary services for everyone while providing protection against financial risk" (FMOH, 2014e). The visioning has been benchmarked to respond to Ethiopia's ambition to reach lower middle-income status by 2025 and middle middle-income by 2035. PHC is envisioned as the principal means to advance towards UHC while simultaneously addressing issues of secondary and tertiary care as well ensuring a continuum of quality clinical care with strong linkage to the PHC (FMOH, 2014e). The emphasis will be on public health approach which give due emphasis for public provision and financing of PHC as well as emphasizing on building a system on people-centered rather than diseases driven approach as clients appear with multiple morbidities.

According to the visioning exercise, below are the key strategic focus areas:

1. **Empower the community to play a significant role in the health sector.** Focus includes — Community ownership of health, active community engagement, household health production and support improved health behaviours, etc.)
2. **Strengthen PHCU within the wider health sector context.** Focus includes — Define standard service package at PHCU, secondary and tertiary levels, expand number of functioning health facilities including provision and maintenance of medical equipment, effective health management and governance structure, support with supply chain and HMIS system, etc.)
3. **Ensure a robust Human Resources Development system that is commensurate with socio economic development of the country.** Focus includes — Develop, deploy and retain high quality health care professionals including health care leaders (licensure, accreditation, and board certification), define career path for all categories including HEW, strengthen human resource information system (HRIS)
4. **Engage the private sector in support of the FMOH's vision.** Focus includes — Better partnership, strengthen capacity of health sector to regulate private sector, attention to traditional medicine etc.
5. **Develop sustainable financing mechanisms necessary to achieve a better health outcome.** Focus includes — Innovative financing, efficiency gains, mobilize domestic resource, expand SHI/ CBHI, etc.

6. **Develop institutional capacity in FMOH, Regional Health Bureaus, and related agencies to be responsive to changing economic, social, environmental, technical, and epidemiologic context.** Focus includes — Build capacity of FMOH and subsidiaries, set up and use of scientific advisory board, collaboration with universities to strengthen capacity of the health sector, strengthen agencies such as EPHI, FMHACA, PFSA, EHIA, etc.

UHC-designated reforms will be initiated as part of the development of the next 5-year health sector plan, the Health Sector Transformation Plan (HSTP). As shown in Table 2.1 and Table 2.2, the country already has various policies and strategies aimed at improving access to a basic package of essential primary health care services and protecting users from catastrophic spending.

Financial protection is of particular concern to the GoE as shown by the various policy reforms, which is focused on bringing about universal health coverage (see Table 2.2).[4] Estimates of the financial burden of OOP spending for households range from 1.07 to 4 percent of household income (CSA, 2011; FMOH, 2014c). To reduce the financial burden of user fees and premiums, the government has established various financial protection mechanisms. Table 2.2 presents each of these mechanisms and their associated challenges.

4 The social health insurance strategy touches on financial protection indirectly by defining the objective of a future social health insurance scheme as "…provide quality and sustainable universal health care coverage to the beneficiary through pooling of risks and reducing financial barriers at the point of service delivery".

Table 2.1: Policies to define and achieve universal health coverage

Laws, Policies and strategies	Provisions
Ethiopian Constitution 1991	- To the extent the country's resources permit, policies shall aim to provide all Ethiopians access to public health and education, clean water, housing, food and social security
Health policy 1993	- Development of an equitable and acceptable standard of health service system that will reach all segments of the population within the limits of resource. - Assurance of accessibility of health care for all segments of the population. - Provision of health care for the population on a scheme of payment according to ability with special assistance mechanisms for those who cannot afford to pay.
Health finance strategy 1998	- Shift is required from the existing crisis management, curative and urban-based expenditures to targeting resources directly to high-risk and focus population groups as well as the poor. - The primary responsibility to provide public health services as near to the people as possible and at a reasonably low or no cost lies with the government. Therefore, substantial government financial support for primary and preventive health care will be required. - User-fee charge needs to be revised and labelled according to the ability of the people to pay for the services they receive and adjusted for cost of living. - Although there is always a cost for health services, out-of-pocket payments at the time of service delivery may not be required. There will be some disease categories, population groups and program entities that will get the privilege of exemption. - Appropriate measures will be taken to ensure that the poorest people benefit from primary health care through fee exemption, subsidies and/or through instituting community-based risk-sharing schemes/Insurance.
Health sector development programs	- Government priority for investment was geared towards strengthening the primary health care system, especially the health extension program (HEP) and health centre expansion (facilities, health officers and nurses) and primary health care services.
Ethiopian essential health package	- EHSP provides a minimum standard that fosters an integrated service delivery approach essential for advancing the health of the population. EHSP services are offered at the district hospital, health center, and health post. The package covers family health, communicable diseases, hygiene and environmental sanitation, essential curative care and chronic diseases, and health education and communication. - High cost services (some in-patient services at tertiary level) are separate from the EHSP and health facilities (district hospitals, specialized hospitals, etc.) need to mobilize their own resources for these services. Exempted services are free for everyone and include TB (sputum diagnosis, drugs, and follow-up); maternal care (prenatal, delivery, postnatal, and deliveries, abortion and post abortion care); family planning services; immunization services; HIV/AIDS (VCT/PIHCT, ART and PMTCT); leprosy; fistula; and epidemics. The government subsidizes the remaining essential health services, allowing health centers and hospitals to charge a minimal fee (known as user fees). However, the government fully subsidizes these services for the poorest households selected into the fee waiver program.
Regional health laws, regulations and guidelines	- The regional governments set the user fees to be charged at facility level that considers ability to pay of the population. - No person shall be denied of medical services in public health institutions upon reasons of not being able to pay; - Fee waiver for those unable to pay and cost covered by the government and how to improve quality of care through retained fees.
Draft insurance strategy	- The strategy defines how formal and informal sector employees will be covered by prepayment and risk sharing schemes. The draft Insurance strategy has the goal of achieving universal health coverage with dual objectives: (i) reduce the burden of out-of-pocket spending by households and (ii) increase access to quality health services. The formulation of the two objectives fits well with the UHC objectives.

Table 2.2: Strategies in place to enhance access and financial protection

	Strategy	Definition	Main issues in implementation
1	**Exempted services**	Free for all regardless of income. Such services are also provided free of charge in private health facilities.	Sustainability of financing for health commodities if and when donor resource is reduced or withdrawn (Mann, Alebachew, and Berman, 2013) *Private health facilities still charge some fee albeit to cover the health worker's time.
2	**Essential services**	Government subsidizes as much as 70% of non-medicine costs in government Health facilities (FMOH, 2010c; Abt Associates, 2011). Medicines are sold at cost + 25% mark-up	Quality of services remains an issue
3	**Targeted Fee Waiver schemes for indigents**	Local governments reimburse health providers for lost user fees when treating fee waiver patients selected by local authorities	Problem of targeting (under-coverage of the very poor and or inclusion of those able to pay) and delay or non reimbursement of cost to Health facilities
4	**Pilot community-based health insurance (CBHI) schemes**	Government subsidizes 25% of the premiums of all members and the full premiums of the poor; CBHI scheme managers and staff at all levels are paid through government allocations.	Low coverage of the poor; various operational challenges around membership adherence, premium collection, registration, record keeping etc.; scalability of the schemes due to huge fiscal implication; inadequate readiness of facilities to provide quality service; and low awareness of the community about the essence of insurance.
5	**Health insurance for the formal sector**	Legal framework in place, Ethiopian Health Insurance Agency and its branches established, some systems designed, but yet to start operation	Management capacity of the agency and SHI systems are concerns; limited readiness of facilities to provide quality care

3. Review Framework and Methodology

3.1 Overall Strategy Review Framework

The overall framework used to review the HCFS is aligned to the overall goals and with the international experience of reviewing health finance strategies.

Universal health coverage (UHC) has emerged as one of one of the overriding health policy agendas for the post-MDG period. Ethiopia has stated its intention to move towards UHC and is already implementing a range of policies related to service delivery coverage and financial protection to advance in that direction as highlighted by draft Vision for UHC. Health financing policies and strategies make critical contributions to national efforts to advance towards UHC.

According to the recent World Health Report on health financing, countries are urged to review their health-financing situation, policies, and strategies to strengthen efforts to move towards UHC (WHO, 2012). Reviewing health finance strategies and revising them to fit into the changing health needs requires the following processes and frameworks:

- Review the current state of their progress towards UHC;
- Review how their health financing systems currently are organized and function;
- Revise their policies and strategies for the health financing system as appropriate to strengthen performance, ideally as a multi-stakeholder process involving all key players — all ministries involved in the provision or financing of health services (including the Ministry of Finance), sub-national governments, civil society, private sector, etc.;
- Implement policies and strategies; and
- Monitor and evaluate progress and revise policies and strategies as necessary (WHO, 2012).

This document clearly states the importance of engaging actors that are not typically technically involved in the dialogue around the development of national health plans, such as Ministries of Finance, Labour, and Social Security in the development of health financing strategyreviews. However, the health financing strategies that emerge from these reviews must be informed by and shape the thinking of how the overall health system will develop and what can be achieved over the time frame of a national health plan (WHO, 2012).

The RTM team uses a widely accepted framework for the analysis of health financing policies and strategies that has emerged from a number of global and national reviews (World Bank, 2007). This assessment also draws on the Health Financing OASIS Approach (Organizational Assessment for Improving & Strengthening) developed by the WHO, which has been used in health financing strategy reviews carried in nine countries since 2010. The only African countries that have used this approach so far are Benin, Mali and Uganda. Our overall approach is based on three key health-financing functions to achieve the following objectives:

- Resource mobilization to ensure sufficient and sustainable revenues in an equitable way;
- Pooling of funds to ensure that costs of accessing health care are shared thus ensuring financial accessibility; and
- Purchasing/provision to ensure that funds to buy and provide health care services are used in the most efficient and equitable way (World Bank, 2007; WHO, 2011).

The study analyses the HCFS 1998 to 2014, and looks at key points including resource mobilization (level of funding and sustainability), equity, efficiency and effectiveness, and institutional environment. The achievement of these health financing targets and health financing performance indicators largely depends on two major factors. The first determinant is the underlying institutional design of the three health financing functions or, in other words, the rules operating and related to the incentives with respect to health financing. The other determinant is the practice of health financing organizations guided or constrained by these rules and the incentives they set. Therefore, a need exists to analyse the institutional set-up and organizational practice in assessing the strengths and gaps in the health financing functions.

3.2 Methodology

The methodology the HCF strategy review uses is a mix of qualitative and quantitative techniques to collect the required data and information on various sources of financing, their institutional mechanisms and their potential capacity and/or limitations to identify the successes and gaps of the HCF implementation and ultimately to contribute towards UHC. The qualitative aspect of the methodology helps generate evidence on, and perspectives about, effectiveness of the HCF strategy in Ethiopia by:

- Providing a retrospective view of experience under the existing HCF policy — what has worked well, what has not worked well and what are the gaps.
- Generating evidence on the rules and regulations in place and the organizational structures put in place to implement the financing strategy.
- Providing HCF strategy stakeholders' (national, international levels) and policy makers' (federal, regional and woreda levels) forward-looking views on potential priorities for the revised HCF strategy and how revisions to the HCF policy could facilitate the implementation of the revised HCF strategy.

The quantitative analysis mainly focuses on analysing a set of key health financing related performance indicators over time for Ethiopia. This includes analysing available evidence from the five rounds of National Health Accounts (NHAs) and other analytical work to show the progress made in health financing since the strategy was implemented in 1998.

Overall this study conducts two types of analyses as part of the review of Ethiopia's HCF strategy over roughly the last 15 years. The first part of the analysis reviews the overall progress of health care finance by looking at issues such as efficiency and effectiveness, equity, resource mobilization and sustainability using secondary data from various reports and routinely collected data including NHA studies, health sector performance reports, HMIS indicators, budget and expenditure data from MOFED. The result of this analysis is shown in Section 6. The second analysis looks at progress around the specific reform components of the HCF strategy such as revenue retention and utilization, fee waiver, exemption, insurance, etc. Findings are presented in Section 7.

3.3 Sampling frame for qualitative data collection

Purposive sampling was applied to select the regions for data collection. There is wide variation between regions in terms of progress in reform implementation. Tigray, Amhara, Oromiya and SNNPR regional states have advanced more than others. Somali and Afar regions have just started implementing health care and finance reforms (HCFR). On the other hand, CBHI is being piloted in 13 woredas found in Tigray, Amhara, SNNPR, and Oromiya regional states while preparations are underway to expand to additional 160 woredas within these regions. Based on the variation between regions the nine regional states and two city administrations were classified into four groups and samples were selected from each for the four groups (See Table 3.1).

Table 3.1: Sampling of Regions

Category of regions as per their status in HCF implementation	Numbers of regions in the Group	Selected samples
Regions with advanced HCF reform	1. Tigray 2. Amhara 3. Oromiya 4. SNNPR	Sample size — 2 **Selected region(s)** — Oromiya and Amhara
City administrations who have started HCF reform	1. Addis Ababa 2. Dire Dawa 3. Harari	Sample size — 1 **Selected region** — Addis Ababa
Emerging regions who have been implementing HCF reform	1. Benishangul-Gumuz 2. Gambella	Sample size — 1 **Selected region** — Benishangul-Gumuz
Regions where HCF reform recently began	1. Afar 2. Somali	Sample size — 1 **Selected region** — Afar
Total Sample regions		5
Selected woreda sample size in each region		Oromiya (6), Amhara (6), Addis Ababa (2), Benishangul-Gumuz (2) and Afar (2)

Based on the classification presented on Table 3.1, Oromiya, Amhara, Addis Ababa, Benishangul-Gumuz and Afar have been selected for this analysis. Furthermore woredas have been sampled within each region. Accordingly, six woredas each from Amhara and Oromiya and two each from Benishangul-Gumuz, Afar, and Addis Ababa regions were selected. The selection of woredas was purposive incorporating well performing and not so well performing woredas. In each woreda, two health centers were identified and one health post within each health center was selected. In Amhara and Oromiya, two primary/district hospitals were selected while in other regions only one was sampled. Selection of health facilities consisted of a balance between strong and not so well performing ones. In Oromiya and Amhara regions, two general and two referral hospitals were identified purposively while in the rest of the regions, one general hospital and one referral hospital was sampled. Table 3.2 summarizes the sample size by type of entity.

Table 3.2: Sample woredas, HPs, HCs, and hospitals by region

Regions	Number of Woredas	Number of Health Posts	Number of Health Centers	Number of Primary Hospitals	Number of Secondary Hospitals	Number of Referral hospitals	Total number of Facilities
Amhara	6	12	12	2	2	2	36
Oromiya	6	12	12	2	2	2	36
Addis Ababa	2	0	4	1	1	1	9
Benishangul	2	4	4	1	1	1	13
Afar	2	4	4	1	1	1	13
Total	18	32	36	7	7	7	107

In each woreda focus group discussions (FGDs) were conducted with two groups of community members: 1) the general population and 2) fee waiver beneficiaries.

As one of the major tasks was to identify the list of exempted services currently being offered in health facilities against the actual exemption service list as per proclamation, a list was collected from all health facilities sampled (from referral hospital down to health post levels).

3.4 Data collection and analysis

Data Collection

The review team carried out field visits to understand the organization of health financing (and the access to and utilization of health care services) and health care provision at regional, woreda and health facility levels. Stakeholder interviews and focus group discussions (FGDs) were conducted with community members, health care providers, and policy-makers.

Key Informant Interviews

The key informant interviews (KIIs) were carried out at federal, regional and woreda and facility levels. At the federal level, we interviewed the FMOH about the Vision 2035 and its implication to UHC and the revision of the HCF strategy. We also explored the institutional and organizational aspects of implementing health-financing reforms in Ethiopia. At regional levels, the interview captured information on issues around the adequacy of resource allocated to health; strength and weaknesses of various health finance sources; successes and challenges of traditional health finance reforms; conditions for scale up of CBHI/SHI; efforts to enhance efficiency and effectiveness of different financing modalities; successes, challenges and efficiency with foreign aid management; and we captured their recommendation about important revisions in the HCF strategy. The interview with the Ministry and Bureau of Finance and Economic Development (MOFED and BOFED) focused on successes and challenges with health sector budget allocation and utilization and the successes, challenges and efficiency with foreign aid management. At facility levels, the focus was on status of implementation of traditional health finance reforms; successes and challenges of traditional health finance reforms; contribution of various financing methods to revenue generation; adequacy and challenges with government budget; and efficiency in financial resource management and utilization. We also interviewed the HFG/HSFR project[5] carried out by Abt Associates, the main implementing partner in the implementation of the health finance reform. The discussion with HFG/HSFR revolved around adequacy of resources allocated to health; strengths and weaknesses of various health finance sources; status of implementation, successes and challenges of traditional health finance reforms; contribution of various financing methods to revenue generation; conditions for scale up of CBHI/SHI; efforts to enhance efficiency and effectiveness of different financing modalities; successes, challenges and efficiency with foreign aid management; and their recommendation about important revisions in the HCF strategy.

Focus Group Discussions

FGDs were carried out with community members and health facility management committee or board. The FGD with community members focused on user fees (affordability, successes, challenges, etc.), fee waiver (transparency and efficiency of targeting, successes and challenges in service delivery to clients), exemption services (confirming exempted list and completeness of service), and quality of service in health facilities. The focus of the FGDs with health facility management (committees and boards) was on status of implementation of traditional health finance reforms; successes and challenges of traditional health finance reforms; contribution of various financing methods to revenue generation; adequacy and challenges with government budget; efficiency in financial resource management and utilization.

Secondary Data

Secondary sources have two components. First, collection of the quantitative information show the impact of the HCF reforms in Ethiopia in terms of increased funding and improved efficiency. This information was collected from different sources as shown below:

- MOFED — Trend in total national budget, budget allocation by sector (special focus to social sectors), distribution of health sector budget by source (domestic, loan, assistance [bilateral/multilateral]), and recurrent/capital budget.

[5] In July 2013, the Health Sector Financing Reform (HSFR) project ended, and has continued its technical support for health care finance reforms through the HFG/HSFR project.

- BOFED and subsidiaries — Trend in budget allocation by cost center with focus on health administrative bodies, training institutes, hospitals, HCs and health posts; recurrent/capital budget distinction.
- FMOH — Health sector budget by source (domestic, loan, assistance), amount of health basket funding and channel 2 funding by development partners (DPs).
- Health facilities (hospitals and HCs only) — Total budget (recurrent/capital), internal revenue, total number of users (outpatient/inpatient), fee waiver beneficiaries, and utilization of funds. Health facilities (all types) — Types of essential health services that are currently being delivered in the respective levels of health facility.

Another form of secondary data comes from an extensive literature review. Various studies, reports, articles, statistical abstracts, national health account studies, etc. that have reviewed health care financing in general, specific aspects of health finance, other country experiences, and assessments that have been conducted around health care finance were closely reviewed and lessons documented.

Data Analysis

Various government documents including sector reviews, policy statements and budgets were collected and analysed. The document review and analysis has three core contributions in the review of the HCF strategy:

1. Analyse the Health Care and Financing Policy in terms of relevance and adequacy of the framework — identifying where it has general and more specific elements, and where these may also be lacking.
2. Explore the available evidence on what has actually transpired since the policy was put in place and how that relates to specific parts of the policy. This helped to highlight some financing actions that may have happened in the absence of policy or occurred differently to what the policy states. This focuses on the aggregate sector level development and on the linkages between health financing at the region, woreda, and service delivery levels.
3. Document the lessons learned from international experiences about innovative and sustainable financing, and how to use it to inform the HCF strategy revision process.

Information from KIIs and FGDs were transcribed and analysed based on the thematic focus and study outline developed pre-hand. Quantitative secondary data was summarized and analysed using tables and charts. Regional reports were developed based on findings from qualitative study and collection of secondary data. Data gathered and analysed from qualitative assessment were triangulated with findings from desk level review of secondary information.

4. Overview of the Health Care and Financing Strategy in Ethiopia

4.1 Description of the contents of the Health Care Financing Strategy

In June 1998, after noting the challenges in the health sector, the Council of Ministers of the Government of the Federal Democratic Republic of Ethiopia approved the Ministry of Health endorsed Health Care and Financing (HCF) Reform Strategy, which established a new policy on HCF. The **goals** of the current HCF strategy is:

1. To identify and obtain resources from both domestic and external sources,
2. To increase efficiency in the use of available resources especially through allocating more resources to primary care,
3. To promote sustainability, and
4. To improve the quality and coverage of health services (Council of Ministers, 1998).

Refer to Box 4.1 for details of strategies and guiding principles of HCF strategy. The strategy was informed by a number of guiding principles, including the following:

- Services will be offered on the basis of cost-sharing between the receiver of services (patient) and provider of services (government); but patients are envisioned to pay according to their ability.
- User fees will be retained and used by the health facilities to improve the quality and quantity of services.
- Fee waivers shall be granted to reduce financial barriers for the poor, and an appropriate third party shall cover its cost.
- Exemptions shall be given to encourage consumption of particular kinds of preventive or public health services.
- Hospitals and health centers will have greater responsibility, authority, and accountability in managing service delivery and the resources they retained through their own facility management boards.
- Opportunities for innovative resource generating or cost saving schemes (including establishment of a private wing/wards for those who can pay more and to outsource non-clinical services to the private sector) were created to hospitals and health centers.

Box 4.1: Strategies and Key Principles of the Ethiopian HCF Strategy

Strategies

- Improving Government Heath Sector (allocative, therapeutic and operational) efficiency through improving allocation, organization and management of existing health resources.
- Generating Additional and New Sources of Revenue (government allocation, revision of user fees, revolving drug sales, various private, community, employer-based social financing and insurance plans
- Encouraging Private / NGO participation
- Promotion of Community Participation
- Encouraging Bilateral and Multilateral Agencies Participation
- Developing Alternative Financing Options for urban areas like Addis Ababa to improve efficiency, quality and to release government resources

continued...

Box 4.1: Strategies and Key Principles of the Ethiopian HCF Strategy (continued)

Guiding principles

- Shift from crisis management, curative and urban-based expenditures to targeting resources directly to high-risk and focus population groups and the poor
- Graduated systems of user fees; privileges to appropriate referrals and by-pass charges for self-referred patient
- Health services at government health facilities based on a cost-sharing principle between the provider and the receiver, with user-fee charge revised according to the ability to pay and the cost of service
- Government is primarily responsible to finance primary and preventive health care
- Active community involvement
- Local retention and use of user fees with vital role for the community in fund management and a say in the overall running of health facilities
- No service is "free", there is always a third party paying for it, but out-of-pocket payment at the time the service is rendered may not be required.
- There will be some disease categories, population groups and program entities that will get the privilege of exemption
- Measures will be taken to ensure that the poorest people benefit from primary health care through fee exemption, subsidies and/or community-based risk sharing/insurance schemes
- All the income generated by health facilities from various income-generating activities (will be considered as "health facility revenue" and will be additional to government budget and retained ad used by the health facility.

4.2 Evolution of the HCF Strategy

The health care and financing reform implementation in Ethiopia has passed through a number of phases to reach to its current status. The first phase can be considered as conceptualization and designing of the major reform elements. In this phase, a number of background researches (see Annex 2) and options for reform were conducted; including:

- Two studies of private health expenditures (one on demand side, the other on the supply side—staffing, costs, and utilization of private medical providers; delineating the functions and roles that public and private sectors;
- A willingness and ability of Ethiopians to pay for medical care;
- A discussion paper on approaches and methods for estimating the potential impacts of implementing the various elements of the HCF Strategy,
- A discussion paper reviewing the concepts and principles of health insurance and prepayment in developing countries, with particular focus on the prospects for applying them to support health financing goals in Ethiopia;
- A study of the policy of facility fee retention at government hospitals in the SNNPR and an assessment of its implementation to date;
- A study of private sector contracting for government health services and its potential benefits for application in Ethiopia;
- A pre-feasibility study assessing the potential benefits from creating CBHI schemes in the cash crop areas of Ethiopia (Oromyia and SNNPR regions);
- Investigation into current levels and policies of fee waiver and exemption ;
- A report on the detailed plan for implementing the Special Pharmacies Project;
- A review of the working environment of NGOs working in the health sector;
- An in-depth survey of current patterns in the supply, distribution, prescription, dispensing, and use of drugs; and
- An assessment of the private for profit sector in financing and delivery of health service.

These studies infomed the design of HCF strategies implementaton in Ethiopia. The second phase was development of legislative frameworks for the implementaiton of the HSFR. This was followed by a third phase of legislation and pilot testing. The fourth phase was consolidation of reforms based on the lessons learned during the piloting phase. Once the supply side reforms were carried out, the conceptualization and piloting of the demand side financing reforms were initiated. Table 4.1 shows the road map of the health care financing implementaiton reform in Ethiopia.

Table 4.1: Phases in the development and implementation of HCF reform

Phases	Conceptualization and interest Generation	Development of Legislative Framework for first Generation Reforms (FGR)	Endorsement and Pilot testing of FGR	Consolidation and expansion of FGR and Intensive External resource mobilization and innovations	Conceptualization of Second generation Reforms and development of preferred aid modality	Maturing FGRs and piloting part of second GR
Time Frame	1998-2001	2002-2003	2003-2005	2005-2008	2008-2009	2010-2014
Major activities	· Carrying out major back ground studies · Designing the reform sequences · Approval of sequences · Extensive sensitization workshops/ trainings for regional government officials, health administrator and Health facilities	· Development of regional legislative framework · Extensive sensitization workshops/ trainings for regional government officials, health administrator and Health facilities · Establishment of special pharmacies · Piloting in SNNPR	· Endorsement of the legal frameworks by the regional governments · Starting up of implementation	· Consolidation of FGR in agrarian regions · Ethiopia was able to mobilize significant resources from external sources · The MDG PF idea matured and its design started	· Development of the SHI strategy · Conceptualization of community based health insurance schemes · Expansion of FGR to some DRSs	· Designing CBHI schemes · Designing of SHI · Piloting CBHI in 4 regions · Sensitization on SHI · Expansion of FGR to all DRSs · Setting up and staffing structure to manage HI (the EHIA)
Major results	· Conesus on the strategy and its elements · Better awareness about HCF strategy and components	· Consensus on the legislative framework · Buy-in by some regional governments (SNNPR, Amhara, Addis Ababa, Oromiya) · Creation of HCF advocates among government officials at different levels		· Deepened the implementation by rolling out to many health facilities · Recorded significant external resource mobilization (the Global fund, GAVI and PEPAR) · Institutionalization of EBP for resource mobilization and enhancing efficiency and effectiveness	· Development of the MDG PF as preferred aid mechanism	· Awareness and common understanding on SHI among civil servants · EHIA established as an independent agency
Major Challenges	· Weak structure at FMOH level to give policy direction and lead HCF implementation process · Lack of dedicated structures at regional and sub regional levels to oversee reform implementation	· Absence of Minister of Health for a long time. Subsequently, there was lack of decisiveness among top management · Lack of dedicated structures at regional and sub regional levels to oversee reform implementation	• Inadequate buy-into and ownership of the reforms by many regions	· Persistence of operational challenges in first generation reforms implementation (even in the consolidated regions)	· Absence of structure at regional and sub regional levels to oversee and implement HCFR (such structure not well specified during BPR)	· Staffing of EHIA not going as per plan · Delay in launching SHI · Absence of structure at regional and sub regional levels to oversee and implement HCFR · Weak ownership of HCFR including CBHI by government entities

Source: Consolidated by authors with input from FMOH

5. Institutional Analysis of the HCF Strategy Implementation

5.1 Roles and structures at the Federal and Regional levels

There is no clearly articulated document that shows the roles of the FMOH and the regions in the design and implementation of health care financing in Ethiopia. The practice of design and implementation so far provides guidance on the definition of their roles. The health care and financing strategy has been implemented through the involvement and active leadership of different government institutions at federal, regional and woreda levels and also different coordination structures, especially at the federal level. Some of these structures have direct responsibility to implement health care and financing strategy interventions. Others facilitate and help implement health care and financing interventions indirectly. Figure 5.1 presents the main institutional structures and tools used to implement each of the goals of the health care and financing strategy.

Figure 5.1: Some institutional structures relevant to health care and financing strategy implementation

HCFS Goals	Invest in Domestic Resources & Allocation	Increase External Resource Mobilization & Utilization	Efficiency & Effectiveness	Equity
Institutional Structures	JCF / FMoH – RHB Joint Steering Committee			
	– MOFED/BOFED/WOFED – HCF reform structures at regional, woreda, facility levels – CBHI structure at regional and woreda levels	– JCCC – Resource Mobilization Directorate – Finance Directorate (Grants Management Unit) – HCF TWG	– PPD at federal and regional levels	– House of Federation – FMoH – JCCC – WOFED
Tools	– Evidence-based planning tool – HCF reforms	– Active resource hunting/ proposals – Compact/JFA – 1 Plan, budget, report – ARMs, JRMs, Evaluation, JANS	– Evidence-based planning tool – Roll out Essential Health Service Package (EHSP)	– Evidence-based planning tool – Resource allocation formula (national, regional, and woreda) – Fee waiver mechanism – Exempted services – Subsidy to premium for CBHI indigents – Subsidy to user fees

*Under institutional structures, those listed in blue are structures not have direct responsibility for HCF

Source: Consolidated by authors with input from FMOH

FMOH-RHBs and sub-national level government coordination

The FMOH-RHBs Joint Steering Committee is chaired by the Minister of Health, and meets every two months. It aims to facilitate the effective and smooth implementation of priority issues of the HSDP IV. This mechanism is functioning well, and the level of attendance has been very high. This organ is critical for program prioritization, resource allocation, and sharing of best practices, as well as initiation and pursuit of new health initiatives, including health financing.

The FMOH conceptualized the HCF strategy agenda, developed reforms and designed parameters as well as guidelines and templates that were shared with RHBs. These templates provided a clear guidance on the type of legal (proclamation, regulation, or guideline) and institutional set up required to implement the proposed reforms under the strategy. Within the FMOH, a number of actors have direct influence of their own functions as related to the HCF strategy, including:

- The Resource Mobilization and Utilization Directorate (FRM): Responsibilities of this directorate consist of active resource hunting, coordination of HCF strategy implementation, enhancing public private partnership, and resource mapping, and NGO coordination.

- Policy, Planning, and Monitoring and Evaluation Directorate: Responsibilities include prioritization, resource allocation, and performance monitoring.
- Finance Directorate: Responsibilities include disbursement of funding, accounting, reporting and auditing of channel 2 resources.
- Ethiopian Health Insurance Agency: Oversees and manages the implementation of SHI and CBHI.

Regions are responsible to establish a mechanism to develop the legal framework for implementation. Most often, a committee established from relevant regional bureaus (health, finance, regional cabinet) steer this process. This process leads to the development, review and endorsement of the HCF agenda by the relevant regional authority (regional council, cabinet or RHB). The practical development of HCF legislations, with the exception of SHI, therefore occurs within the regions rather than at the federal level.

Although the structure varies from region to region, a focal person guides the HCF reforms at the regional level. There is also a single person at the zonal level for some regions where zones have administrative responsibilities as well as focal people at the woreda level. The strongest structure in terms of HCF exists at the facility since facilities need to employ the minimum staff necessary to manage HCF reforms. According to HCF Implementation Manual (FMOH, 2005b), a health center needs to have about eight staff for administration and finance such as accountant, cashier, procurement, property administration, statistician etc. Hospitals on the other hand, are required to have minimum of 10 staff undertaking similar responsibilities. Since the Business Processing Reengineering (BPR)[6] initiative aimed at addressing major challenges on curative care at health facilities, there is concern that the structures put in place at regional level for support services, including health financing are inadequate. The HCF officers at the regional level are unable to reach and support health facilities and woredas in the implementation of the HCF reform activities. There is no structured system to monitor performance and provide support at the regional level. Had it not been for the partner support, the achievements made so far to implement the HCF reforms would not have been achieved. According to stakeholder views, the reforms that could sustain without external technical assistance is revenue retention and utilization.

Sector coordination structures

The coordination structure of the HSDP at federal level consists of the Joint Consultative Forum (JCF), Joint Core Coordinating Committee (JCCC), and the Annual Review Meeting (ARM) for the health sector. There is also a formally established Country Coordinating Mechanism with the aim of overseeing programs funded through the Global Fund to Fight AIDS, TB, and Malaria (GFATM). The JCF serves as a joint forum for dialogue on sector policy and reform issues between GOE, DPs, NGOs and other stakeholders. The members of this forum oversee the implementation of the IHP, allocation and utilization of MDG/PF, Promotion of Basic Services (PBS), GAVI and all other donor-supported projects. The HSDP IV midterm review (MTR) found that JCF is meeting regularly with good levels of attendance (FMOH, 2013). The JCCC is the technical arm of the JCF that serves to give operational oversight; monitor the implementation of both pooled funds (Health Pooled Fund (HPF) and MDG/PF); organize and coordinate the monitoring, review and evaluation missions and meetings of HSDP; and facilitate the implementation of the findings and recommendations of these meetings and missions. Furthermore, the JCCC reviews quarterly financial and activity plans, and reports; and discusses and facilitates the allocation or reprogramming of pooled funds. According to HSDP IV's MTR, the JCCC is functioning well and meets every two weeks, at times more frequently, when needed (FMOH, 2013).

A number of technical working groups exist to support JCCC and JCF by providing technical inputs to the policy and strategy development. Until recently, there was no structure and capacity at the federal level to bring together all the relevant stakeholders to steer the functioning and strategic direction of health care financing in Ethiopia. As a result, the discussion and dialogue around health financing has been limited to either the first generation reforms or insurance schemes. In the development of health sector development programs so far, every strategic initiative developed its strategic objectives and targets, and is properly followed. When it comes to HCF, a five-year plan has not been developed and followed up. This is usually masked under costing and financing. The FMOH recently established a health care financing technical working group (HCF TWG) to provide technical expertise on health financing. The development of this TWG was promising given members' initial active participation and regularly scheduled meetings. However, most recently this TWG has not become the prominent think-tank as outlined in its terms of reference.

[6] The BPR undertaking re-designed the work process as well as the staffing structure at all levels in the health sector as well as other public sectors.

Roles of Ministry of Finance and its regional and woreda counterparts

The management of channel 1 funding is the responsibility of the finance structures at all levels. WOFED/BOFED manage and are responsible for expenditure management and reporting of channel1 funding. Because there is not finance structure at the woreda level, WOFEDs are also responsible to manage channel 2 funding (management of expenditure and reporting) at woreda level. Furthermore, they are expected to play a significant role in resource generation, allocation and utilization. While the BOFEDs and WOFEDs are actively engaged in the design and implementation of many of the HCF reforms at the regional levels and below, the involvement of MOFED at the federal level is not that visible.

The WOFED is expected to oversee the utilization of facility revenue. However, this arrangement is not functioning well, as WOFED's do not own this activity as their own and have limited capacity to undertake their function (e.g., auditing health facility utilization of resources). The exception to this is in Oromiya where BOFED and WOFED are committed to execute their duties to help implement the health finance reforms introduced at the facility level including undertaking annual audits reviews at the regional level. Auditing health facilities revenue is planned to be a part of the WOFED annual plans. The recent move to show the facility retention funding at the regional level could help address some of the challenges that are observed in this regard.

Technical support to the implementation of health care financing reform

Overall, while the government has provided the enabling environment for implementing the reforms by putting in place the necessary legal frameworks, the actual day-to-day support and monitoring of the reform heavily rests on the HFG/HSFR project implemented by Abt Associates. Additionally, other partners are supporting this reform in different ways, such as CHAI with resource mapping and WHO; however their role was not clearly visible during the field visits. Ownership and capacity of government structures (RHBs) to lead and manage the HCF strategy is of a critical concern. Since health financing is an important health system building block, government at all levels needs to strengthen its capacity and structure to manage these health finance activities.

5.2 Tools/mechanisms used to implement the strategy

Many tools and mechanisms have been used to realize the different goals of the health care financing in Ethiopia. Evidence-based planning is the primary technical instrument, which justifies mobilizing government funding from government budget at the woreda level. (Evidence-based planning was developed based on the "marginal budgeting for bottlenecks" concept, which links funding decisions to specific steps to increase inputs, access, coverage, and quality of services.) The concept of "matching health center" introduced by the FMOH during the expansion of primary health facilities has helped to motivate woredas and regions to allocate more resource to develop service delivery capacity. This concept consists of FMOH allocating resources for one health center's construction and cost of equipment in a match for each health center the regions constructed using their own budget. The implementation of user fee retention helped facilities to generate additional own resources from out of pocket spending. Launching of private wing service is also another mechanism that helps generate additional resource besides encouraging retention of senior professionals.

Active resource hunting through proposal writing mobilizes significant external resources from GFATM, GAVI and some other partners. The design and implementation of the pooled funds the technical assistance pool fund, and especially MDG Performance Fund, has mobilized significant funding from the development partners. The success of the PHC approach in service delivery and especially the health extension program was used as evidence of value for money to pull additional funding from external resources.

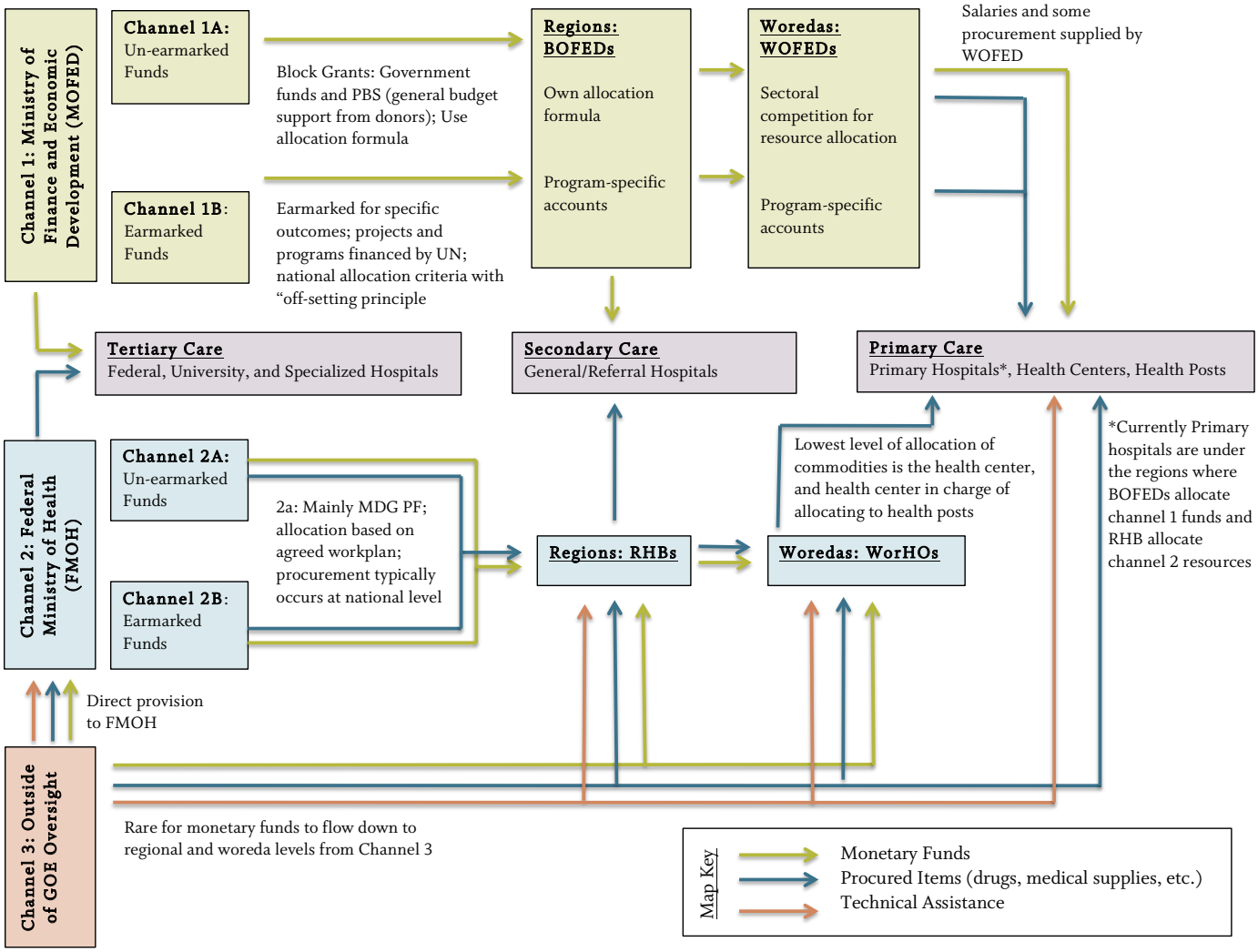
Equity has been a consideration in resource allocation. Public resource allocation to regions and woredas is guided by the federal and regional resource allocation criteria endorsed by the respective councils. Equity here is ensured among woredas and regions but this is across all sectors, not just for health. The FMOH also allocated resources, especially commodities, to regions based on either the national resource allocation criteria or specific disease burdens (for HIV/AIDS and malaria for instance). Woreda administrations identify and finance the health care of the very poor based on their available funding through the fee waiver program. There are also list of services which are provided free of charge to all irrespective of income (exempted services). Additionally, subsidies are given towards the CBHI scheme from federal, regional and woreda levels.

Evidence-based planning was also used to help prioritize and enhance effectiveness through investing in primary care and cost effective services.

5.3 Funding channels and their management

There are three broadly distinct funding channels available being used by government and DPs to channel resources from federal level to woredas in Ethiopia — Channels 1, 2 and 3. Refer to Figure 5.2 for the graphical depiction on the flow of resources with these three channels from the federal level down to the woreda level. *Note: Contributions of household out-of-pocket spending from user fees and health insurance is not included in the funding flow diagram.*

Figure 5.2: Channels of funding flow in Ethiopia



Source: Developed by authors with input from FMOH

Channel 1: Ministry of Finance and Economic Development (MOFED)

This channel of funding uses MOFED's financial management system, integrated budget and expenditure (IBEX) system and is fully on budget, on treasury and on account and has two subcomponents: Channel 1a and Channel 1b.

Channel 1a (un-earmarked): The GoE, along with DPs, provides general budget support (GBS) using this channel of funding. The fiscal transfers from the federal government to the regions are based on national resource allocation criteria approved by the House of federation and takes into account of 1) population, 2) revenue generating capacity, and 3) development status. Many regions have been implementing a similar formula to transfer funds down to the woredas based on current expenditures, development status, and revenue generating capacity. The fiscal transfers use Ethiopia's Treasury system — meaning at the federal level the MOFED transfer funds to the regional Bureau of Finance and Economic Development (BOFED), which are then transferred to the Woreda Office of Finance and Economic Development (WOFED). Since this system is automated using wire transfers through the bank, delays in the flow of Channel 1 funds is uncommon. This is the GoE's most preferred modality.

Channel 1b (earmarked): Funds through this channel are earmarked for specific activities and outcomes agreed by government and a particular DP, and are consistent with Ethiopia's priorities. Program-specific bank accounts for these resources are used. Funds are transferred from the donors "special accounts" to MOFED and follow the same government financial management system as described in Channel 1a (MOFED to BOFED to WOFED). Although Ethiopia's health sector is focused on harmonizing its system with "one plan, one budget, and one report", DPs that use this channel of funding also require a separate planning document with their own separate format, agreed by the Government.

Channel 2: Federal Ministry of Health (FMOH)

This channel of funding is managed by the Finance Directorate at the federal level with the Grants Management Unit (GMU) overseeing the specific programs with resources allocated by donors through this channel.

Channel 2a (un-earmarked): This channel mainly consists of the MDG Performance Fund (MDG PF). Resources are allocated based on agreed work plans during the woreda based planning process and follow the decentralized system, meaning the FMOH allocates resources to the RHBs which are then allocate to the WorHOs. These allocations are in the form of commodities and supplies either procured at the national level or are in-kind donations, with minimal funds being allocated. This is the FMOH's preferred channel of funding.

Channel 2b (earmarked): Similar to Channel 1b, these funds are program-specific and allocations through this channel follow the agreed upon project/program plans. These resources are managed by the FMOH but accounting and reporting mainly follow donor procedures. Resources from partners, such as Global Fund, GAVI, and UN agencies transfer resources through FMOH to WOFEDs to manage and report the use through Government agreed procedures.

Channel 3: Limited Government Oversight

Resources through this channel do not use government systems; instead DPs or their implementing agencies manage the resources. Currently, most of the donors report the use of these funds through resource mapping. However, donors handle the day-to-day financial management of these resources. Some examples of this are United States Government (USG) (United States Agency for International Development (USAID), the President's Emergency Fund for AIDS Relief (PEPFAR), and the Center for Disease Control and Prevention (CDC)). Funds given to implementing partners are provided based on annual contracts. Work plans might be shared with the FMOH or RHBs but budgeting and reporting is separate from Government institutions.

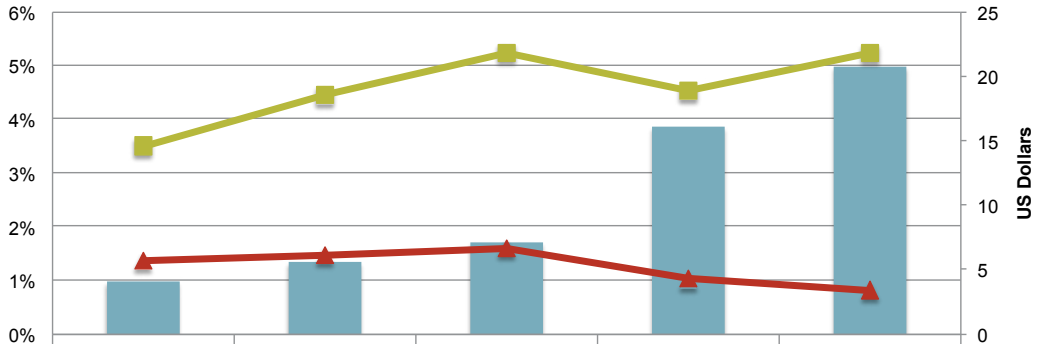
6. Overall Achievement of HCF Strategy

6.1 Increasing Resource Mobilization

One of the major policy objectives of the strategy has been to increase resources to the health sector. Several elements of the strategy contribute to this end including clearer policies on user fees; development of evidence based planning; private wings in hospitals; and increased efforts to mobilize external resources from development partners.

While user fees were institutionalised for more than 50 years, the first generation of reforms clearly articulated that user fees will be set based on cost sharing principle and will be retained at the facility levels. The government has also introduced evidence based planning to justify increased resource allocation to health from government budget at lower levels. Private wings have been also established in hospitals. In addition, revised fee waiver system introduced the reimbursement of costs to health facilities for the services they rendered for patients with fee waiver benefit. The FMOH has also worked hard to mobilize external resources from development partners through demonstrating results and value for money for the assistance it received and by introducing different strategies to mobilize, harmonize and align aid. These reforms have resulted in increasing resources to the sector. According to the NHA (the authoritative exercise for estimating the total health spending) total health expenditure (THE) per capita increased by about 400% from US$4.09 in 1995/96 to US$20.77 in 2011/12, at current prices. While this is a significant absolute increase, THE as a percentage of GDP increased from 3.5% in 1996/97 to only 5% in 2004/2005, and remain at 5% since (see Figure 6.1).

Figure 6.1: Total Health Expenditure (THE) in Ethiopia, 1995/96 to 2010/11



	1995/96	1999/00	2004/05	2007/08	2010/11
THE per capita (USD)	4.09	5.6	7.14	16.09	20.77
THE (% of GDP)	3.5%	4.4%	5.2%	4.5%	5.2%
Government spending (% of GDP)	1.4%	1.5%	1.6%	1.0%	0.8%

Source: Data from FMOH (1996); FMOH (2003); FMOH (2006); FMOH (2010a); and FMOH (2014a)

The Commission for Macroeconomics and Health (CMH), estimated that by 2015 the per capita resource requirements in low-income countries to avail essential services should total $38 (expressed in 2002 dollar terms) while the High Level Task Force (HLTF) for innovative financing put that figure at US$54 (expressed in 2005 dollar terms) to avail the more comprehensive services included in its estimates. In 2012, the CMH estimate is equivalent to US$71 and that of the HLTF is US$86 (McIntyre and Meheus, 2014). Although it is known that Ethiopia's requirement could be less given its low cost and better comparative advantage in terms of purchasing power parity when compared to such resource requirement estimates, it can be seen that the health sector expenditure in Ethiopia is low relative to CMH and HLTF benchmarks meeting — only about 38 and 25 percent, respectively of the proposed levels.

Government Financing

According to McIntyre and Meheus (2014), there are two major reasons now for the call for increased government funding of health and other social services. First, UHC calls for investing in a health system in which everyone has access to the services they need (irrespective of whether such services are preventive, promotive, curative, rehabilitative or palliative), services of adequate quality to be effective and universal financial protection from the costs of using those services. In this regard, World Health Report 2010 recommends that in order to move towards UHC, mandatory

pre-payment financing mechanisms must form the core of domestic health care financing. These could be from tax and other government revenue, e.g., royalties on the exploitation of mineral resources and can be placed in a general government revenue pool or dedicated to the health sector and mandatory health insurance contributions. Second, four dimensions of sustainable development (inclusive social development; environmental sustainability; inclusive economic development and peace and security) are being considered on the Post-2015 UN Development Agenda. As noted by the UN System Task Team: 'Ensuring people's rights to health and education, including through universal access to quality health and education services, is vital for inclusive social development' and requires investment to 'close the gaps in human capabilities that help perpetuate inequalities and poverty across generations' (ibid. p. 26). Inclusive economic development similarly requires investment in people's capabilities through public spending on social services, particularly health, education and nutrition, as noted in the most recent Human Development Report (UNDP, 2013). Public spending on social services is a means of income redistribution and contributes to sustained inclusive economic development.

At present, the only target related to government spending on health care that has been approved by a group of countries is the 'Abuja target'. In 2001, the heads of state of the African Union member countries called for at least 15% of total government spending to be devoted to the health sector (OAU, 2001). Elsewhere, WHO recommends that countries should strive over time to achieve government health spending levels of at least 5% of GDP, supplemented by a minimum target of $86 per capita government and donor funding in low-income countries in order to ensure basic PHC services in cases where meeting of the 5% target alone would be insufficient. The appropriateness of these norms can be debated in relation to each country's specific conditions. For example, while heads of state agreed to the "Abuja target", most of the signatory countries have not achieved the target although as a percent of government spending this is presumably within their power to do. However, one can certainly agree that moving towards internationally proposed health system goals will require more resources than are currently being spent by many lower income countries, including Ethiopia. In view of these arguments, it is essential to analyse the current patterns, determinants, and potential for improving government's funding allocations to health in Ethiopia.

When we look at government resources, it can be seen that overall government spending[7] as well as health sector spending has been growing in nominal terms over the year except in 2012/13 (Table 9.1). This is true at sub-regional levels as well. Discussions at different levels have shown that the health sector is one of the priority areas for government spending. For example in Addis Ababa, the City Administration directs block grant to sub city administration, which allocates it between sectors with the exception of health, education, dry waste management and police functions. When it comes to these four sectors, the city administration makes the allocation to ensure that they are not compromised in the fight for limited resource between competing sectors at sub city level.

Table 6.1: Total government and health sector nominal budget and share of health budget out of total government budget in ETB, 2005/06 to 2011/2012[8](in '000 birr)

Budget Type	1998 (2005/06)	1999 (2006/07)	2000 (2007/08)	2001 (2008/09)	2002 (2009/10)	2003 (2010/11)	2004 (2011/12)
Total Government budget	41,326,360	52,746,988	69,559,876	88,045,476	104,494,913	133,431,991	182,435,792
Health Sector budget	2,313,898	4,108,332	6,407,529	7,995,944	8,954,913	12,167,526	14,254,244
Health out of total (%)	6%	8%	9%	9%	9%	9%	8%

Source: MOFED (2014b)

[7] Government spending or budget is different from expenditure (actual utilization). Analysis of budget against expenditure is shown in Section 6.3.

[8] Both total government and health sector budgets come from three main budget sources: government treasury, loan and assistance from DPs.

Nationally, government health sector budget as share of total government budget has been maintained between 8% and 9% during the years 2006/07 to 2011/12[9] (see Table 6.1). Share of health budget out of total regional government budget similarly lies between 8% and 10% as the data from sampled regions shows. National data on share of government health budget at woreda level out of total woreda government spending (considering only channel 1 donor support) shows that it grew from 7% in 2005/06 to about 10% in 2011/12 (see Figure 6.2). Data from visited woredas shows that government allocation for health of total woreda government budget averaged between 9% and 10% (in Amhara and Oromiya), between 16% and 21% in Benishangul-Gumuz and around 14-15% in Afar (Table 6.2).

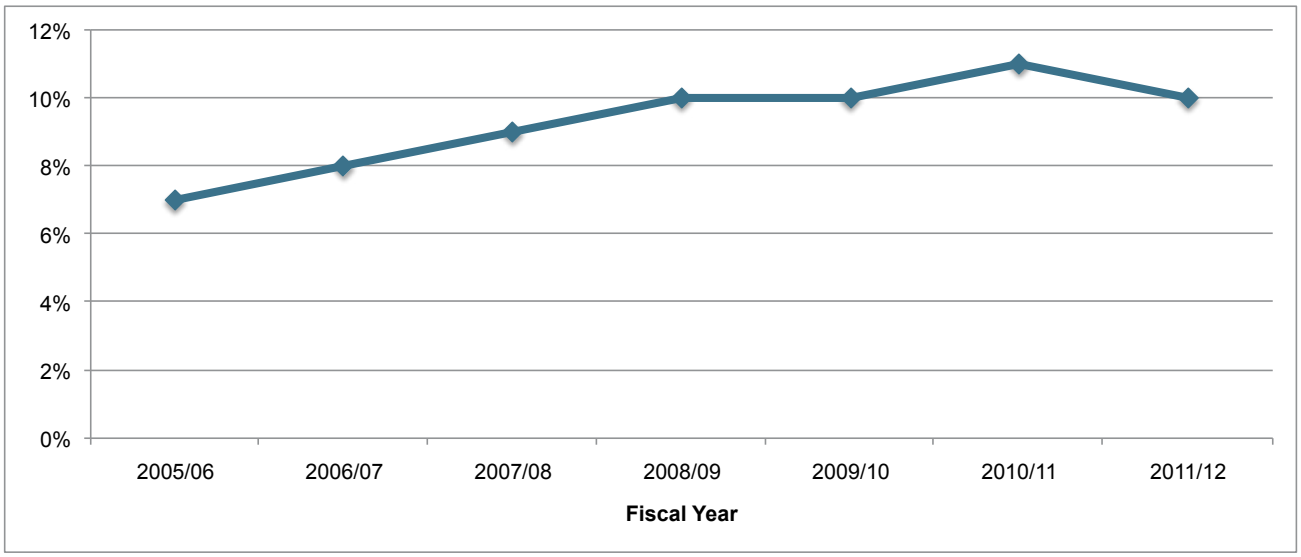
Table 6.2: Health budget as percent of total woreda government budget in sampled woredas

Woreda	Budget	
	2012/13	2013/14
Amhara region average of five woredas	**10.4**	**10.5**
Bahir Dar Zuria	10.1	11.7
Sekota	11.3	8.3
Dangla Zuria	8.7	9.6
Ambasel	10.7	9.1
Worebabu	11.4	10.0
Oromiya region average of six* woredas	**9.1**	**10.2**
Benishangul-Gumuz region average of two woredas	**18.5**	**20**
Homosha	21	23
Bambasi	16	17
Afar average of two woreda**	**14.8**	**14.2**

Source: Data collected during review

Note:
* Lekempt town, Gudyavila, Ejera, Habro, Bedessa, and Asasa woredas
** Awash Sebat kilo and Mille woredas

Figure 6.2: Health budget as percentage of total woreda budget, national average

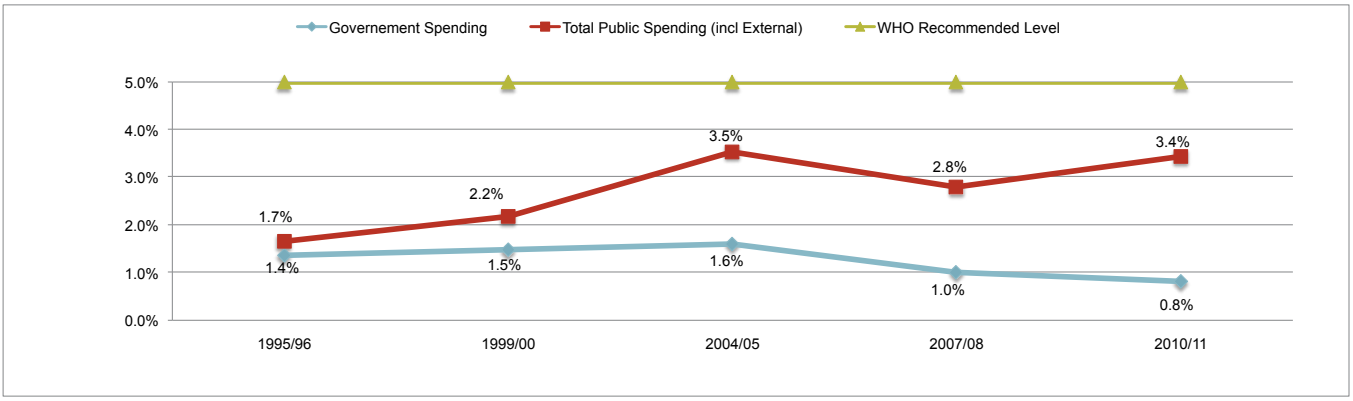


Source: Altman, Alebachew et al (2012)

[9] This calculation includes DP contribution (assistance) in the form of direct budget support (channel 1A and 1B). It is important to note that NHA accounting methods exclude external contributions to general government budget support from government spending, whereas MOFED counts some external support as part of government budget.

Despite the increase in government spending on health (Figure 6.2), its share as percent of GDP is still below the WHO recommended level of 5%, ranging between 0.8% and 1.6%. Even after adding health spending through government and development assistance, share as percent of GDP has only reached a maximum of 3.4% during the five NHA years (see Figure 6.3). We have seen in Figure 6.1 THE, which consists of public, rest of the world, OOP expenditure, and private spending stood at around five percent of GDP. In the medium to long term, the government needs to take over expenditure funded by external partners given Ethiopia's aspirations to become a middle-income country, and the expected decline in donor funding. In addition, given its intentions to move to UHC, the government should shoulder some of OOP expenditure by subsidizing the enrolment of the poor in CBHI– estimated at ETB 1 billion per year (CBHI Evaluation). Increasing government spending on health from own resources should be a critical element of a comprehensive health financing strategy going forward.

Figure 6.3: Government health expenditure and total public health expenditure including rest of the world as percent of GDP 1995/96 to 2010/2011



Source: Data from FMOH (1996); FMOH (2003); FMOH (2006); FMOH (2010a); and FMOH (2014a)

The government budget is allocated for recurrent and capital functions. Recurrent budget is mostly consumed by salary and other personnel related expenses. As can be seen in Table 6.3, of the average recurrent budget between 2005/06 and 2012/13 shows that only 30% is available for operational expenses while 70% is consumed by salary. This situation is more or less similar in the regions. Of the personnel-related expenses, there is also shortage of budget for duty and allowances faced by many health facilities. During this assessment, it was seen that many health facilities feel that the budget allocated for other operational expenses is inadequate. While health facilities try to cover their drug and medical expenses from their own internal revenues, low level of budgets allocated for duty allowance and other operational expenses has remained their concern. In Amhara, the overall government allocation at woreda level is increasing while the budget per health center is declining. There is a general trend that the operational budget is not allocated to health centers[10]. However, the regional government has passed a direction that a minimum of ETB 180,000 per year should be allocated for each HC for drugs and medical supplies. The regional government also allocated ETB 148 million to reimburse health facilities for providing delivery service free of charge; regional MDG fund is also being used to finance such reimbursements. As indicated in subsequent sections, because of shortages of non-salary operational budget, health facilities are forced to allocate part of their internal revenues forfunctions which are not allowed in HCF implementation manual (negative list) such as for fuel, tyres for ambulances, and also purchases of uniforms, bedding etc.

[10] Services rendered at woreda level are all primary care including allocation to WorHO, which is providing support to primary care.

Table 6.3: Share of non-salary recurrent health budget out of total recurrent health budget

Fiscal Year	Tigray	Afar	Amhara	Oromiya	Somali	BG	SNNPR	Gambella	Harari	Dire Dawa	Addis Ababa	Federal	National
1998 (2005/06)	31%	40%	31%	33%	26%	38%	26%	30%	33%	40%	41%	50%	32%
1999 (2006/07)	26%	52%	30%	31%	35%	50%	25%	25%	35%	40%	40%	50%	31%
2000 (2007/08)	23%	28%	27%	24%	34%	75%	20%	18%	29%	37%	41%	53%	30%
2001 (2008/09)	25%	28%	26%	25%	40%	25%	26%	8%	33%	39%	38%	53%	28%
2002 (2009/10)	26%	30%	22%	29%	38%	31%	29%	12%	32%	41%	41%	55%	29%
2003 (2010/11)	27%	29%	23%	31%	28%	25%	29%	14%	33%	36%	40%	55%	30%
2004 (2011/12)	29%	28%	22%	30%	33%	37%	24%		43%	45%	37%	49%	29%
2005 (2012/13)	40%	29%	27%	16%	32%	30%	30%			46%	43%	45%	
Average	28%	33%	26%	27%	33%	39%	26%	18%	34%	40%	40%	51%	30%

Source: MOFED (2014b)

6.2 Increasing external resource mobilization, alignment and harmonization

External resource mobilization and utilization

The government of Ethiopia has been able to mobilize resources from external sources through proactive resource mobilization mechanisms. It established a long-term strategy and priority that external sources can align to. It also established systems and structures to utilize the resources mobilized. More importantly, it was able to strengthen overall health system (access to and utilization of services) from resources generated from vertical program funding agencies: the Global Fund and GAVI. It has developed a series of aid effectiveness mechanisms (Code of Conduct (2005), Compact (2009) and Joint Financing Agreement (2009)) to ensure alignment and harmonization of funding from external partners. This has enabled the country to mobilize and effectively use external resources. Ethiopia was also able to show that it can reach the very poor and deliver results and value for money for the resources it gets from development partners (DPs), which encourages other DPs to join in.

According to the NHA estimates, the major driver of the increased per capita spending in Ethiopia in recent years is the accelerating contribution from external resources. As can be seen from Table 6.4, with the exception of 2007/08, more than 80% of the change in per capital health spending came from increased external resources. The lower share of the external resources in 2007/08 in the per capita change can be explained mainly due to different methods to estimate household spending on health by replacing the Household Income, Consumption and Expenditure survey (HICE) with a special purpose NHA household survey. This resulted in doubling the estimate of household spending on health, and thus lowering the percent contribution of per capita health expenditures from external resources.

Table 6.4: Contribution of external resources compared to growth of per capita spending on health (USD)

Year	Actual per capita expenditure		Increment of per capita health spending	Increment of external resource per capita health spending	Percent share of increment per capita health spending
	THE	External resource			
1999/00	5.6	1.21	1.51	1.19	79%
2004/05	7.14	2.63	1.8	1.51	84%
2007/08	16.09	6.32	9.5	3.85	41%
2010/11	20.77	10.34	3.87	3.79	98%

Source: Authors calculations from FMOH (2003); FMOH (2006); FMOH (2010a); and FMOH (2014a)

Despite efforts to conduct resource mapping, there is still difficulty to get data on external assistance coming through channel 2 and channel 3. Table 6.5 and Figure 6.4 shows the contribution of some of the resources that were being spent through the knowledge of government. It is important to point out that some official government documents (e.g., the Annual Performance Reports for the health sector) report a more comprehensive funding picture for external commitment and disbursement than provided in this report. However the FMOH states that this data is not entirely accurate, and therefore we show the external contribution data documented by the Grants Management Unit (GMU) under the Finance and Procurement Directorate in the FMOH.

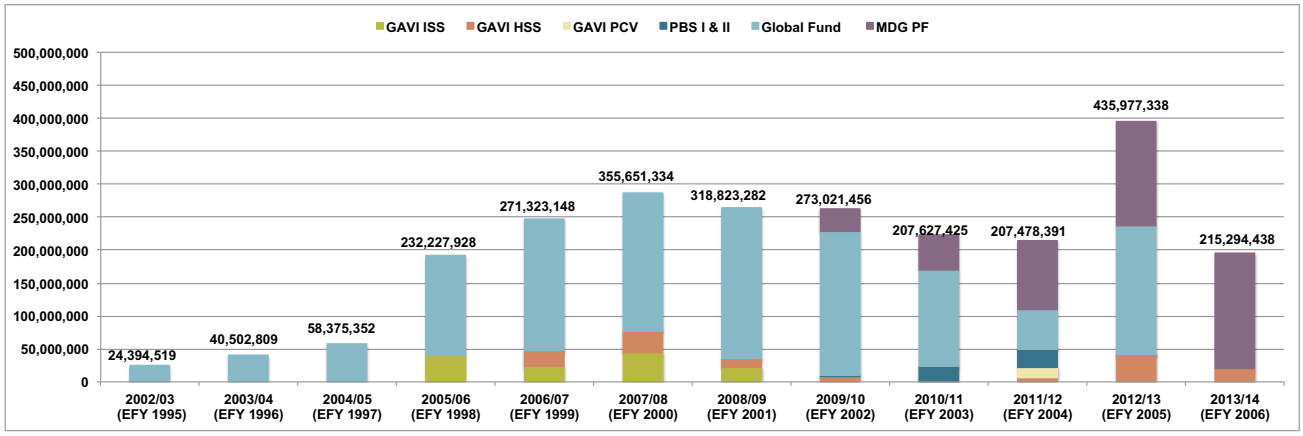
The Global Fund and GAVI have been supporting different vertical and health systems strengthening efforts in the county for more than ten years. The contribution of the MDG Performance Fund from the total sector is growing, and it has been funding major health system gaps for more than five years. The Promotion of Basic Services (PBS) scheme has a major role in financing the recurrent budget through block grants. Although in recent decline, PEPFAR and USAID have played a significant role in financing some of the vertical health programs and systems (not shown in Table 6.5 or Figure 6.4).

Table 6.5: External funding under channel 1 and 2 from 2007-2014, in million USD (nominal)

Source	2007/08 (EFY 2000)		2008/09 (EFY 2001)		2009/10 (EFY 2002)		2010/11 (EFY 2003)		2011/12 (EFY 2004)		2012/13 (EFY 2005)		2013/14 (EFY 2006)	
	disbursed	utilized	disbursed	utilized	disbursed	utilized	disbursed	utilized	disbursed	utilized	disbursed	utilized	disbursed	utilized
GAVI ISS	44.40	0.25	22.28	0.96	-	0.47	-	1.26	-	90.42	-	5.66	-	6.25
GAVI HSS	32.11	64.86	12.63	3.61	8.03	8.03	-	-	6.26	-	40.44	3.13	19.66	35.13
GAVI PCV	-	-	-	-	-	-	-	-	15.07	2.04	-	1.79	-	.02
GAVI Grand Total	68.09	0.25	54.39	65.82	12.63	4.08	8.03	9.28	21.33	92.46	40.44	10.57	19.66	41.40
PBS I & II	-	-	-	-	2.34	-	23.83	-	28.26	-	0.50	-	-	-
Global Fund	211.09	136.43	229.52	202.83	217.90	252.65	146.35	222.09	59.49	26.79	196.34	14.21	-	-
MDG PF	-	-	-	-	34.47	38.96	53.25	33.72	105.34	87.18	158.75	119.09	175.97	39.75
Grand Total	355.65	201.79	318.82	273.21	273.02	304.18	207.63	266.35	207.48	298.89	435.98	154.45	215.29	122.55

Source: This data was acquired directly from the Grants Management Unit (GMU) within the FMOH during review.

Figure 6.4: External disbursements made under channel 1 and 2 from 2002-2014 (in nominal USD)



Source: This data was acquired directly from the Grants Management Unit (GMU) within the FMOH during review.

For channel 3 funding, it is even more difficult to get an idea as these funds are flowing outside of the government's oversight and hence the only means of getting an estimate is from the source i.e. DPs. Table 6.6 shows estimates of funding from different DPs by channel based a resource mapping exercise conducted for EFY 2002. Accordingly, 36% of the donor resources are going through channel three. Biggest channelling mechanism for most of this multilateral and bilateral donors is channel 2b (earmarked) which accounted for 43% of all transfers in 2002 EFY. During the same year MDG PF accounted for 10% of donor transfers.

A more recent estimate (2013) has put the relative share of different channels in EFY 2004. Accordingly, the preferred (un-earmarked) channels (including 1a, MOFED/PBS) made up 38% of all the available resources, whereas channel 3 (outside FMOH oversight) contributed 33%. The two earmarked channels (1b and 2b) together contributed almost 30%. The review also documented that the contribution of the preferred channels as part of all available resources is increasing, the increase coming from GoE block grant resources (1a, MOFED/PBS) and from the various partners' contribution to the (un-earmarked) MDG/PF (channel 2a).

Ethiopia's engagement and leadership in mobilizing and using external resources is by and large centered on strengthening health sector priorities and systems as outlined in major strategic documents such as the Code of Conduct (FMOH, 2005c), IHP+ Compact JFA (FMOH, 2008b) and HHM (FMOH, 2007b). Consequently, unlike many other countries, it has managed to capitalize on the increased funding from external resource flows to strengthen its health system. The major contribution of external resources in strengthening the health system is the following:

- The transformational effect on the health system from introduction and expansion of the Health Extension Workers is partly achieved through regional block grants that are partially financed by the PBS fund (Reshad, 2014)
- Ethiopia managed to construct nearly 3,000 health centers, of which about 50% (Reshad, 2014) of them were financed from external resources, especially from the Global Fund and GAVI support. The gains in service delivery in terms of access, and meeting some of the MDG goals, were possible through the investment made by partners.
- The HCF strategy has been implemented and shown very good achievement in terms of revenue retention and utilization, fee waivers, community oversight of facilities, piloting of CBHI due mainly to the technical and financial support provided by USAID.
- The availability of public health commodities, those outside the revolving drug scheme, and the strengthening of logistics management system in Ethiopia (quantification, warehousing, distribution, etc.) were mainly financed by external partners.
- The standardized health management information system (HMIS) through PEPFAR funding.

Table 6.6: Support from DPs by channel, EFY 2002, in ETB

Name of DP	Total value of support	Funding Channels					
		Part of Channel 1a: PBS Component 2 (health commodities)	Channel 1b: (earmarked support to regions and woredas)	Channel 2 other than MDG PF and HPF	MDG PF	HPF	Channel 3
Austria	38,050,894		4,616,534		-	-	6,800,510
UNFPA	95,000,000		30,600,000	41,100,000	13,700,000		9,600,000
JAICA	38,000,000	-	-		-	-	38,000,000
WHO	299,087,744	-	113,277,122		4,960,000	-	180,850,622
Spain	438,246,360	-	3,533,260	-	117,775,000	-	78,610,100
CIDA	258,485,260	243,129,700		15,355,560			
Italy	291,426,667	165,000,000	-	38,426,667	63,800,000	11,000,000	13,200,000
Clinton	102,370,400						102,370,400
Netherlands	189,945,859	51,185,200	-	-	-	3,838,890	134,921,769
CDC	1,637,926,400	-	-	-	-	-	1,637,926,400
UNICEF	358,296,400	-	332,703,800		-	-	25,592,600
GAVI	936,689,160				936,689,160		-
EU	12,158,718						12,158,718
DFID	512,664,800	-	-	-	221,584,000	3,021,600	2,014,400
USAID	3,873,029,148	-	-	981,240,000	-	-	2,891,789,148
World Bank	195,870,674	107,576,204	-	88,294,470	-	-	
Global Fund	4,934,922,066	-	-	4,934,922,066	-	-	
France							
Irish Aid	84,700,000		11,000,000		39,600,000	-	34,100,000
Total ETB	14,296,870,550	566,891,104	495,730,716	6,099,338,763	1,398,108,160	17,860,490	5,167,934,667
Total ($)	1,117,265,971	44,301,173	38,740,161	476,648,622	109,258,783	1,395,754	403,861,637
Percent Share of Channels		4%	3%	43%	10%	0.12%	36%

Source: Waddington, Alebachew and Chabot (2011)

6.3 Pooling

In principle there are four main financing mechanisms used to pool health risks, promote prepayment, raise revenues, and purchase services: state-funded systems through ministries of health or national health services; social health insurance; voluntary or private health insurance; and community-based health insurance (Gottret and Schieber, 2006).

The dominant financial pooling mechanism in Ethiopia is collective public financing, in which the government at federal and regional levels collect funds from a variety of sources on behalf of the citizens and uses those funds to pay for mainly public provision of designated health care services. Some regions have also started supporting pilots of community-based health insurance, which pools government contributions with household contributions at woreda levels. This is being scaled up from the pilot phase in the coming years. At the time of writing, social health insurance is at the design and preparatory phase and private health insurance is very limited.

Sufficient risk sharing arrangements are yet to take root in Ethiopia, but there is progress in working out the preparatory phases to move in that direction. In 2010, the government ratified the Social Health Insurance strategy and the legal framework (Proclamation & Regulation) in order to establish the SHI and the Ethiopian Health Insurance Agency (EHIA). With the establishment of the EHIA, with about 500 employees at the federal and regional level offices, the government has looked into other necessary systems like provider payment mechanisms and financial sustainability. The implementation of CBHI schemes has been piloted in 13 woredas based on a feasibility study and is moving from piloting to scaling up phase.

In Ethiopia although the resource mobilization and allocation for the overall government budget is carried out at different levels, the majority of government resources allocated to regions and woredas comes from the federally assigned taxes and external resources which accounts for close to 60 percent of the overall government fiscal space. These are allocated using a federal block grants allocation formula to the regions.

Ethiopia practices fiscal decentralization, where different tiers of government are assigned with defined expenditure discretion (expenditure assignment), revenue-raising powers (revenue assignment), and defined intergovernmental transfer and borrowing functions, as provided by Federal and Regional States Constitutions. The expenditure assignment of the three government levels for the health sector is shown in Table 6.7.

Table 6.7: Responsibility and expenditure assignments

Federal Level	Regional Level	Woreda Level	
		Recurrent	Capital
Tertiary hospitals and parastatals	General and primary hospitals, health training colleges, regional referral laboratory	• For health facility equipment and furniture • Per diem for routine immunization • Per diem and medicines for epidemic control • Procurement of malaria spray chemicals and associated per diem • Medicines • Recurrent budget for new health facilities	Construction of health posts and health centers

Source: Alebachew and Alemu (2010)

Since the investment made over the last 15 years is more on PHC, the expenditure assignment on health is more at the lower levels (woredas and regions) than the national level. However, resources are pooled and invested through government transfer mechanisms. At present, financial resources are transferred from federal government to regional governments in the form of both general-purpose grant (block grants-channel 1a) and specific purpose grant (channel 1b); and at the regional level, transfers are made to woredas in the form of general-purpose grant. Since 2007, per capita relativity based formula', which is similar to the Australian Common Wealth Grant Commission system, has been adopted. It consists of an integrated expenditure need and Fiscal capacity criteria. Federal subsidies are allocated to the regional governments based on the size of population, ability to spend, and capacity of revenue collection. Developing regions have also some percent to compensate them for their disparity in growth. Allocation to capital budget especially expansion of primary health facilities is driven by the set population standards (HP for 5000 and HC for 25,000) is largely target those that do not have access to care. It is therefore largely fair. Allocation of recurrent budget is largely driven by the number of health workers in the health facilities, which favors areas with better functioning health facilities.

In the current system, there is no systematic tracking and reporting of for in-kind donations allocated through channel 3 at woreda level.

6.4 Payment and Purchasing Arrangements

There are two primary mechanisms accounting for most of the payment for health care in Ethiopia: budget financing and payment by government, primarily for service inputs; and out-of-pocket spending by households for service outputs, drugs, tests, supplies, etc.

Payment and purchasing arrangements can be important determinants of better resource allocation and efficiency. For the most part, government health care does not make much use of payment and purchasing to influence service delivery performance. Rather, government relies more on managerial mechanisms and performance monitoring and planning. A major vehicle for this is the annual evidence-based planning process which seeks to plan for improvements in service coverage, quality with a methodology based on the marginal budgeting for bottlenecks (MBB) approach.

Out-of-pocket payment by households for government services is significant and does provide incentives and enabling resources at facility level to deliver services not fully covered by government financing. In general, however, government services in Ethiopia have not relied on incentives to individual workers to motivate resource allocation or efficiency, choosing rather to emphasize public service ethics as a main motivator. One exception to this policy has been the development of pay wards at public hospitals under the HCF strategy (see Section 7.8). The World Bank approved a new project in Ethiopia following its "Program for Results" (P4R) approach. Most of this project is an IDA loan that is disbursed to the MDG Performance Fund based on achievement of agreed upon results. A grant component to develop pilots through the World Bank's results-based financing trust fund was also included in the package.

6.5 Enhancing efficiency and effectiveness in resource allocation and utilization

Over the past two decades, the government has given high priority to expand the primary health care system and the services provided at this level of care. The health sector saw an unprecedented expansion of PHCUs, with all kebeles having their own health posts with HEWs and having more access to health centers. In addition, PHCUs are getting stronger with a linkage to district/primary hospitals. The investment in health infrastructure was also supported by investment on human resources for health with emphasis on appropriate cadres of human resource for primary health care. Utmost priority is given to reduce maternal mortality. Accelerated midwifery training program and the plan to staff each HC with two midwives is one such initiative. Also attention is given to the training and deployment of professionals in integrated emergency surgery and obstetrics (IESO) to improve the provision of emergency obstetric care and surgical services at primary hospital level where a gynaecologist or surgeon are not available.

Table 6.8: Physician training

Name of University	1st Year	2nd Year	3rd Year	4th Year	5th Year	6th Year	Total
Adama	171	125	164	105	93	294	952
Addis Ababa	367	245	320	235	290	294	1,751
Arba Minch	200	125	107	62	62	51	607
Bahir Dar	166	235	169	106	108	72	856
Defence	0	16	0	23	0	28	67
Gondar	403	245	100	200	212	173	1,333
Haromaya	340	225	225	188	108	66	1,152
Hawassa	394	252	258	125	258	110	1,397
Jimma	410	395	310	222	213	199	1,749
Mekelle	298	252	323	175	184	199	1,431
St. Paul	130	170	125	127	42	33	627
Adigrat	115	0	0	0	0	0	115
Wachamo	78	0	0	0	0	0	78
Debre Tabor	53	0	0	0	0	0	53
Axum	28	66	45	0	0	0	139
Wollo	43	76	56	0	0	0	175
Debre Markos	41	72	50	0	0	0	163
Debre Birhan	43	62	65	0	0	0	170
Ambo	38	73	80	0	0	0	191
Wolloga	25	60	60	0	0	0	145
Wolayitasodo	38	68	66	0	0	0	172
Medawolabu	17	64	52	0	0	0	133
Dilla	18	48	68	0	0	0	134
Dire Dawa	31	58	62	0	0	0	151
Yekatit 12 Hospital	57	72	85	0	0	0	214
Adama Hospital	47	76	56	0	0	0	179
Yirgalem Hospital	32	65	59	0	0	0	156
Total	**3,583**	**3,145**	**2,905**	**1,568**	**1,570**	**1,519**	**14,290**

Source: FMOH (2014b)

Note:
The years in the table heading show the year of medical training, which takes 6 years to complete medical degree (MD).

In order to address the dire shortage of physicians in the country especially in rural areas, the government is implementing a policy of 'flooding' whereby it plans to undertake massive training of physicians to counteract internal as well as external brain drain[11]. Accordingly, the government has undertaken monumental expansion of universities in general and medical schools in particular. The New Medical Education Initiative (NMEI) has been implemented in 13 medical schools. In EFY 2006, 3,583 new students were enrolled in 27 public medical schools (13 NMEI and 14 from the previous system), making the total medical students on training to be 14,290 (Table 6.8).

[11] There is internal brain drain from public towards private sector or NGO and external brain drain to other countries.

Figure 6.5(a): Health sector capital budget spending between federal, region and woreda, 2005/06 to 2011/12

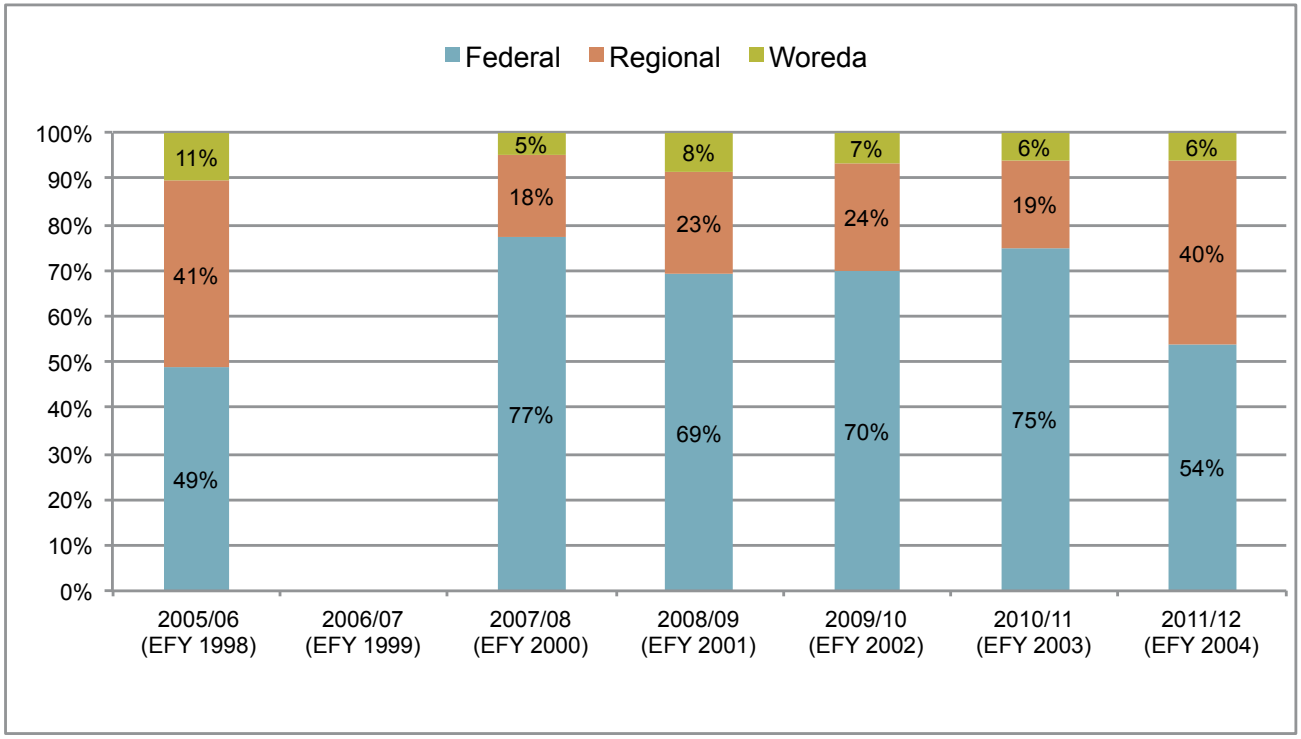


Figure 6.5(b): Health sector recurrent budget spending between federal, region and woreda, 2005/06 to 2011/12

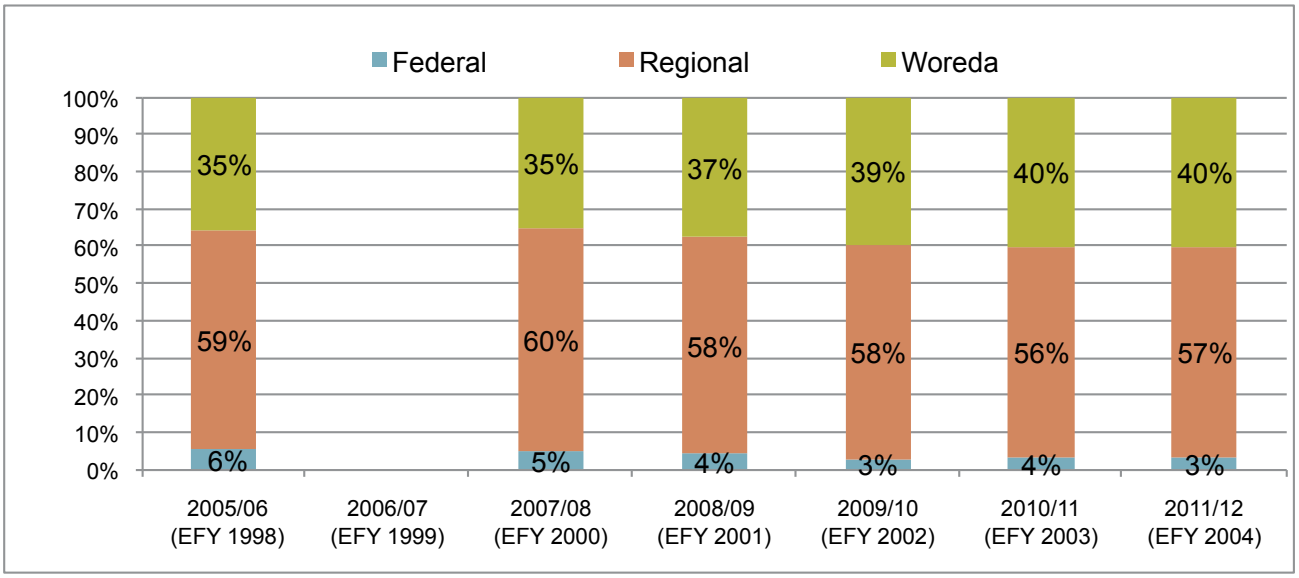
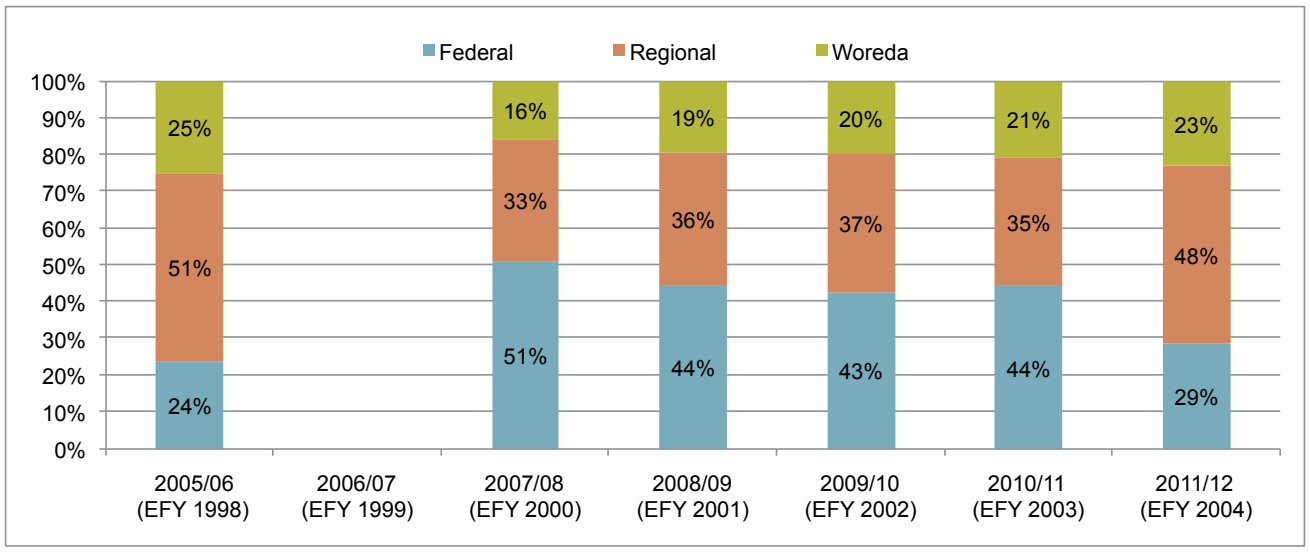


Figure 6.5(c): Total health sector budget spending between federal, region and woreda, 2005/06 to 2011/12



Source: MOFED (2014b)[12]

When we look at the pattern of government budget spending at different levels one can see that more of capital budget (minimum of 49% and maximum of 75% between 2005/06 and 2011/12) is allocated at federal level. This is explained by the fact that the FMOH was able to mobilize and guide external resources for various health sector expansion undertakings including the accelerated expansion of health centers (see Figure 6.7a). While the FMOH's service delivery responsibility assignment as shown above is on tertiary care, its investment records show that is more concerned on effectiveness and efficiency as it invests on PHC. On the other hand, most of the recurrent budget (between 94% and 97%) is spent at regional and woreda levels with woredas getting a substantial share (Figure 6.7b and 6.7c).

Analysis of effects of spending at woreda level suggested that it improves health outcome (Khan et al, 2014). Results showed that spending via channel 1 at woreda level appear to improve rates of penta-3 vaccination, ANC, contraceptive use and delivery by skilled attendants (Khan et al, 2014). Ethiopia has declared that it has achieved MDG 4 well ahead of time and is one of the few countries to meet many on the MDG goals.

The focus on investing in primary care as well as prioritizing training of HR that is an input for primary care, spending of more government resources regional and woreda levels, and below, suggest an overall improvement in allocative efficiency. However, this cannot be attested from the NHA data because of change in methodology between various rounds of the NHA studies.

Another major initiative that is intended to increase efficiency in planning and implementation, increase effectiveness and mobilize resource is the evidence based planning (EBP) also known as woreda-based planning. Several elements including the bottom up approach and use of evidence-based approaches such as marginal budgeting for bottlenecks (MBB) have a great potential in enhancing effectiveness and efficiency in resource allocation and utilization. There are key features of EBP that result in efficiency and effectiveness: first, prioritizing and investing in high-impact interventions; those with strong evidence base for improving health outcomes; second, use of evidence in decision-making; third aligning health priorities, plans, and budgets within the government and between the government and development partners and fourth, harmonization or coordination of activities among all health sector stakeholders to reduce the transaction cost of delivering aid and services. Stakeholders reported that evidence based planning has had a major impact on increasing the prioritization of high-impact interventions. National-level interviewees perceived that this has been the most important EBP impact so far at the woreda levels. Interviewees at all levels saw a strong link between EBP, the prioritization of high-impact interventions, and the achievement of national health goals and Millennium Development Goals (MDGs) (Altman, Alebachew et al, 2012).

[12] Government audited accounts capture treasury (tax and non tax income), loan and assistance through channel 1. Spending in the health sector through channel 2 and 3 are not captured here.

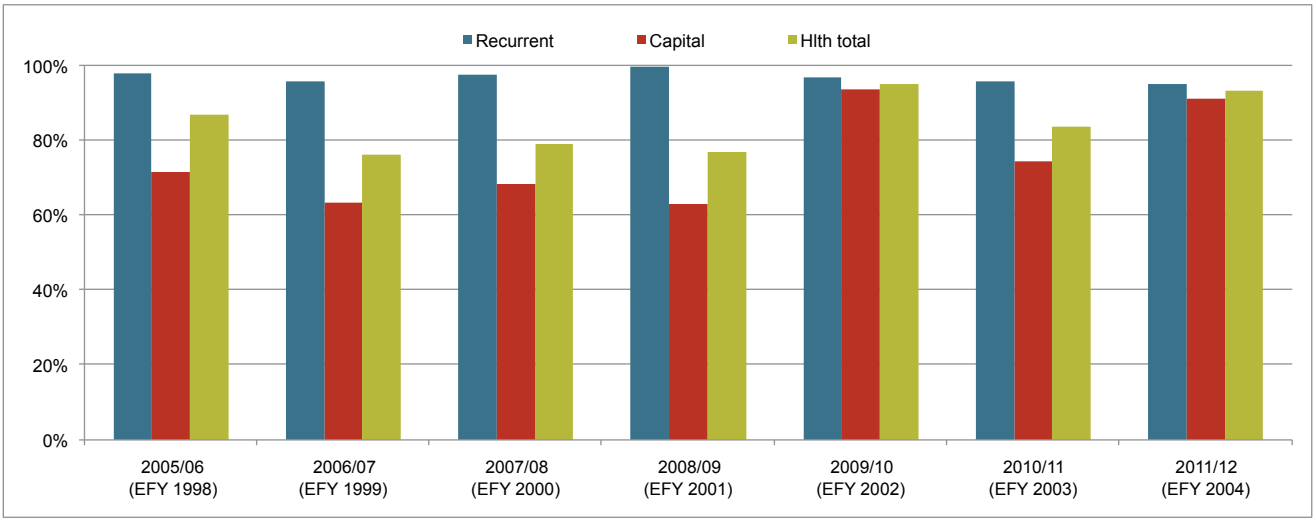
A recent review of the implementation of this planning approach (Altman, Alebachew et al, 2012) has reported that the EBP in Ethiopia has brought about agreement between the government and development partners about interventions needed to achieve national health goals. The assessment also indicated that decision makers both at national and lower levels have a strongly positive view about the contribution of this approach towards the prioritization of high-impact interventions and hence its contribution towards improving the health outcome related to these interventions. The EBP also contributed to increase funding to the health sector as the process involves key actors in the resource allocation including the district council and BOFED at each level. Although there are also other factors including the inclusion of health as one of the priority poverty-reducing sectors that contributed to the increased funding to the health sector, the EBP had also contributed to garner more funds for the health sector at all levels including districts.

However, despite these positive achievements, there are also some challenges and gaps that negatively affect the efficiency gain from the EBP process. The first and most important gap is despite the fact that this approach has been in place for the last number of years, it still has not been integrated into the government's own planning and budgeting structures and processes, as there is a separate planning and budgeting processes led by MOFED, BOFED and WOFED. It also heavily relies on the support from partners financially for it takes place each year. According to a recent estimate, the annual investment required to maintain evidence-based planning in Ethiopia is approximately around $1.6 million per year (Altman, Alebachew et al, 2012). Second, there is uneven implementation and variation in the steps and actors involved in the planning process. At sub-national level, the involvement of key players is limited and this may affect the funding level as well the harmonization and alignment process.

The other side of the story to an efficient allocation and evidenced based planning is how well health facilities and the health sector in general utilizes allocated resources. First, we will see utilization pattern for regular government budget. Second, we will look at utilization rate of health facility internal revenue. Finally, we will review utilization of external resource to the extent possible given available data.

When we look at the overall utilization of health sector government budgetary resources, there is a high level of use ranging from a minimum of 76% to a maximum of 93% and averaging at 85% between 2005/06 and 2011/12 (Figure 6.8). However, variations emerge when the budget is broken down into recurrent and capital components. Accordingly, recurrent budget emerges as the main driver of high level of utilization; recurrent budget utilization did not go below 95% in the seven years between 2005/06 and 2011/12. This is explained by the fact that more than two thirds of the recurrent budget is consumed by salary and the resulting shortage of operation budget. Capital budget, on the other hand, is expended at a much lower proportion averaging at 75% in the same period. This highlights an implementation capacity and efficiency issue.

Figure 6.6: Utilization rate of government budget, 2005/06 to 2011/12



Source: MOFED (2014b)

When it comes to utilization of internal revenue, the most relevant indicator would be utilization as proportion of appropriated[13] amount because health facilities can only utilize resource if they have it proclaimed as part of the overall government budget. Based on data gathered from the field and compiled HFG/HSFR, Health facilities in SNNPR (both HC and hospitals) have higher rate of utilization as percent of both collected and appropriated amount (Table 6.9). Health facilities in Addis Ababa also utilize higher share of their appropriated budget especially health centers. However, health centres in Oromiya, Benishangul-Gumuz and Amhara show that they have issue with utilizing appropriated fund where only half to 60% is utilized. This suggests a need to assess the challenges faced which was beyond the scope of this study.

Table 6.9: Revenue appropriated, collected and utilized for EFY 2005

Indicators	Health Facilities	Oromiya	SNNPR	B-Gumuz	Addis Ababa	Amhara
Amount appropriated in 2005	Health Center	197,092,007	111,673,737	7,396,977	26,037,030	102,996,176
	Hospital	137,603,817	66,715,340	5,646,000	22,417,744	38,212,762[1]
Amount utilized in 2005	Health Center	99,782,279	109,781,378	4,485,166	26,557,771	56,362,273
	Hospital	111,960,794	64,872,695	3,001,771	19,339,788	39,635,514[1]
Amount of revenue collected in 2005	Health Center		120,793,852	7,284,144	33,710,820	117,259,286
	Hospital		71,931,199	4,843,176	28,573,944	50,958,616[3]
Utilized as proportion of collected 2005	Health Center		91%	62%	79%	48%
	Hospital		90%	62%	68%	78%
Utilized as proportion of appropriated 2005	Health Center	51%	98%	61%	102%	55%
	Hospital	81%	97%	53%	86%	104%

Source: Adapted from HFG/HSFR (2013)

Note:
[1]Data collected from 10 hospitals in Amhara out of the 18 that have started RR&U.

Health facility staffing is improving overtime due to massive health professional training and deployment especially midwives, nurses, physicians. However, most rural health facilities are still relatively underused because of demand constraints. In some facilities, there is concern over the productivity of the health staff given the service they provide per day. Although improving, the use and respect of referral system is also a challenge, reducing the efficiency within which service delivery is organized. In addition, the supply chain management system (SCMS) needs further strengthening. Despite efforts to improve the SCMS with the creation of Pharmaceutical Fund and Supply Agency (PFSA) regional hubs and capacity building activities to minimize drugs and supply shortages, challenges remain. These inefficiencies lead to shortages of essential drugs and supplies and health facilities having to procure drugs and supplies from the private sector at a much higher price. This negatively affects affordability of drugs and supplies, the satisfaction of patients and the extent to which health outcomes are met. It also limits health facilities ability to generate more internal revenues.

The health financing strategy aims at moving towards hospital autonomy. They have better composition and skilled service provider and managers and have the potential to provide better quality of service. Although there are some bright spots (Felege Hiwot, and Bishoftu hospitals), overall this initiative is not being pushed with commitment.

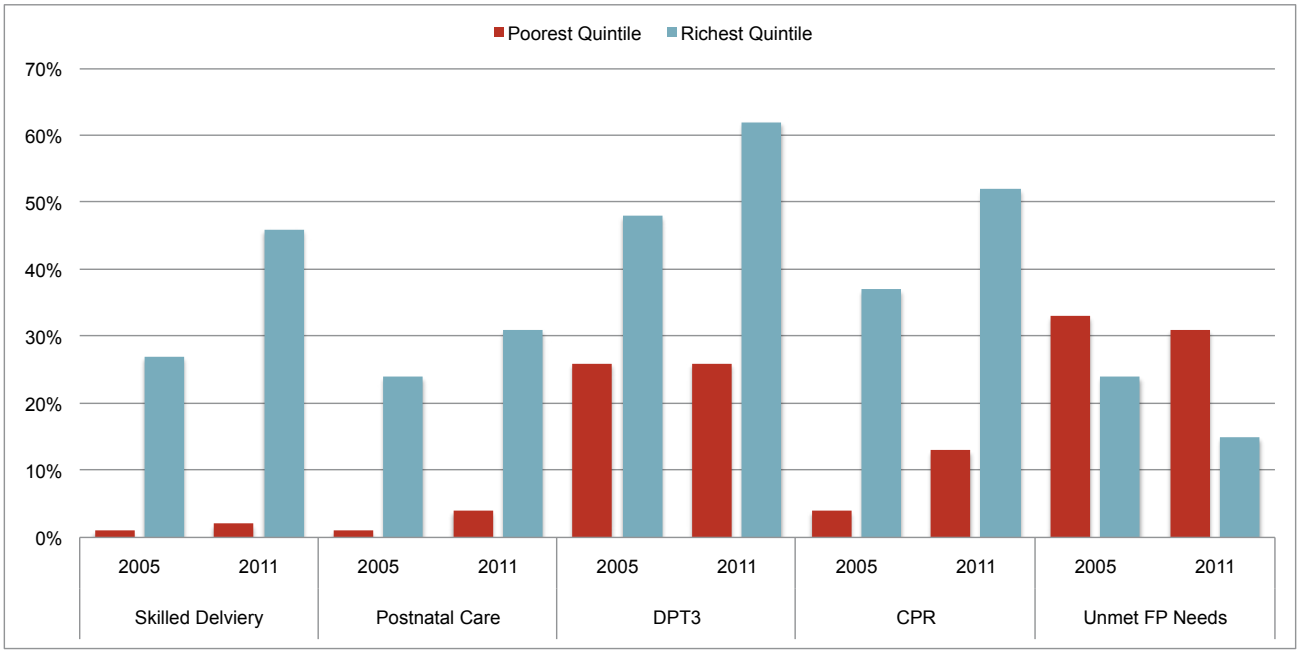
[13]Amount appropriated refers to the amount of money that is proclaimed by health facilities to be utilized during a specific fiscal year, and is approved by respective Finance and Economic Development Offices. This sum could be less than, equal to or more than what is collected in the year as Health facilities are allowed to revolved funds.

6.6 Enhancing equity in resource allocation and utilization

Development and provision of an equitable and acceptable standard of health services to all segments of the population of Ethiopia has been a major policy objective of the government since the issuance of the 1993 health policy. The concept of Universal Health Coverage (UHC) also entails guaranteeing access to essential services for everyone while providing protection against financial impoverishment. In addition to improving service coverage, UHC thus entails designing payment mechanisms to protect those who need and use the services from facing significant financial risks from having to pay directly for services at their time of need. Thus, ensuring equity requires both addressing the issue of service coverage (physical access) and financial protection so that the more disadvantaged segments of the population will be reached and disparities in access (physical and financial) will be reduced. Considering the disease burden and the uneven distribution of public facilities for provision of basic services, the emphasis towards expanding PHC services is another important element included in the successive Health Sector Development Plans (HSDPs) to improve the effectiveness and efficiency as well as equity of health services. At policy level, each successive HSDP plan has advanced the goal of expanding PHC through accelerated expansion of PHCU. The government has also taken practical steps to reallocate resources away from urban hospital-based curative services toward more preventive care, with an emphasis on the rural population through expanding PHCU including the flagship the Health Extension Program (HEP), expansion.

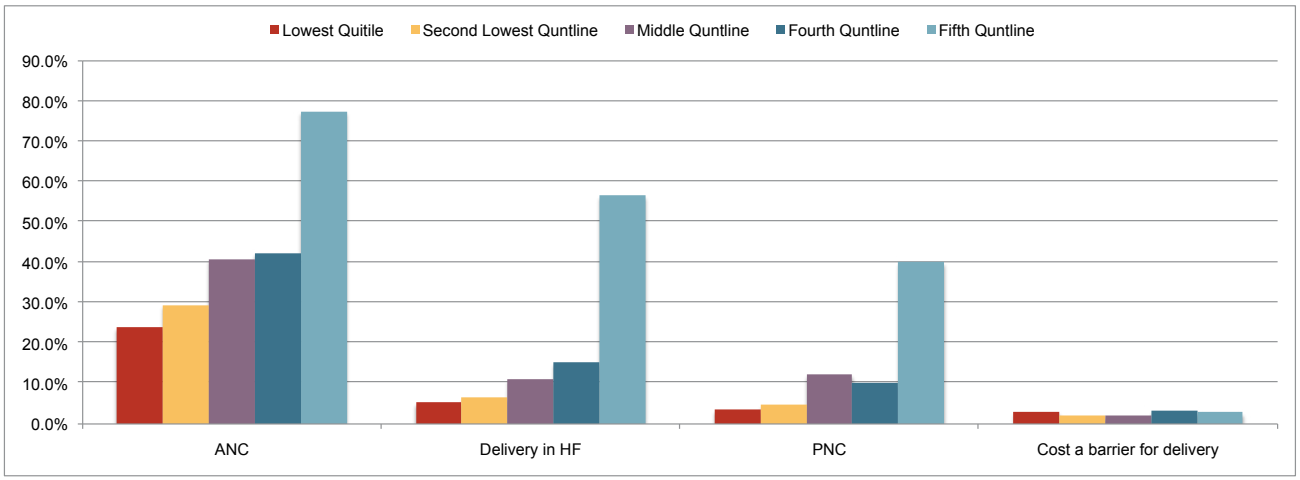
Along with the expansion of PHCU, the government has also scaled up the number and skill mix of health workers through focusing on mid-level professionals and through this, the number of HEWs and midlevel health workers has increased significantly in the past decade. Although the disparity in access to and utilization of services between rural, urban and pastoralist areas as well as among different regions and woredas have reduced from the level in the late 1990s, disparity still persists. For example, the welfare monitoring survey (WMS) 2012 found that for the 30 percent of respondents who did not seek care for a recent illness, their major reported barrier was the cost of care. Analysis of utilization of selected fee-exempted services shows that the poorest quintile is far behind in using these services (see Figure 6.9 and 6.10) for reasons related to social and cultural factors as well as cost and geographic access. According to the Mini-DHS in 2014, only 3% of the very poor attributed their not delivering in health facilities to cost. Cost as barrier is uniformly insignificant for all the socio-economic groups (see Figure 6.10). Seventy-three percent of the lowest quintiles' and 79% of all sample mothers' delivery at home was attributed to non-financial demand side barriers (not necessary and not customary). Despite progress made in expanding primary care to rural areas across all regions and woredas, the largest improvements in service coverage between 2005 and 2011 occurred among the wealthiest households.

Figure 6.7: Coverage rates for selected services between poorest and richest quintiles



Source: CSA and ICF International (2012)

Figure 6.8: Disparity in using some exempted services by income quartiles



Source: CSA (2014)

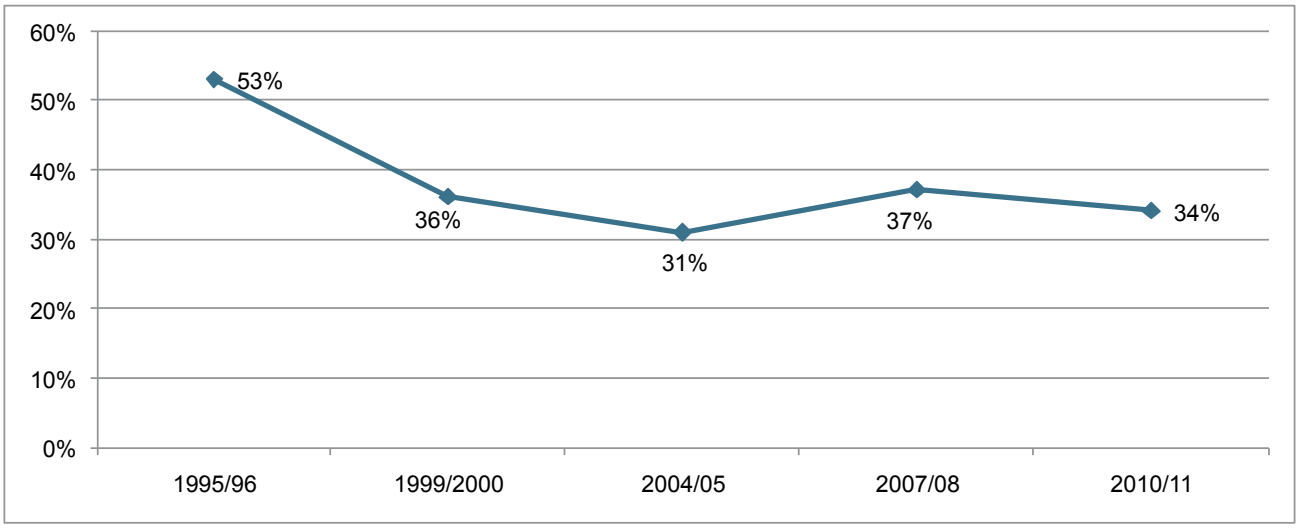
Despite the glaring service coverage gaps currently visible, recent findings from a recent World Bank study (Khan et al, 2014) clearly documented that government spending on health through the form of woreda block grants (channel 1) is pro-poor. The findings state that,"63 percent of the health expenditure at the woreda level accrued to the bottom 40 percent, whereas 10 percent accrued to the top quintile". Therefore among the bottom quintile (40%), the benefit incidence of per capita woreda-level health spending was more than three times higher than it was for someone in the top quintile (20%) (Khan et al, 2014). Furthermore, in terms of gains in health outcomes for the poor, this study states that:

> "…the substantial improvement seen among rural people for all six health indicators between 2005 and 2011. It also shows that—in the majority of cases—the improvement was greatest between the bottom two-wealth quintiles. Contraceptive acceptance rates increased over 200 percent for the bottom two wealth quintiles, more than twice as much as in the top two quintiles. Similarly, for measles vaccination rates, antenatal care, and delivery by a skilled birth attendant, the poorest quintile showed the largest improvement. The poorest quintiles also saw improvements in child and under-five mortality, more so than the richest quintile, but to a lesser degree than other quintiles. Outcomes for these indicators, unlike those for the other indicators, are particularly susceptible to factors outside the control of local recurrent health expenditure. Food security, nutritional status, and a mother's education all play a larger role than local health spending in driving these outcomes and can have an out-sized effect among poorer individuals. It is telling that improvements in child mortality are larger than improvements in under-five mortality. The implication is that services—in the form of the health extension packages offered by HEWs target children more than infants." (Khan et al, 2014)

Direct payment at the time of sickness is a regressive form of financing and impacts equity as it inhibits access to the poor. It also contributes to impoverishment of family due to having to pay to health care services at the time of illness. According to the WHO, the reliance on direct payment as a form of financing should be less than 15-20% of the total health expenditure to avoid the risk of financial catastrophe or impoverishment from having to pay for the health care. In Ethiopia, household OOP payment accounted for 53% of THE in 1995/96, which then declined, to 34% in 2010/11 (see Figure 6.11), which is still above the threshold recommended by WHO. The reduction in share of Ethiopia's OOP payment likely reflect more the increase in other sources of financing, especially external resources, rather than a reduction in OOP. The declining share should be interpreted not so much as providing substantial risk protection by government financing but rather as reflecting a still significant barrier to access care, resulting in relatively low utilization of services. According to NHA Household Survey conducted in 2010, about 11 percent of household members had been sick or injured during the four weeks preceding the interview (FMOH, 2010c). Of those that had health problems, 45% visited a health care provider. On the other hand, about 49% did not seek care. The most important reason mentioned by 42% of these households is because they lacked money. This holds true across all expenditure categories, with minor variations. On the other hand, according to the WMS, 2011 incidence of illness stood at 15.5% (CSA, 2012). Of those with a health problem in the four weeks preceding the survey, 75% sought

treatment. However, the survey showed that close to one-third the total population (29.6%) who had health problems and consulted for medical assistance reported that the major problem they faced was that service is too expensive (CSA, 2012). These findings show that OOP for health care remains one of the major barriers to access health care.

Figure 6.9: Trends in OOP Spending as a Share of Total Health Expenditure (%)



Source: Data from FMOH (1996); FMOH (2003); FMOH (2006); FMOH (2010a); and FMOH (2014a)

A number of reforms were introduced to reduce disparities outside of the health care financing strategy. These include: change on overall government resource allocation criteria; overall government special support to Developing Regional States; overall government focus on poverty reducing sectors, which included health; introduction of three different types of health extension program as driver to increase access to and utilization of primary health care services; definition of standards for new expansion of health facilities and commitment of FMOH and RHBs to build PHC as per this standard; and the expansion of regional universities to produce the required human resources for the ever expanding health providing facilities. Overall, there are the main drivers of health sector transformation in Ethiopia including reduction in disparities in access to and utilization of services. However, as part of health financing, there were also important factors that contributed to reduction of inequalities:

1. The establishment of the exempted service list and provision of such services free of charge irrespective of income, which is funded by the government and DPs.
2. The effort to subsidize user fees (as much as 60-70% of the total cost) to reduce financial barriers to utilization.
3. Introduction of the fee waiver program to cover the health cost (user fees) for the very poor at all levels of the care delivery system.
4. The recent introduction and expansion of CBHI scheme to pool the risk, minimize catastrophic spending through the prepayment mechanism, and also the focus given by the regions to pay for premiums of the poor[14].
5. The effort being made to increase resource mobilization (such as RR&U, PW etc.) that has been also allocated to meet the identified gaps including equity.

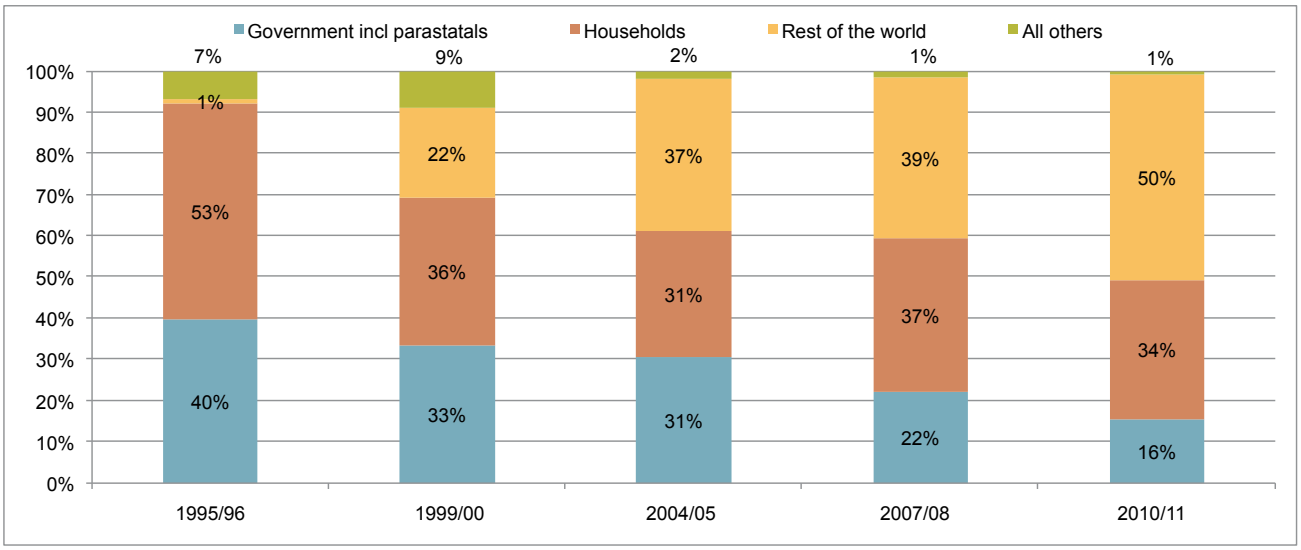
The other major reform element to improve equity is the pre-payment mechanisms (SHI and CBHI). However, despite the finalization of the legal framework the SHI, has not been rolled out. Similarly, CBHI, which is expected to cover the vast majority of the population, is still in pilot phase to have any measurable contribution towards financial risk reduction.

[14] In woredas that have piloted CBHI, the fee waiver program has been replaced with CBHI whereby premium of indigent household sis covered by the government.

6.7 Fostering sustainability

The series of NHA studies have shown that total health expenditure has massively increased both in absolute as well as per capita terms over the years. However, closer look at the financing sources shows that most of the increase is coming from external financing sources whose share in THE more than doubled from 22% in 1999/00 to 50% in 2010/11 (Figure 6.12). Similarly, the share of household OOP is quite high, standing at 34% in 2010/11 while share of government financing is quite small (reduced by half from 33% in 1999/00 to 16% in 2010/11. Development assistance in general and aid going to the health sector in particular has been criticized for being unpredictable and volatile which impacts sustainability (Gottret and Schieber, 2006). OOP payment, on the other hand, is not pooled and has a well-known and documented negative impact on access and equity.

Figure 6.10: Total Health Expenditure by Source



Source: Data from FMOH (1996); FMOH (2003); FMOH (2006); FMOH (2010a); and FMOH (2014a)

Table 6.10: Sources of finance for different health services, NHA sub-accounts 2010/11

Source of Finance	General	HIV	Reproductive Health	Child Health	Malaria	TB
Government	15.6%	14.1%	24.8%	24.8%	7.0%	12.0%
HHs	33.7%	2.0%	27.6%	47.9%	14.0%	36.0%
External Resources	49.9%	83.3%	47.0%	27.1%	79.0%	51.0%
Others	1.0%	0.6%	0.6%	0.2%		1.0%

Source: FMOH, 2014c

Looking in more detail at the shares of different financing sources supporting various health programs accounted through the available NHA sub-accounts, we can see the extent of the sustainability issue. Eighty three percent of spending on HIV is financed through external resource (Table 6.10). Similarly 79% of spending on malaria and 51% of spending on TB is financed by external resource. On the other hand, almost 48% of spending on child health is financed through HH OOP payment.

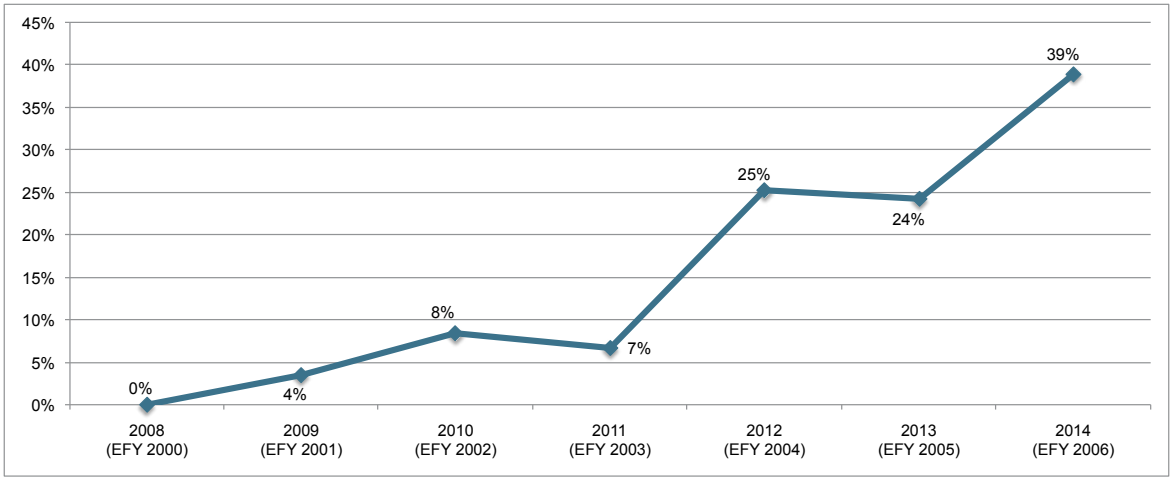
In the current situation, a number of essential program commodities i.e. inputs used to provide exempted services such as immunization, family planning, antenatal and postnatal care, HIV, TB, malaria, etc. are expensive in relation to Ethiopia's per capita expenditure and are fully financed by external donors such as the MDG Performance Fund, Global Fund, GAVI, US Government and other bilateral and multilateral donors. There is concern and uncertainty regarding the continuity of such massive support after 2015. In addition, given Ethiopia's aspiration to advance to middle-income country status, donor resources may decrease significantly as income rises. Most exempted services are provided at primary health care (woreda) level. Relying on woreda's own fiscal resources to supply costly commodities for such services is likely to exceed the fiscal space of woredas.

As of 2012/13, about 23% of federal block grants to regions were financed through the PBS program, which is a funding channel launched in 2006 to support local provision of basic services (Khan et al, 2014). While the PBS helps to achieve many of the MDGs, its primary focus is on achieving universal primary school education (MDG 2), reducing child mortality (MDG 4), and improving maternal health (MDG 5) as well as having a direct impact on the eradication of extreme poverty and hunger (MDG 1) and the promotion of gender equality (MDG 3) (Khan et al, 2014). At woreda level, federal block grant in general and PBS in particular are significant sources of finance. Salary for civil servants at woreda level is financed through the federal block grants. According to Khan et al (2014), about 20% of PBS resources channelled to the local level are used in the health sector, mainly to hire frontline health extension workers. This raises a big sustainability question given that PBS is externally financed.

On the positive side, the current health-financing plan is to shift from high OOP spending on health towards a more predictable and sustainable financing mechanism through the launching of insurance. SHI and CBHI are the two financing mechanisms, which Ethiopia proposed to move towards universal health coverage. These prepayment mechanisms facilitate pooling of resource thereby helping the sector to improve efficiency and sustainability as compared to OOP. CBHI was initiated in 13 woredas on pilot basis covering about 137,000 households. Currently preparations are underway to expand CBHI in additional 160 woredas, estimated to cover close to 1.7 million households (about 8.4 million people) (HFG/HSFR, 2014). CBHI is expected to eventually scale up to remaining woredas in the country. On the other hand, the SHI, as or recent consensus, is planned to be launch among formal sector employees (including NGOs and private for profit sector) simultaneously. This will be a significant stride towards universal health coverage.

Of the external resources flowing to the health sector, 36 percent comes through channel 3 (see Table 6.6), which is outside of government's oversight. Of the external resource coming through channel 2, increasing share is being channelled through MDG PF, whose share rose from none in 2008 to 39% in 2014 (Figure 6.13). The government has no or limited say on where money is spent regarding OOP and channel 3 DP support of total health expenditure. This is another big concern for sustainability.

Figure 6.11: Share of MDG PF in total external resources flowing through channel 2



Source: FMOH (2008c); FMOH (2009b); FMOH (2010d); FMOH (2011b); FMOH (2012b); FMOH (2013); and FMOH (2014b)

7. Specific Reforms and Interventions of the HCFS

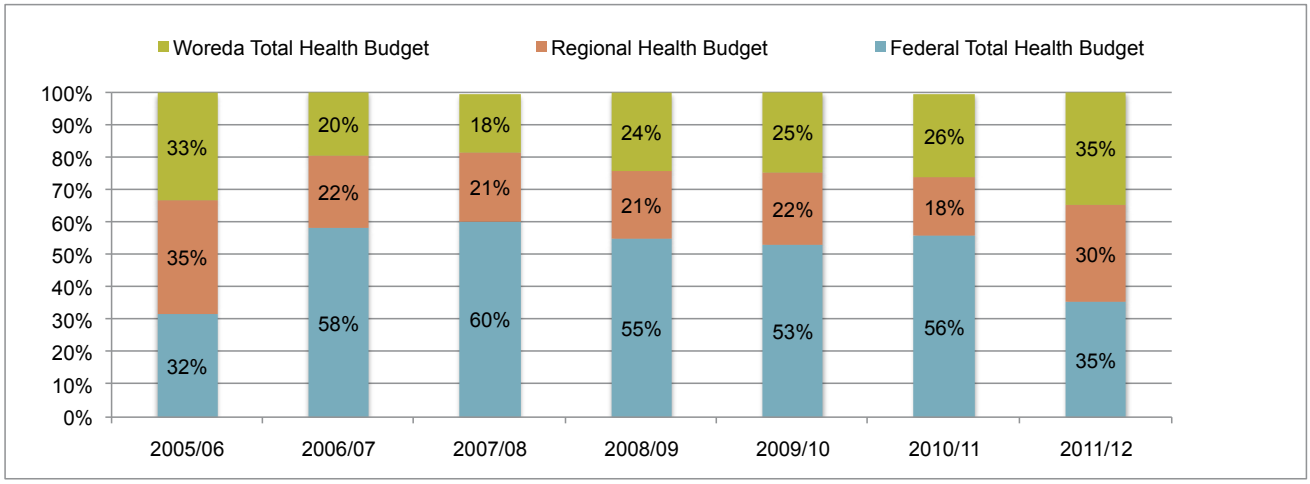
7.1 Evidence based planning to mobilize funding at woreda levels

From November 2011 to September 2012, the FMOH and Health Systems 20/20 project conducted an assessment of the implementation of Ethiopia's evidence-based health sector planning (EBP) approach. The study documented how this customized health-planning tool has been applied in Ethiopia. The study looked at woredas the FMOH perceived to be "high-performing" and "low-performing" in the area of EBP and analyzed trends of resource allocation and its findings is summarized in this sub-section (Altman, Alebachew et al, 2012).

All stakeholders interviewed for the study perceived that funding to the health sector had increased in the last five years. Nearly all stakeholders at the regional and woreda level perceived that the inclusion of health as one of the poverty-reducing sectors was one of the main drivers of increased funding for the sector. Many stakeholders also attributed funding increases to the HSDP, the GTP, the Health Extension Program, and the rapid increase in human resources for health and health facilities nationwide in the last five years. According to the data collected in 2011, many health and finance officers at the national, regional, and woreda levels perceived that EBP had helped garner more funds for the health sector at all levels. One WorHO respondent stated that "we still don't get 100 percent of what we plan for, but there has been improvement in budget allocation to [the] health sector since we started EBP (Altman, Alebachew et al, 2012).

It is very difficult to attribute the changes in government resource allocation at lower levels to only EBP. But trend analysis provides of government allocation provided some context for a discussion about the role of annual, evidence-based planning as a resource mobilization tool. Total health sector resources at the national level in Ethiopia — aggregating federal, regional, and woreda budget allocations — increased more than four fold from the 2005/06 fiscal year (Figure 7.1).[15]An analysis of budget allocation trends shows that an increasing amount of funding to the health sector was financed by the woredas — from 20 percent in 2006/07 to 35 percent in 2011/12. The federal government played a dominant role in mobilizing funding for health from 2006/07 to 2010/11-earmarked external resources as part of the capital budget, which accounts for 94 percent of the federal budget. When the federal level capital budget is excluded from the equation (from this total share), the role of woredas and regions in financing from domestic source becomes more prominent.

Figure 7.1: National Health Budget dis-aggregation at federal regional and woreda levels



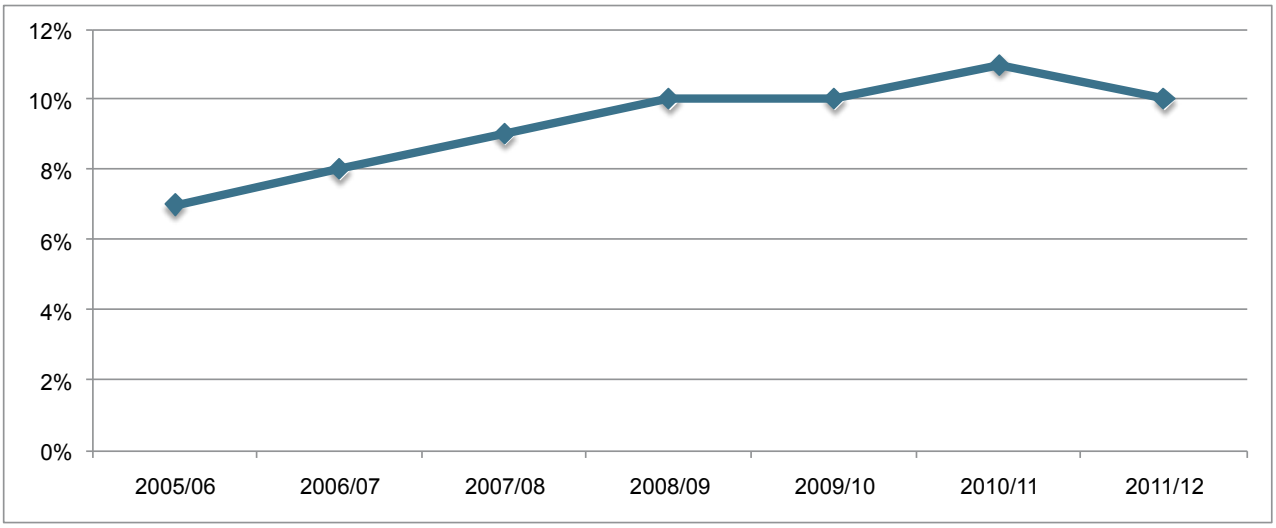
Source: MOFED (2014b)

At the sub-federal level, the data show that regional and woreda budgets have grown rapidly. Woreda budgets, specifically, have grown at an annual average growth rate of 30 percent. The increase in the annual woreda health budget does not automatically

[15] Figure 10.1 and later figures are based on budget allocations that were adjusted for inflation to the prices of the 2005/06 fiscal year using the "Medical Care and Health" subcomponent of Ethiopia's Consumer Price Index.

translate into higher priority as the overall woreda budget also increased significantly. However, Figure 7.2 does indicate that the percentage of woreda resources allocated to health steadily increased from 7 percent in 2005/06 to about 10 percent in 2011/12.

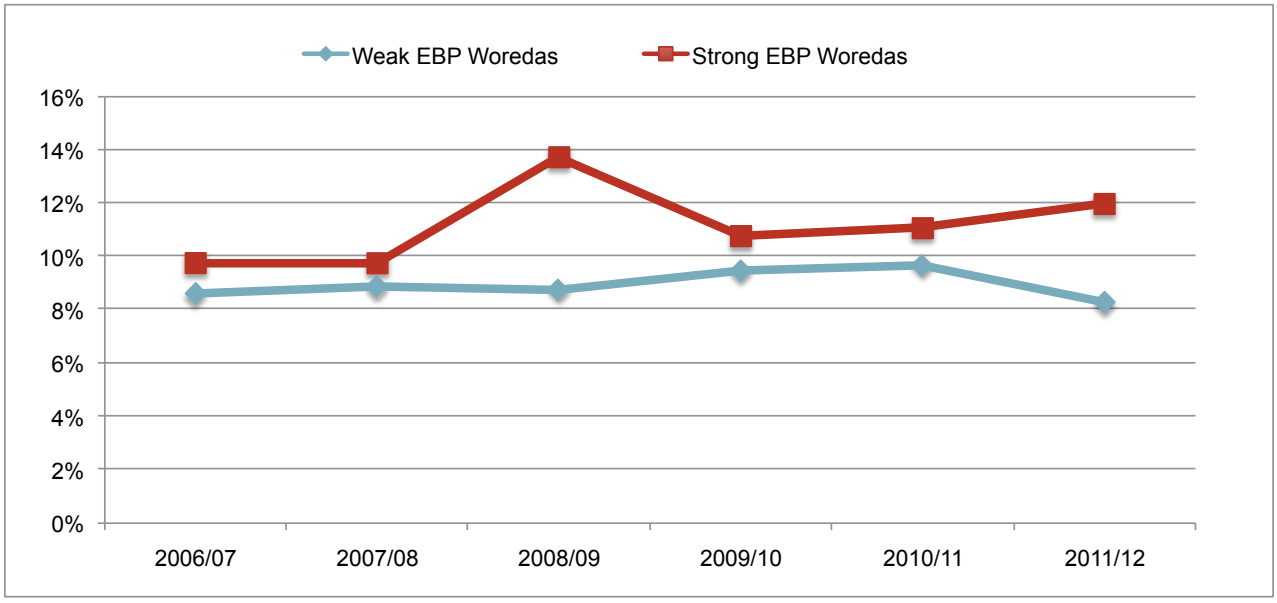
Figure 7.2: Health budget as a % overall woreda budget, all woredas



Source: MOFED (2014b)

The study also tried to look into increasing resource allocation to the sector by weak and strong EBP woredas. The data generated from government-audited accounts reflect the fact that, on average, high-performing EBP woredas allocated about 11 percent of their overall resources to health while the percentage for low-performing EBP woredas was 9 percent over the six-year period. As can be seen in Figure 7.3, the percentage of allocation is consistently higher for high performing than for low-performing woredas. Although it is difficult to attribute this difference to the EBP process alone, it suggests that it might be having some influence in increasing resource allocation at the woreda level.

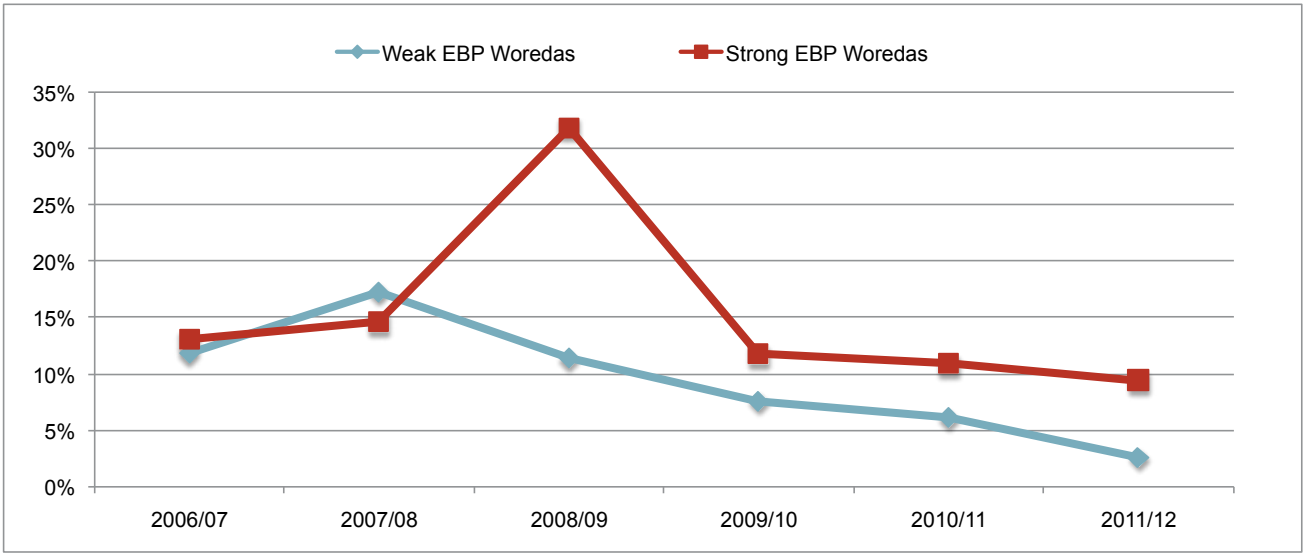
Figure 7.3: Health Budget as a % of total woreda budget, selecting strong and weak EBP performing woredas



Source: MOFED (2014b)

A similar pattern is also reflected in the trend of capital budget allocation between low-performing and high-performing woredas (Figure 7.4).

Figure 7.4: Health capital budget as a % of total woreda capital budget, selecting strong and weak EBP performing woredas



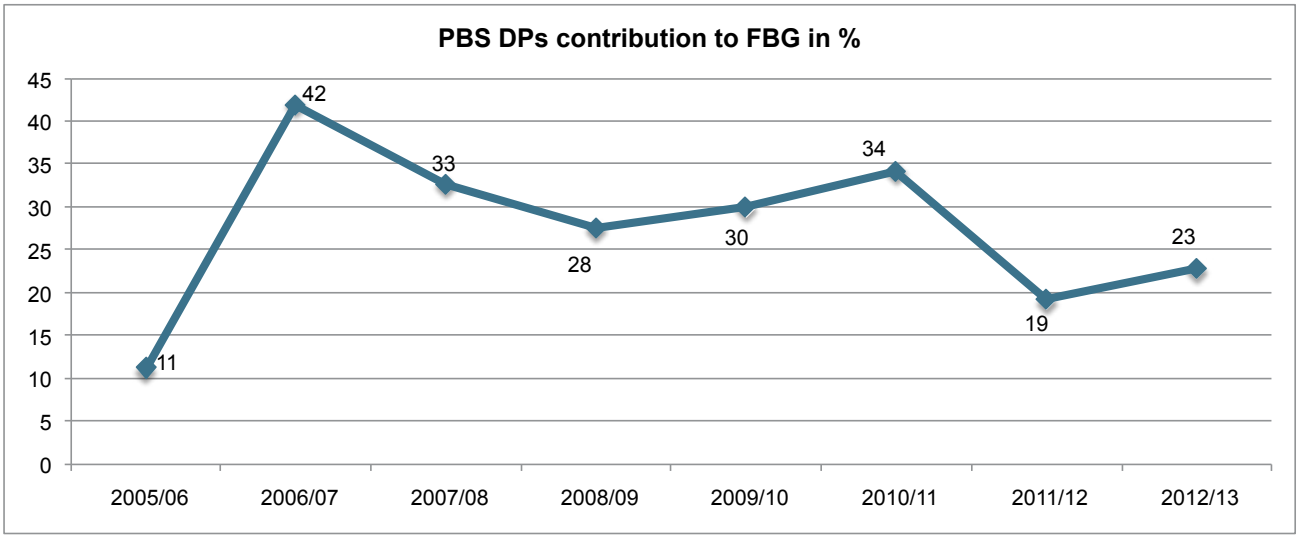
Source: MOFED (2014b)

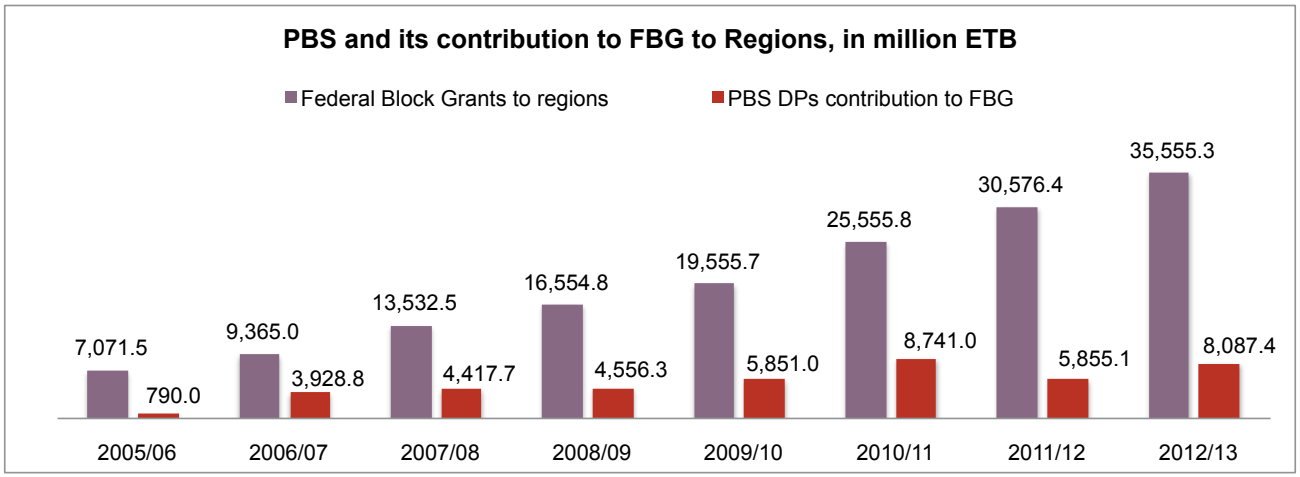
Despite the efforts made to ensure that EBP also informs planning through informed resource mapping at all levels, this is only successful at the federal level. According to the study carried out in 2012, three out of six RHBs assessed reported that they do not try to collect information about resources from implementing partners and NGOs within regions. Four out of 18 WorHOs reported receiving resource-mapping information from the region or zone. Only five out of 18 WorHOs assessed attempted to collect resource-mapping information, four of which were in the high-performing group. Very few NGOs interviewed reported awareness of or involvement in resource mapping or EBP at lower levels (Altman, Alebachew et al, 2012).

7.2 Innovations in coordination and alignment of aid

The efforts to coordinate and align external aid to country priorities and systems have been led and managed at two fronts: the national (overall country) and sector levels. At the national level, the Ministry of Finance and Economic Development has been active in working with partners to mobilize and align their contribution to become on budget. As a result of this effort, the Government of Ethiopia and development partners co-finance block grants to support the provision of basic services at regional and woreda levels. The contribution of PBS in terms of volume increased from 790 million 2005/06 to 8,087 million ETB in 2012/13. Its share from the total block grants, however, is on the decline as can be seen from Figure 7.5. This fund mainly helped to finance the salaries of woreda level health professionals through government budgeting process. Because of this effort, the Government of Ethiopia and development partners co-finance block grants to support the provision of basic services at regional and woreda levels. The contribution of PBS in terms of volume increased from 790 million 2005/06 to 8087

Figure 7.5: PBS contribution to the federal block grants (FBG) to regions[16]





Source: Khan et al, 2014

At a sector level, the FMOH and Health Partner Network (HPN) members developed and signed a series of documents to improve aid effectiveness in the health sector in Ethiopia (see Section 6.2.1). These agreements charted the processes and mechanics of not only on how the health sector will move towards 'One plan, one budget and one report' but also support the sector through a sector budget mechanism. As a result, the sector was able to set indicators for monitoring DPs performance on alignment and harmonization. According to the latest reports available close to 80% of DPs contribution is reflected in the government's plan, about 40% reflected in the government budget and only 14% of resources channelled through the government preferred modalities: channels 1a and 2a.

[16] Federal block grant (FBG) is an allocation by the federal government and is overall budget support by federal government to regional governments, which is not allocated between sectoral functions. FBG will form part of regional government resource pie that will be shared between woreda block grant and budget for regional executive bodies.

Table 7.1: Performance of DPs in meeting alignment and harmonization targets

Indicators	Target for 2009/10 (EFY2002) (Compact)	Baseline 2007/8 (EFY 2000)	Achievement 2009/10 (EFY 2002)
Number of DPs mapped		12	19
% of Development Partners' activities reflected in the Government's plan (by monetary value)	100%	44%	76%[1]
% of Development Partners which do not ask Government for a separate planning document	77%	5%	42%
% of DPs' funding reflected in the Government's budget	90%	Not known	39%
% of Funds provided through Government preferred modalities (pooled funds — MDG PF, Health Pooled Fund, PBS Component 2)	14%	60%	14%
% of DPs requiring a separate report		25%	42%
% of Development Partners only using indicators specified in HSDP IV and annual woreda plans	100%		67%

Source: Janovsky et al (2014)

The recent IHP+ mission (Janovsky et al, 2014) reviewed six of the seven behaviors by all stakeholders on opportunities for, and obstacles to, having more support on plan, on budget and using government systems, and to explore how current constraints might be addressed both at country level and in agency headquarters. Overall, the review documented that mutual accountability in the Ethiopian health sector is strong, both across DPs, and between FMOH and DPs (Table 7.2). Important progress has been made in the sector that has improved the aid coordination and effectiveness including:

- Existence of comprehensive plan informed by the resource mapping exercise. DPs largely have been providing the necessary information for annual planning.
- The establishment of MDG Performance Fund that pooled the resources of DPs to finance the underfinanced health systems.
- The interrupted process of undertaking annual, midterm and joint reviews to inform planning that have increased confidence.
- The functioning of the coordination structures (JCF and JCCC).

Further progress is possible by considering how the existing range of meetings and working groups can be used to foster further open and in-depth discussion of critical issues, particularly where opinions and practices are diverse and greater harmonization is needed. It recommended for DPs to explore with the headquarters about the about rules and procedures, testing limits and finding ways of overcoming barriers on how they contribute to 'One Plan, One Budget, One Report'. To build the gains made so far, it also suggested that DPs might also want to monitor progress the depth (e.g. the proportion of funds using country systems) and breadth (numbers of partners involved) of the seven behaviours at country level. The review teams finding on the six behaviours is summarized in Table 7.2.

Table 7.2: Findings of assessment on stakeholders' performance on the seven behaviours

Behaviours	Government	Development Partners (DPs)	Major Issues
Agreement on priorities that are reflected in a single national health strategy through a process of inclusive development and joint assessment, and a reduction in separate exercise	Existence of sector and subsector strategies that guides prioritization Existence of inclusive process for developing these strategies Resource mapping exercise guiding annual resource allocation and alignment Existence of dialogue mechanisms (Annual Review Meeting (ARM), Joint Consultative Forum (JCF), Joint Core Coordinating Committee (JCCC))	Most development partners (DPs) align their priorities with government priorities Existence of health, population and nutrition (HPN) Forum	Some agencies unable to provide the necessary resource mapping information (e.g. USAID) as required Collecting expenditure data from lower administrative levels is an imperfect and time-consuming process
Resource inputs recorded on budget and in line with national priorities	Growing amount of support for health goes through Government's preferred channels Around 16% of the funds disbursed to local government through Promotion of Basic Services (PBS) are used for health, mainly to support salaries The MDG Performance Fund (MDG-PF) is continuing to grow in numbers of contributors and funds managed.	Most DPs are financing MDG PF Major donors amending their procurement or reporting requirements to enable them to join the MDG-PF (e.g. World Bank funds via the MDG-PF use the national procurement process; all share one audit World Bank and GAVI providing funding through the MDG-PF There are prospects of additional donors joining the MDG-PF: Global Fund malaria and TB funds and USAID for procurement The European Union (EU) has had to channel funds via UNICEF to the MDG-PF due to constraints emanating from Brussels.	There would be few partners entirely outside the preferred MDG-PF or PBS channels (PEPFAR and Global Fund support for HIV) The provision of funds earmarked for HIV/AIDS (particularly from PEPFAR and Global Fund) have led to a large share of the total international funding being allocated to HIV/AIDS
Financial management systems harmonized and aligned; requisite capacity building done or underway, and country systems strengthened and used	A large share of support for the health sector is being channelled through Government financial management (FM) systems (the PBS, MDG-PF and other channel 2 support) The MDG-PF is subject to an annual external audit conducted by the Government auditor. This seems to be a constructive process that enables gradual improvement through continuing review of financial management system performance, identifying areas of vulnerability and how to address these.	Funding mechanisms typically include support for strengthening financial management Development partners have assessed financial management systems and used this to identify areas in need of strengthening. Follow up actions to improve financial management are recorded in the updated Joint Financial Arrangement (JFA), with a requirement for the FMOH to report on progress with implementation every six months to the JCF	Weaknesses in the implementation of systems and procedures that leave the system at risk of inappropriate fund use or inability to report as required remain-e.g. delays in audits and in implementing the agreed action plans, to follow up audit and assessment findings, and improving but weak strong internal audit Partners continue to apply their own assessment tools, making demands on Government limited capacity, are costly and time consuming

Behaviours	Government	Development Partners (DPs)	Major Issues
Procurement/supply systems harmonized and aligned, parallel systems phased out, country systems strengthened and used with a focus on best value for money	Pharmaceutical Fund and Supply Agency (PFSA's) procurement volumes have increased rapidly, from some USD 278 million in 2011/12 to USD 500 million in 2013/14, with 80% of procurement funded by international donors. There is substantial harmonization and use of Government systems in procurement of medical supplies and equipment by DPs (MDG PF, domestic budget, Global Fund Other types of procurement (e.g. construction, vehicles, vaccines) are handled by Federal Ministry of Health (FMOH), through a Project Management Unit (PMU) and may involve contracting procurement to UN agencies (UNICEF and UNOPS)	World Bank has requirements for approval from headquarters level for high value procurements (with set thresholds e.g. over $30 million). In order to avoid the need for a different procurement process in the MDG-PF, the Program for Results support was designed to exclude such large-scale procurements.	Some partners continue to use their own procurement arrangements most of the time, notably US Government implementing partners and some UN agencies The PFSA still has some weaknesses in its capacity and in compliance with the procurement needs of the regions and woredas
Joint monitoring of process and results is based on one information and accountability platform including joint annual reviews	The Annual Review Meeting provides a mechanism for review of results by FMOH and DPs, drawing on the Annual Performance Report and work of the Joint Review Mission. Additionally, there was an extensive mid-term review of the Health Sector Development Program (HSDP) in 2013, which has generated a list of issues to address, and there is a process to follow this up.		There appears to be a lack of open communication about concerns on data quality that were expressed by some DPs DPs' continuing requirements for data on indicators that are not collected in the HMIS remain an issue.
Strategically Planned and Well Coordinated Technical Assistance	Technical assistance is provided in response to multiple requests, coming from different parts of government via different channels The health pool fund (HPF), established in 2005, is an important instrument for providing technical assistance, managed by UNICEF on behalf of the FMOH and intended to complement other donor investments		Strategic planning for technical assistance and its coordination appears to be weak on both the demand and the supply side

Source: Summarized from Janovsky et al (2014)

7.3 Internally Generated Revenue

One of the key components of the first generation reform (FGR) is revenue retention and utilization. Over the past 65 years, well before the introduction of structural adjustment programs, health facilities in Ethiopia have charged user fees. However, before the 1998 HCF Strategy the revenue collected from user fees at the facility were transferred to the Ministry of Finance, and health facilities were not receiving enough resources from the government allocated budget to provide adequate services. In other words, allocations of budgets to health facilities bear no relationship to the capacity of the health provider to mobilize resources. Therefore, there was little incentive for providers to collect fees from services. Consequently, the reform agendas of reducing leakage through better targeting, increasing the supply of drugs through revolving drug schemes, and revising user fees have few direct impacts on public sector provider behaviour. The HCFS intended to change that provider behaviour through retention and utilization of user fees at the facility level.

One important highlight of the 1998 HCF strategy is that all regions started with retention of revenue and managed to increase the coverage of facilities that introduced this reform component. As can be seen from Table 7.3 there is successful implementation of this program in early initiating regions such as Oromiya, Amhara, Tigray, and SNNPR in the three largely urban states as well as Benishangul-Gumuz with coverage of 100%. In Oromiya, the HCF reform in HC begins immediately when a new facility starts functioning. The performance of the pastoralist regions of Afar, Gambella, and Somali regions on the other hand remain very low. Somali and Afar regions just started piloting HCFR in few facilities. The federal level is the only exception in that it has not initiated this reform, with the exception of special pharmacies, in its facilities at all. Oromiya utilizes the government system for the generation, banking and utilization of internally generated revenue, which is part of the Integrated Budget and Expenditure (IBEX) system. Every health center has become a cost center and its allocation from both government and internal revenue can be tracked down. There is an annual audit review meeting to explore the best practices and challenges to take corrective actions. Other regions should learn from this best practice.

The main reform objective of revenue retention and utilization (RR&U) is to enable health facilities mobilize resources additional to their budget and use it for quality improving activities. The implementation of RR&U has contributed significantly to the mobilization of resources within health facilities. Health facilities have started to generate more and more finance every year. Referring to Table 7.4, the total amount of revenue collected by HCs varied from about ETB 7 million in Benishangul-Gumuz to almost ETB 121 million in SNNPR in EFY 2005. Among hospitals this varied from almost ETB 5 million in Benishangul-Gumuz to almost ETB 72 million in SNNPR in EFY 2005. The average revenue per HC ranges from about ETB 155,000 in Amhara to more than ETB 500,000 in Addis Ababa. For hospitals, the average revenue collected was around ETB 2.4 million in Benishangul-Gumuz to ETB 6.6 million in Oromiya.

Table 7.3: Proportion of health facilities that have started revenue retention, 2014

Indicators	Health Facilities	Oromiya	SNNPR	BG	Addis Ababa	Afar	Amhara	Tigray	Dire Dawa	Harari	Gambella	Somali	Federal
Total no. of functioning health facilities	HC	1250	660	31	65	62	761	214	16	8	29	130	0
	Hospitals	41	17	2	6	6	18	13	1	1	1	8	13
Health facilities started retention (#)	HC	1250	655	31	64	14	758	214	16	8	20	6	0
	Hospitals	41	16	2	6	5	18	13	1	1	1	0	0
Health facilities that started re-tention (%)	HC	100%	99%	100%	98%	23%	100%	100%	100%	100%	69%	5%	0%
	Hospitals	100%	94%	100%	100%	83%	100%	100%	100%	100%	100%	0%	0%

Source: HFG/HSFR (2013)

Table 7.4: Revenue collected for EFY 2005 and 2006

Indicators	Health Facilities	Oromiya	SNNPR	BG	Addis Ababa	Amhara
Amount of revenue collected in 2005	HC		120,793,852	7,284,144	33,710,820	117,259,286
	Hospital		71,931,199	4,843,176	28,573,944	50,958,616[3]
Amount of revenue collected in 2006	HC			9,483,863		
	Hospital			6,690,478		
Average revenue per HF	HC	306,933[1]	184,418	234,972	526,732	154,696
	Hospital	6,633,889[2]	4,495,700	2,421,588	4,762,324	5,095,862

Source: Adapted from HFG/HSFR (2013)

Note:
[1]Average for 2005 and 2006 EFY, based on data collected in Oromiya from eight HCs during field visit
[2]Average for 2005 and 2006 EFY, based on data collected in Oromiya from five hospitals during field visit.
[3]Data collected from 10 hospitals in Amhara out of the 18 that have started RR&U.

The importance of retained funds to health facilities is more visible when one compares it to budget allocated to health facilities (see Table 7.5). Data for 2005 and 2006 EFY shows that in Oromiya, user fee revenue alone amounts to 48 percent of recurrent budget in hospitals and as high as 35 percent in health centers. In Addis Ababa, it accounts for about 18 percent in hospitals and 19 percent in health centers. Total revenue (user fee and other internal revenues generated from non-medical services rendered by health facilities — see Box 7.1 for some examples) as a share of non-salary recurrent budget ranges from a low of 43% to a maximum of 146% in hospitals and between 55% and 153% in health centers. Health facilities are raising revenue, which is quite significant compared to resources they are getting, form the government. Hence, health facilities have also started being creative about various income generating approaches (see Box 7.1). This has enabled health facilities to expand service scope, coverage, as well as improve quality by investing internal resources where needed.

Table 7.5: Internal revenue as share of recurrent allocation to health facilities

Indicators	Health Facilities	Oromiya	Afar	B-Gumuz	Addis Ababa	Amhara
User fee as % of Recurrent Budget	HC	35%[1]	Initial phase of implementation — no data	17%	19%[4]	26%
	Hospital	48%[2]		19%	18%[5]	52%
Total Revenue as % of Recurrent Budget	HC	41%[1]		18%	26%[4]	39%
	Hospital	57%[2]		21%	43%[5]	79%
Total revenue as % of non-salary recurrent budget	HC	153%[1]		55%	71%[4]	204%
	Hospital	146%[3]		43%	59%[5]	194%

Source: Data collected during review

Note:
[1] Average for 2005 and 2006 EFY based on data collected in Oromiya from 8 HCs for this assessment.
[2] Average for 2005 and 2006 EFY based on data collected in Oromiya from 5 hospitals for this assessment.
[3] Average for 2005 and 2006 EFY based on data collected in Oromiya from 3 hospitals for this assessment.
[4]Average for 2005 and 2006 EFY based on data collected in Addis Ababa from 4 HCs for this assessment.
[5]Average for 2005 and 2006 EFY based on data collected in Addis Ababa from Ras Desta Hospital for this assessment.

The stakeholders in all regions stated that the implementation of health financing reform in general and the contribution of the retained funds to quality of services largely depends on the strength of the health facility managers and management committees/boards. While there are regions and health facilities that are utilizing internal revenue

in a timely manner, there are also health facilities that are not utilizing their revenue optimally. For example in Amhara, with the exception of North Gondar, Awi and Oromiya Zones, all the HCs in other zones spent less than 50% on average from their annual revenue. In particular, Waghemra, North Wollo and Gondar town are the three least performing zones in their respective order. A visit in one of the least performing zone i.e., Waghemra Zone, Sekota Woreda showed that the three HCs which embarked on implementing HCFS have only bought safe boxes to keep their collections until deposited to bank. The key informant interviewees in the HCs indicated that they have never been trained on how to implement the HCFS in general and on which specific cost lines internal revenue should be spent in particular. In Addis Ababa City Administration, although RR&U has been decreed as one component of the reform in the relevant proclamation and directive, its implementation is far from the principles outlined in the implementation manual. The major issue is that Health facilities in Addis Ababa has not been allowed to open a Type A bank account, which would allow them to retain and revolve their internal revenue. They are only allowed to open Type B account, which will be blocked at the end of the fiscal year in June[17]. Thus at the end of the fiscal year, Health facilities have to directly negotiate with Finance and Economic Development Offices, which requires lots of communication and long time. In some sub cities, it is not possible to get the refunding (e.g. Arada sub city). Thus, expected result from RR&U in Addis Ababa has not been optimal.

One of the principles of the RR&U has been that this resource should be 'additional' and the government should not reduce allocation because of this. The data shows this additionality principle is not always respected and there are tendencies by woredas to offset budgets i.e. when Health facilities collects more resource, government reduces its budget allocation to each facility. From all the stakeholders' meeting at facility, woreda, and regional levels, there is consensus that the additionally concept has not been respected. Increasingly health facilities are covering their operational costs, including drugs and medical supplies.

Utilization

The utilization of retained revenue is guided by principles set in regional guidelines on what activities they will use and not use the resources. In each region, there is a 'positive' and 'negative' list that guides where the retained revenue will and will not be used. Revenue generated is utilized mainly for the purchase of drugs and medical supplies, medical equipment purchase, expansion/rehabilitation of health facility premises and purchase of generator etc. that all fall within the positive list provided in the RR&U implementation manual. However, there are also cases whereby retained fees are utilized to fill the gap in regular recurrent budget, those that fall within the negative list. Examples of such function include, fuel and lubricant, printing, uniform, per diem, payment of position and motivational allowances for health personnel etc. For example, among health centers in Amhara, about 40% of the internal revenue spent is used to purchase drugs and other medical supplies and about a quarter of the total expenditure is used for investment purposes, either for construction and rehabilitation of buildings or acquisition of fixed assets such as medical equipment, generator etc. A small portion of the money was spent on uniform, bedding and clothing, per diem for board members and other similar activities. Refer to Box 7.2 for examples of internal revenue utilization from Oromiya.

The instances of utilization of retained funds to activities that are categorized under negative list is generally the result of inadequate government resource allocation in general and specifically the budget offset being used by woredas in allocating resources to health facilities. Addis Ababa pushed to plan for higher amount of revenue collection target, health facility plan and approved plan by sub-city finance office is different etc. Despite these offsets, the facilities visited have not used their retained revenue for training or any travel abroad; local training of more than one month; any gift or subsidy to a third party; consultant payments etc.

[17] According to the government's financial guideline, government institutions are usually allowed to open Type B (blocked account). With Type B account, at the end of the fiscal year in June, any fund unutilized will be remitted to respective Offices of Finance and Economic Development and form part of the government's non-tax income. On the other hand, if government institutions are allowed to open Type A account, if they have unutilized fund at the end of the fiscal year, the institution can keep this in its bank account and revolve it from year to year. Thus, any fund unutilized in the previous year would be available for use by the institution in the current or future fiscal years. Type A account is the preferred bank account type for institutions that implement RR&U.

Overall, there is an understanding that the HCF strategy, especially RR&U has improved access, quality and sustainability of services. Key informant interviews at regional, woreda and facility levels pointed out the following overall contribution of the HCF reform:

- There is better availability of drugs and medical supplies, minimizing the possibility of stock outs of drugs at the facility level. The frequency of taking prescription papers out of the facilities to buy elsewhere has been reduced. The stakeholders stated that lack of resources is no longer the determinant factor for the availability of drugs at the facility level, but lack of it in PFSA stores.
- The health facilities were able to procure and make available different medical equipment (ultrasound, EKG, City scan, beds, etc.) that improves diagnosis and treatment-quality of care.
- Contributed to improving access to additional health services by enabling facilities to build blocks of service provision areas and introduce new services.
- It assisted facilities to improve facility infrastructure, including water, electricity and power in some cases.
- There is increased user/patient satisfaction.

7.4 Policy and Practice in Provision of Essential Health Services

Essential Health Service Package (EHSP) also called the Minimum Health Services Package, refers to a set of cost-effective, affordable and acceptable interventions for addressing conditions, diseases, and associated factors that are responsible for the greater part of the disease burden in a country. The Ethiopian EHSP has been designed based on the core health and health related interventions to address major health problems and disease conditions of the country. It includes the basic preventive, promotive, curative, and rehabilitative interventions that are considered the minimum that people can expect to receive through the various health delivery mechanisms and facilities within their reach. Ethiopia's EHSP was developed in 2005, the scope is limited to the provision of essential services at the health post, health center and district hospital levels and the service beyond this level were not included.

The major components of the EHSP for Ethiopia are aligned with the thinking that the health extension package (HEP) is an essential health services package for a community level. Thus, the EHSP is organized into five major components of HEP while adding a category containing basic curative care and treatment of major chronic conditions starting from the health center level. The main EHSP components fall under:

- Family Health Services;
- Communicable Disease Prevention and Control Services;
- Hygiene and Environmental Health Services;
- Health Education and Communication Services; and
- Basic Curative Care and Treatment of Major Chronic Conditions.

Box 7.1: Some income generation approaches applied in Health facilities

- Adama Hospital constructed shops and rented them out, which turn in a monthly rent income of about Birr 43,000.
- Bishoftu hospital earned more than Birr 800,000 from hall rent per annum.
- Gendeberet hospital started fattening of cattle and selling them at higher price earning large profit
- Fee waiver reimbursement from woredas as provided in HCFS also becomes one of the major sources of revenue to hospitals. Except Gendebert District Hospital, the other sampled hospitals have raised more than half a million Birr from this source.
- Assassa HC is engaged in providing cafeteria services. The HC constructed a cafeteria with the purpose of serving its customers and getting additional revenue for the facility. The initial construction and facility cost was about Birr 400,000 but currently the cafeteria building and assets are valued at more than a Million Birr. The HC also carries out farming and sells its produce.
- With the support of the Woreda Agriculture Office, Assasa HC also engaged in modern farming of wheat in its compound. It has the size of 5 hectares of land. The management expects to collect more than 160 quintals of wheat, which it would sell. The farm also serves as a pilot in modern farming methods for the woreda farmers.

Although the current package encompasses some major aspects of essential services, it is high time that it needs to be revised considering many factors. First, the health care delivery system has changed since the development of the EHSP and hence needs to be revised accordingly. Secondly, the scope of the EHSP is limited to the district hospital level (and below) and it is left up to interpretation for essential services that are to be provided above this level. The existing hospitals standards are not useful in this regard, as they are mainly input and service standards and do not prescribe any type of essential services to be provided at hospital level. Thirdly, new developments and initiatives on health service delivery need to be included in the package. Lastly, the minimum package of health services needs to be reviewed and updated in order to meet changes in health needs as Ethiopia's economy continues to develop as well as be aligned with the FMOH's vision for UHC.

7.5 Exempted Services

The provision of exempted services is guided by two factors. The first one is the list of services that are exempted from payment by regional proclamations and supported by rules and regulations. These services include family health services, selected communicable diseases and epidemic[18]. Deliveries at hospital levels are also included recently. The second category of services are those that are not supported by the regulations but are provided free of fees due to external support mobilized by the program. Examples include Community management of acute malnutrition (CMAM), HIV/AIDS related opportunistic infections, malaria treatment etc. There are some additional services, which are exempted in selected health facilities, especially hospitals such as hypertension, diabetics, epilepsy, and asthma although it is not clear where the mandate emanates from (see Table 7.6). There are also missed experiences with regard to services such as control of diarrheal disease, IMCI etc. In those types of exempted services supported through vertical program funding, one of the major issues is equity. Woredas with vertical program support benefit more from implementing such services while those without external support have to use different strategies.

Box 7.2: Experiences of Internal Revenue Utilization from Oromiya

In Oromiya Region, Health facilities have used their internal revenue for:

- Procurement of drugs and reagent and inputs for exempted services where there is gap
- Hire contract workers, payment for part time workers,
- Pay for allowances — for governing body members
- Procure fixed asset purchase — X-Ray machine and other medical and laboratory equipment, laundry machine, computers, photo copy machine
- Construction and rehabilitation additional room for service delivery, patient waiting, incinerator etc.
- Procurement of sanitation materials,
- Pay for other costs such as fuel, printing, utilities (water, telephone, electricity) and staffs' gowns and badges,
- Procurement of generators for power.

Box 7.3: The Tale of a Physician in a Hospital in Amhara

A family member of a physician got seriously sick and he was called to take her to the hospital. He took her in the middle of the night and managed to save her life after ordering 11 types of medicines and medical supplies. All the prescribed items were available within the hospital compound. After saving his family member the doctor stated that " I have now confirmed the success of the health finance reforms in ensuring quality of care".

[18] According to the prototype **Health Service Provision and Administration Proclamation** that provided the basis for HCF Reform, Epidemic refers to "a phenomenon where excess numbers of people are affected by a certain type of outbreak of diseases exceeding to the ceiling of the internationally set criteria".

Table 7.6: List of exempted services and status of implementation

Reason for exemption	List of Services	Exemption implementation status (average of 26 HCs)
As per proclamation and regulation	1. EPI	100%
	Antenatal care	100%
	Post natal services,	100%
	Delivery at health center levels (Deliveries at hospital levels was included recently)	100%
	FP	100%
	Fistula	62%
	VCT	96%
	PMTCT	100%
	ART	100%
	TB	100%
	Leprosy	100%
	STD	88%
	Emergency response	31%
Due to external support	1. CMAM	35%
	Opportunistic infections,	NA
	Malaria treatment,	69%
	Abortion care,	NA
	Trachoma	69%
Not known (in selected hospitals only)	1. Hypertension	69%
	Diabetics	69%
	Epilepsy	65%
	Asthma	54%

Source: Data collected from health centers during review

As findings from the field visits show, of the 26 health centers for which data is available, eight services i.e. ANC, PNC, Delivery, FP, EPI, TB, Leprosy and ART are free to all in all health centres. However, according to the most recent SPA+ survey, a small number of health centers are still charging a fee for certain services that are to be exempted. One percent of health centers (2 out of 182) have a fee attached to family planning services (including commodities), normal deliveries, HIV diagnostic tests, and ART for PMTCT, while 15% of health centers (27 out of 182) charge a fee for malaria rapid diagnostic tests (EPHI, FMOH, and ICF International, 2014). On the other hand, EPHI, FMOH, and ICF International (2014) found that zero health centers were charging fees for ART and TB medicines. There is STI treatment which is exempted in 88% of the HCs while many services such as children under five, diabetes, hypertension, epilepsy etc. which are exempted in 60% to 69% of HCs. Services with diverse practices are epidemics and nutrition which are exempted in 31% and 35% of the HCs (see table findings from regional reports). The pattern of exemption at hospital level is similar.

The guidelines for exempted services do not clearly stipulate the type of services that should be provided under each category, which leads to confusion among health professionals at these facilities. For example a key informant in Woldiya Hospital indicated that there is confusion among health professionals whether postnatal care includes the infant or only mothers. In addition, what happens if a mother suffers some health problem unrelated with the pregnancy during the antenatal period? Thus, a need for clarity exists in the exempted service guidelines to avoid possible misinterpretations of types of services that are mandated to be provided free.

Regional visits have shown that it might be worthwhile to consider including coverage for some diseases, which, if not treated at early stage, could bring permanent damage. For instance, families usually give less attention to patients suffering from glaucoma and mental disorders. The latter may be attributed to evil-deeds. Similarly many diabetics are reported to come to the health facility after they fall into a coma due to an extremely low blood pressure. This may be because they are unable to follow up their initial illness due to financial constraint. HIV/AIDS counselling and testing is free, but medication of opportunistic diseases is a paid service, although many sufferers are financially incapable of paying for the needed services. Dealing with such diseases should be taken as a social responsibility and may need to be part of exempted services.

The cost of providing exempted services is believed to be high, although here are few detailed estimates of cost. (The RTM Project is carrying out a costing study which will provide some field based estimates of exempted services costs). For example in Amhara region, close to 14 million birr has been spent to provide exempted services for close to 605,000 users. These costs are related to direct service provision, and do not include commodity costs, which are financed by federal level. The average unit amounts to 24.2 birr per person allocation (see Table 7.7), but vary from 19at health center level to 168 at hospital level. Exempted services, which are suffering the most, are ANC, PNC, delivery and opportunistic infections, as these eservices do not get donor support. This puts pressure on internal revenue of Health facilities. For instance, in 2013/14, in Lekemt Hospital alone, more than 4,000 women have delivered. The cost of delivery is born by internal revenue of the hospital, which is more than a million birr (about 250 birr per capita). Comparatively, the Amhara region has allocated 144 million ETB for exempted services: delivery, ANC, PNC and drugs for opportunistic infection.

Table 7.7: Number of people accessed exempted services in Amhara and Benishangul-Gumuz regions, 2005 EFY

Region	Item	HC	Hospital	Total
Amhara	Served	585,566	19,301	604,867
	Total expenditure	10,875,751	3,097,067	13,972,819
	Unit cost per beneficiary	19	160	23
BG	Served	20,298	2,776	23,074
	Total expenditure	633,368	616,044	1,249,412
	Unit cost per beneficiary	31.2	221.9	54.1
Total	Served	605,864	22,077	627,941
	Total expenditure	11,509,119	3,713,111	15,222,231
	Unit cost per beneficiary	19.00	168.2	24.2

Source: Data extracted from health financing database at Amhara regional office of HSFR/Abt Associates during review

The other problem reported by regions is that program drugs, which are inputs to exempted services, are in short supply at PFSA and supply is often unreliable at facility level. In addition, drugs with short shelf life may not be well managed leading to wastage. In cases of drug supply failure, clients are asked to buy drugs from private pharmacies, which erode the gains made by providing the service free at the Health facilities.

Sustainability of exempted services is under question for various reasons. Development partners such as GF, GAVI, US Government, and those that contribute to the MDG PF currently finance inputs/commodities for the services, some of which are very expensive. In the medium to long term, it is not certain if this funding will continue at the current scale. The Millennium Development Goals, one of the key mechanisms that led to mobilize massive resources for health will end next year. In addition, with Ethiopia's aspiration to move to middle-income country, donor resource may decrease. Most exempted services are provided at primary (woreda) level, hence availing commodities for such services is beyond the fiscal space of woredas. There is thus a need to explore how such public health function is delivered to the population in a sustainable manner.

7.6 Fee waiver

In woredas where the new fee waiver system is functioning, households qualify for waivers community processes. ID cards identifying the poorest of the poor are issued to qualifying households. As a result, a significant number of the poorest of the poor were able to access free health care. This has played a key role in expanding access to the poor as more than 1.4 million fee waiver beneficiaries were screened for the service in the country. However, 82% of the beneficiaries are from Amhara region as the reform is fully implemented there. As highlighted during the KII, there are issues around ownership of the fee waiver component. While legally it is responsibility of the Woreda Administration Office, in reality responsibilities have shifted to WorHO because the former is not assuming ownership. Hence, there are concerns that fee waiver beneficiary record keeping, might have underestimated the number of beneficiaries. In addition, there are regions, which have not fully implemented HCF reform whereby the old fee waiver system is still in practice. Number of fee waiver beneficiaries in such regions is not capture here. According to the 2011 HICES, about 29.6% of total population lives below poverty line, which amounts to 24.24 million people based on 2011 level of population. Thus, only about 6% of people living below the poverty line are covered through fee waiver scheme. In addition, woredas and regional governments have allocated more than 19.4 million birr for waiver (FMOH, 2014b). Data from field visit reports shows not all fee waiver beneficiaries are using the services. Overall, given the population size, poverty level and limited resources especially at woreda levels, the coverage is still low. There is uneven implementation of this reform among regions as the vast majority of the beneficiaries are from those few regions where the system is fully implemented.

Overall, as detailed in the regional report there are several challenges in the allocation and utilization of resources to enhance equity. There are regions, which have yet to completely implement the HCF strategy. Among those who have initiated the reform except for Amhara the implementation within the region is uneven and major gaps that negatively affect equity and efficiency of the fee waiver scheme have been reported. With exception of Amhara, woredas may lack the commitment and resources to allocate adequate sufficient budget for fee waivers. Some regions like Oromiya are not documenting the number of fee waiver beneficiaries, the resources allocated, and number people using services.

The design of the waiver reimbursement system is not appropriate for the needs of referral hospitals. It is difficult for them to follow up with individual woredas to obtain payment for the cost of exempted services. This would entail very high transaction cost for the hospitals. Federal hospitals do not entertain waiver certificates as a means for getting free services. In some woredas, health facilities reported that local authorities issue fee waiver certificates to the poor at the time of sickness without allocating budget for the program. There is no adequate and strong administrative accountability mechanisms in the fee waiver guideline to ensure woredas do not default on payment on payment to health facilities.

Limit on the number of waiver beneficiaries that can be identified and under utilization of services by waiver beneficiaries is another issue. The woredas fear that selecting more people will cause them to allocate more budget, which they may not afford. In practice budget allocated by woreda for fee waiver reimbursement in Amhara and Benishangul-Gumuz regions is not even fully utilized (see Table 7.8). The unutilized budget could have increased the number of beneficiaries by at least 25%.

Table 7.8: Utilization of fee waiver budgets in Amhara and Benishangul-Gumuz

	Budget for fee waivers	Utilized	Rate
Amhara	5,230,332	3,905,070	75%
BG	549,000	243,552	44%

Source: Extracted from HSFR/Abt Associates Amhara Regional Office during review

In summary, there are various challenges associates with targeting the right people. Delays or no reimbursement from the third party payer, poor financial recording and reporting, delays or in some case no reimbursements for the services provided, poor understanding and interpretation of the exempted service list are issues mentioned. In addition, there is also challenge of marginalization of poor people with a need but without proper identification or address such as street children.

7.7 Community Based Health Insurance Schemes

The Government of Ethiopia launched pilot CBHIs in 13 selected woredas of Amhara, Oromiya, Southern Nations, Nationalities and Peoples (SNNPR) and Tigray Regions in 2010/11 to provide risk protection mechanisms for those employed in the rural and the informal sectors. These pilot schemes were evaluated in 2014 and this section summarizes the major findings and recommendations (HFG/HSFR, 2014).

Ethiopia's CBHI design was informed by evidence from international experiences which avoided small scale, voluntary membership and instituted mechanisms to finance the membership of the poor, with its own features: enrolment into CBHI scheme was decided collectively at kebele level as opposed to decision made at household level: the association of kebele sections formed a larger woreda CBHI scheme; scheme management is integrated and works within the overall Woreda Administration office; general subsidy is provided to all members of the CBHI by the federal government while targeted subsidy from the regional and woreda governments is provided to the very poor who cannot afford to pay the contribution, and scheme managers are also employed through government payroll.

The overall enrolment of all pilot woredas reached 48%, with variation ranging from 25% in Deder to universal enrolment in Yirgalem. The average percent of HHs registered as indigents in pilot woredas stood at 7%, with variations ranging from 1% in Deder to 15 % in Tehuledere and Yirgalem. The per capita health service utilization rate of CBHI members was 0.7 visits per person for the year 2012/13. This compared to the overall OPD utilization rate of the country—0.3 per capita visit—is higher by about 50% percent. Of the 13 CBHI woredas, 10 of them have a healthy financial status while the other three (one in Amhara and two in SNNPR) are in financial difficulties. The study recommended various measures to improve financial sustainability:

- Introduction of penalties for households that do not renew membership and pay premium for more than 6 months
- Revision of premium level and introduction of higher premiums for urban dwellers
- Solidarity between woreda and regional schemes (risk pooling)
- Provide incentives to kebeles to enhance timely collection and deposit of premiums
- Consider introduction of co-payment

The major determinants of enrolment into CBHI scheme were found to be size of household, age of the head of the family, education, sex and cultivated land size (not only own land). Overall, the targeted subsidy allocation seems largely fair as 60% and 83% of the households benefitting from targeted subsidy came from the lowest and second lowest expenditure quintiles respectively. The affordability of premiums and registration fee was found to be an issue for 16% of registered members as well as 39% of non-members.

All of the qualitative KII respondents felt that the introduction of CBHI has increased health service utilization. Eighty-two percent of CBHI members have reported to use their membership card for utilizing health care. The likelihoods of CBHI members visiting a health facility when feeling sick in the pilot woreda is higher by 26.3 percentage points relative to non-members. The establishment of CBHI scheme provided health professionals with some degree of freedom to prescribe the appropriate diagnostic test and drugs without any worries about the ability of the CBHI member to pay. In all measures of perceived quality of care, more CBHI members feel that there is improvement in quality of services over time than non-members. When asked to report their level of satisfaction using various perceived quality parameters, about 90% of these respondents reported to have either been satisfied or very satisfied with cleanness of the facility, courteousness of health professionals, and waiting time with no significant difference between members and non members. However, there are major challenges in the quality of services provided. First, contracted providers differ in their supply-side readiness such as pharmacy services, laboratory facilities, reception, OPD, etc. and this affects quality. Second, there are shortages of drugs in health facilities, especially in hospitals. Referring patients to buy items from outside (private retailers) is a frequent phenomenon. Shortage of pharmaceuticals in PFSA hubs has been the major reason given by Health facilities in most of the regions for the shortage of drugs in their premises. There are reported cases of moral hazards by both providers and CBHI members.

The evaluation asserts that CBHI members have less chance to be impoverished because of OOPs than non-members do. Using a cut-off of OOP health spending exceeding 15% of non-food expenditure, the estimated incidence of impoverished households due to OOPs was about 7% for CBHI and 19 % for non-members. At a 25% threshold, the estimates were 3% and 9% respectively. The evaluation also attempted to estimate the head count, poverty gap and normalized poverty gap for members and non-members by adopting the Soumitra Ghosh (2010) model. A regression analysis, based on a dichotomous choice (logistical regression) model, controlling for other factors, also shows that being a member is negatively related to impoverishment due to OOPs. The evidence in Ethiopia therefore shows OOPs in general have an impoverishing impact to households. However, CBHI membership shows a significant protective effect relative to non-membership.

The CBHI schemes have been able to mobilize Birr 22.7 million in the form of premiums in all the pilot woredas. CBHI schemes reimbursed about Birr 16.9 million for contracted health centers and hospitals for the services rendered. Key informants and focus group discussions with health facility staff confirm that CBHIs have increased the utilization of services and retained revenues in Health facilities particularly of health centers. More than 90% of utilization of services by members and more that 90% reimbursement are made to health centers in Amhara, SNNPR and Tigray CBHI schemes. Overall, the schemes were able to finance the health service costs using resources generated from premium collections. Premium collections were 134% of the total health service reimbursements paid out without any subsidy. However, three woreda CBHI schemes (Fogera, Yirgalem and Damot Wayde) would not have been able to finance their health service costs without subsidy.

The CBHI evaluation report clearly documented that CBHI is making a difference on utilization, financial protection, and resource mobilization for health facilities. The plan to scale up the scheme to other woredas is timely. Given the evidence generated in this evaluation, CBHI as a path to UHC needs to be pursued with commitment at all levels of government and be scaled up. Internationally acknowledged CBHI pillars however should guide the scaling-up to UHC (promoting equitable access by removing financial barriers, especially direct payments; making prepayments mechanisms compulsory; creating larger risk pools for financial sustainability and governments need to cover the premiums of very poor). There is a need to develop a comprehensive CBHI scaling up strategy to guide its implementation. It is recommended that the scaling up strategy need to have phased implementation. In such a strategy, it is necessary to consider different design parameters and implementation arrangements be considered for urban and rural areas. The evaluation report provided suggestions on the different design issues and parameters that need to be explored beforehand during the scaling up.

7.8 Private Wing

Another area of enhancing efficiency is introducing different incentive mechanisms within public health facilities. Establishing private wing within a public hospital is one of the other HCF elements to improve efficiency and effectiveness of services through increasing revenue, expanding service availability in off hours, improving quality as well as improving retention of key staffs. According to the latest HSDP Annual Performance Report, 48 hospitals have opened private wing services (FMOH, 2014b). The performance assessment of private wings towards realizing these objectives showed that the initiative has been successful in addressing some important challenges both on the supply side such as improving service availability, retention of key staffs and reducing waiting time (FMOH, 2011b). The services are also responsive to the client needs as close to 90% percent of the clients were satisfied by private wing services (FMOH, 2011b). Data for 2012/13 shows that bed occupancy rate was 24% nationally (FMOH, 2014b). By extending the working hours and by utilizing excess (bed) capacity[19], private wings has increased HF utilization rate resulting in some efficiency gain.

7.9 Outsourcing

The HCF strategy proposes outsourcing of non-clinical services such as catering, laundry, cleaning, gardening, security, etc. to improve efficiency by allowing hospital management to focus on essential/core activities rather than spending considerable time and resources on routine administration and management of non-clinical services. Currently, 65 hospitals in nine regions (with the exception of Afar and Somali) have already started the process of transferring non-clinical services to an outside supplier.

[19] The private wing assessment showed that majority of hospital (83%) used the regular ward rooms for private wing inpatient services while 17% used rooms specifically built for private wing services and extra blocks of the hospital.

Based on the findings during field visit, Amhara region has more elaborate information on the status of outsourcing in hospitals in the region (see Table 7.9). Many hospitals in the region outsourced non-clinical services such as security, food supply, food preparation, laundry, cleaning and transport services. In Oromiya, of the visited six hospitals, five have already started outsourcing non-clinical services. In Benishangul-Gumuz, the two hospitals have outsourced catering service first to private business and now to associations[20]. In Addis Ababa, security and food supply are the most commonly outsourced functions. There is a very limited experience in out-sourcing clinical services. Among visited hospitals, it is only Felege Hiwot Referral Hospital in Bahir Dar that outsourced a clinical service i.e. dialysis services to a Swedish company, where medical equipment have already been bought and the hospital already began providing dialysis services.

Table 7.9: Outsourcing of non-clinical services and their perceived benefits in Amhara

Name of Hospital	Type of services outsourced	Month and Year of outsourcing (in E.C.)	Expressed Benefits Gained
Hidar 11	All food items	November 2004	None
Debre Markos	All food items	June 2004	Minimized procurement complexity; reduced cost; and improved quality
	Security	June 2004	
Debre Tabor	All food items		Reduced cost, improved quality, reduced administration cost and time
Ataye	Security	—	—
Debre Birhan	All food items	July 2001	Improved quality, Saved cost and time, Ease of management, Comfort for the customers
	Laundry Service	July 2001	
	Security and Gardening	July 2003	
	Cleaning service	July 2004	
	Transport service	July 2003	
Felege Hiwot	Injera	July 2001	Reduced cost, improved quality
Shegaw Motta	All food items	January 2003	Saved time, saved cost
Finoteselam	All food items	July 2004	Saved time, saved cost
Debark	All food items	January 2004	Ease of management, reduced wastage, improved quality, improved efficiency
Metema	All food items	June 2002	Ease of management, reduced wastage, improved quality, improved efficiency
Mekane Selam Hospital	Food Preparation	September 2006	Minimized administrative burden
Mekela Jegnoch hospital	Cleaning service	October 2006	Minimized cost & time
	Security service	November 2006	Lowered administrative burden
	Laundry service	November 2006	Avoided complicated purchasing processes
	Food Preparation	December 2005	Created job opportunity for others
Tefera Hailu Hospital	Cleaning service	February 2006	Lowered cost, improved quality of cleaning service
	Dry Injera	November 2004	
Woldiya Hospital	Security Service	February 2006	Minimized managerial burden
	Laundry	April 2006	Improved quality of service
	Food preparation	November 2003	Improved quality of service

[20] Such associations are formed by unemployed youth who will then be organized under the so-called "small and micro enterprises". The government then gives them some skill and business management training in their preferred area of trade. Priority is given to hire such associations when government institutions require purchasing services from a third party. Currently, this is the government's main employment generation mechanism for youth.

The respondents expressed the benefits gained from outsourcing nonclinical services. Some the gains mentioned include reducing cost and time, reducing wastage, improving quality, decrease burden on management so management focused on core business, minimizing administrative burden, creating job opportunity and improving efficiency. Beyond these expressions of benefits by respondents, a more objective comparison of unit cost before and after outsourcing has not been conducted.

Although the implementation of this reform component is still limited and uneven, stakeholders in the three major regions (Amhara, Oromiya and SNNPR), Oromiya reported initial success in improving quality and decreasing cost in areas where such reform has been implemented. For instance in Amhara, the performance review of out-sourcing in hospitals claims there is cost reduction, reduction in administrative complexity, and improved ability to provide quality services. It has also been reported that the benefit extends to non-health sector given this initiative allowed new micro-enterprises to grow and prosper.

7.10 Community participation

Enhancing community participation is one of the key strategies defined in the HCF strategy. Accordingly, various platforms have been created to enable the community to become more involved in health care governance. The main ones are in the health facility Governance Boards, in CBHI Boards and General Assembly and involvement in selection of indigents in CBHI pilot schemes and waiver beneficiaries. Health facility governance boards are set up in hospitals and health centres to bring decision-making closer to the community and give facilities autonomy. The Board is responsible to give guidance and high-level decision to health facilities, including implementation of various HCF reform components. In particular, the Board is responsible to review and approve the HF's annual physical and financial work plan, review and approving the utilization plan for the internal revenue, approve user fee revision proposals among other tasks. CBHI General Assembly (GA) and Board of Directors (Board) oversee CBHI scheme's overall management at woreda levels. The General Assembly is the higher decision making body for CBHI, entrusted with the following responsibilities:

- Approves the annual budget;
- Reviews and approves annual financial performance reports;
- Review the scheme's financial and technical management;
- Revise and approve its operational manual; and
- Elects Board members and terminating them when their term is over (FMOH, 2010e).

At the CBHI Board level, seven people from each kebele are represented comprised of kebele cabinet members and government leaders. The Board is responsible for:

- Reviewing quarterly financial and physical report;
- Reviewing that operation is as per plan;
- Overseeing the technical and financial operations;
- Preparing agenda for GA meeting; and
- Presents annual report to GA and to members (FMOH, 2010e).

At woreda/community levels, there are seven community organization structures i.e. youth league, women league, youth forum, women forum, residents forum, women development group, and special committees. When it comes to identification of fee waiver beneficiaries, woredas conduct the selection through waiver committees. The committees comprise of members from community through residents' forum, Youth League and Women League. These community structures have first hand information about living standards of residents in a woreda and play active role in the selection.

Findings from field visits showed limited financial contributions from the community. Only a handful of experiences were found from Amhara and Oromiya. In Oromiya, it was stated that there was a onetime region-wide community contribution to improve maternal health during last fiscal year, which was in-kind support mostly in the form of agricultural products. Very few health facilities visited received money from the community, which ranges from the minimum 7,000 birr in Deraku health center to 108,000 birr in Kubsa health center in EFY 2006 (see Table 7.10). Community contributions range from 2% of health facility recurrent budget in Deraku to 14% in Kubsa, which is significant.

Table 7.10: Community Contribution in few HCs in Oromiya in 2006 EFY

HC	Amount of Community Contribution	As % of HF recurrent budget
Deraku	7,000	2
Asasa	90,000	9
Gera	23,000	3
Kubsa	108,000	14

Source: Data collected during review

Findings from Amhara show that other types of community contribution also occur. For instance, there have been instances of contribution of food ingredients to prepare porridge for mother who just delivered with a health facility and in some cases contribution of local material for fencing etc. The food is given to mothers waiting for delivery or those that already gave birth, patients arriving from distant places and with nobody to support them. For instance, in Golbo health centre of Ambasel woreda, South Wollo, the community contributed Birr 5,740 worth of cereals for porridge. The same community contributed wood and fenced the health centre. In Machakel woreda, communities grow cereals in the compounds of HPs to be used for porridge. In Yinesa HC, Bahir Dar Zuria woreda, the kebele administration covered the cost of strengthening doors and windows with metal bars. There has been no report of community contribution in the other regions visited. However, general experiences of community contributing labour and local material during construction of HPs exist.

7.11 Governance Boards

All facilities that implement health finance reform established the facility governance boards (FGB). These governance boards and management committees were implemented to allow devolution of the responsibility and authority from the regional level to local levels. The FGBs were designed to reduce the administrative complexity, enhance effectiveness and efficiency of management, increase accountability for public funds, create a sense of ownership by management, increase the role of the local community, respond better to local needs, and improve resource mobilization by allowing local decision-making.

Of the total 3335 health centers and 150 hospitals available in the country, 2,849 health facilities (101 hospitals and 2,748 HCs) have established governance structures and managed to retain and utilize internally generated revenues to improve the quality of health services. The regional performance in establishing such structures is shown in Table 7.11.

Table 7.11: Health facilities governed by board

Regions	Functional HCs (No.)	HCs governed by Board	
		No.	Percent
Amhara	804	758	94%
BG	31	31	100%
Oromiya	1250	1250	100%
Afar	62	14	23%
Addis Ababa	65	62	95%

Source: Abt Associates (2014)

Board and committee meetings are normally held once a quarter, but this varies by region and facility, with some meeting more frequently and some less frequently or not at all. Normally, formal minutes of the meetings are taken and reviewed.

One of the major challenges to the facility governing body process is the high turnover of the board members, due to a variety of reasons but often because of the competing priorities. Irregularities in governance structure meetings and lack of commitment or absenteeism of some members was found to be one of the challenges. Some of the reasons for members' absenteeism include work overload in their regular engagements, weak revenue collection capacities of some health facilities to merit a regular meeting to make substantive decisions and failure or inability of health facilities to pay allowances as per the HCF implementation manual. There is lack of uniformity in paying allowances for members of the boards even within regions and woredas. There are, however, boards that are not paid allowances and yet contribute in the management of health facilities. The other issue around proper functioning of governance structures is inadequate knowledge on their roles and responsibilities partly because they have never trained or participated in a workshop on the HCF strategy. The regional Abt Associates report indicated that nearly 70 percent of GB members never attended training on the HCF strategy. It is either because of the fact that they are newly assigned members to replace those, which left from the committee and from governance board for health facilities, which embarked on implementing HCF strategy very recently.

7.12 Public Private Partnership

Public private partnership (PPP)[21] in health is a relatively newly emerging practice. Contracting, leasing, franchising, and social marketing serve as examples of private sector interventions in health that have been practiced globally. Despite accomplishments made in Ethiopia's public health sector, key health financing issues still limit the GoE's ability to efficiently and effectively provide quality health care services that meet the demands of the country. As the private health sector has rapidly grown over the past decade, an opportunity exists to leverage public health resources through partnerships with the private sector to narrow the gaps of resource constraints as well as improve access to quality health care services. According to the most recent National Health Accounts household survey report in 2010/2011 about 20% of households receive care from private health facilities (FMOH, 2014d).

Box 7.4: Highlights from the PPP Case Study (FMOH and HEPCAPS II (2015))

Contracting partnerships between the GoE, Ethiopian Catholic Church Development Office, and health institutions has allowed facilities such as Dubo St. Mary Catholic Primary Hospital, St. Luke Catholic Primary Hospital and School of Nursing, and Wasera Health Center to expand coverage of health facilities and provide quality primary care services in SNNPR and Oromia. Furthermore, contracting partnerships between government and private-for-profit health institutions for the provision of select health care services, specifically focusing on HIV/ART, TB as well as provision of clinical diagnostic services (Debre Berhan hospital outsourcing advanced clinical laboratory services) and non-clinical services (e.g. Mizan Aman Hospital's outsourcing daily cash collection and patient registration) are contributing their share in expanding access to treatment and care services.

Infrastructure-based hospital PPP arrangements, seen in the establishment of specialized medical care services like dialysis (Melese Zenawi Dialysis Center in Mekelle) and eye care (OIC eye care center at Zewditu Memorial Hospital in Addis Ababa) within public hospitals have created opportunity for affordability and accessibility with a more conveniently located service rather than traveling to Addis Ababa for such services.

Social marketing (of family planning and child health commodities by DKT Ethiopia) and franchising (Marie Stopes Blue Star clinic model for the provision of family planning and abortion care) are increasing access to sexual and reproductive health services.

FMOH and HEPCAPS II (2015), a PPP case study report still in draft form, demonstrated that contracting, leasing, social marketing, and franchising arrangements between the GoE and private-non profit and for-profit organizations has expanded the number of health facilities providing health care services at a lower cost for households as well as improve the quality of public health facilities throughout Ethiopia. Box 7.4 highlights some of the findings from this case study.

[21] A PPP is a partnership between a private party and a government agency characterized by the sharing of common objectives, as well as risks and rewards, which are formalized through a long-term contract, as a means of providing a public asset or contract effectively and efficiently (World Bank, 2012).

The different types of PPP practices in Ethiopia are being implemented at varying degrees of intensity. Lack of a standardized PPP operating procedures is a major limitation in the implementation of PPPs in Ethiopia. The work on strengthening PPPs must begin by addressing this challenge. Additional challenges consist of regulation being more focused on private health service providers compared to public; lack of legal framework, which is a huge gap for PPPs in every sector; and lack of strong structures, like a dedicated PPP unit, inhibiting PPPs to be guided in a systematic and organized way for design, management, monitoring and evaluation of contractual agreements as well as other PPP modalities.

8. Gaps in the Implementation of the HCF Policy

The following sections highlight some of the overall challenges and constraints as well as gaps in the implementation of the health care financing strategy.

8.1 Overall Domestic Resource Mobilization

Increasing but inadequate resourcing from government: According to the latest NHA, the total per capita spending on health is $20.77 and government spending is less than 1 % of GDP. This is still well below the resources needed to achieve the desired level of universal health care coverage with quality. While external resources have made important contributions to Ethiopia's health progress, there is an increasing pressing need to increase domestic spending.

Most of the attention given to resource mobilization under the HCF strategy has been towards external resources (development partners) and user fee development and retention. While these efforts have been successful in dramatically increasing resources mobilized, there has been a relative decline in government effort with own-generated revenues during this period. Of course, these have increased in absolute terms with Ethiopia's rapid economic growth. But government spending on health from own-generated revenues, not including externally financed general budget support, has been declining as a share of government spending and as a share of GDP. The relative decline was compensated for by increases in other sources of funding to government. Nonetheless, government's own financing for health is an area of domestic resource mobilization, which has not received sufficient attention.

In recent years, the development of CBHI pilots and their proposed expansion and the launch of Social Health Insurance, are two initiatives for increasing governments resource mobilization. At this time, they remain relatively small (CBHI) or in the process of development (SHI). Additional efforts are needed to chart a more comprehensive pathway forward for increasing government financing of health in Ethiopia.

As shown in the preceding sections, half of the health sector funding is coming from external resources. With the completion of the MDG agenda and expected decline in external aid due to the economic down turn in countries that provide external aid, it could be difficult to sustain the gains made over the last ten years especially public health services, whose commodities are financed through these funds. The successes in malaria, HIV/AIDS, TB, child immunization, etc. services are partly driven by the resources available from the external resources. Without concerted effort to mobilize domestic financing either through the normal budgeting process or through innovative financing there is a risk of losing the gains made so far.

8.2 Resource mobilization through fees and retention

Finding new and innovative ways of increasing domestic financing is therefore very critical. One such innovative way introduced in the HCF strategy has been user fee retention. Indeed the retention of fees has contributed to the provision of services at facility level by increasing resource availability. The overall policy guidelines stated in the HCF strategy has been that retained fees will be additional to government financing. As described in the previous section, government allocation to health, especially at lower levels is increasing. However, the evidence from the health facilities shows that allocation to operational costs to health facilities from government budget is declining. In some facilities, government allocation is limited to paying for salaries. The principle of 'additionality' of retained funds does not seem to be the rule in the allocation of resources at the woreda level as originally designed.

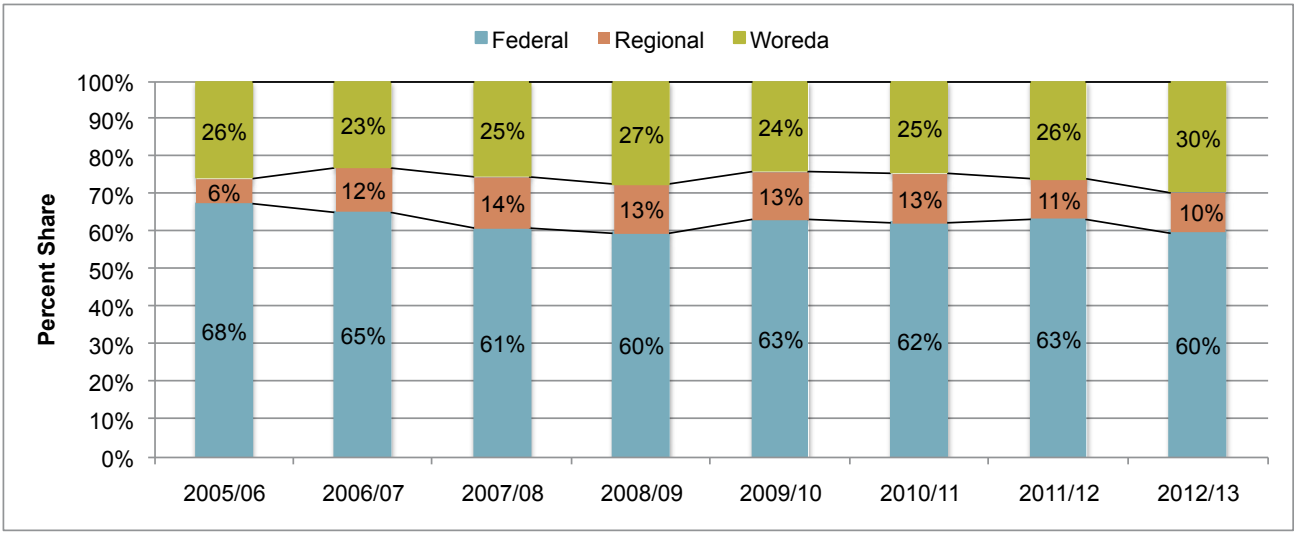
The implementation of reforms under the HCF strategy varies from region to region: Some regions may be ready to graduate from support for HCF reforms implementation (Amhara, Oromiya), others will require continued support (Afar and Somali). Traditional HCF reforms are still being at pilot phase in pastoralist regions. There is even difference among Developing Regional States (DRS). In Benishangul-Gumuz for instance, all health centers except one are implementing user fees retention. In Afar, on the other hand, out of the available 6 hospitals, 78 health centres and 315 health posts, the Afar Regional State has started the implementation of health care financing at pilot level on only 14 HCs and 5 hospitals. This shows that targeted support of implementation may be required even for the next few years. Even in regions with mature traditional HCF reforms, reliance on technical

support provided by partners' remains. In order to remain financially sustainable, and continue such needed activities, the government needs to take over such functions. This could be facilitated through support from graduating regions from HCF traditional reforms.

User fee revision has not occurred systematically across the country: While some user fee revision was carried out in Amhara that is not the case in Oromiya. In some regions, user fee revision is the mandate of the regional cabinet and the Regional Health Bureau. The FGDs with health facilities reflected that neither fees charged nor the budgets allocated by government do cover the full cost of some the services, especially cards and impatient beds. From the focus group discussions held with the users of the services in all visited health facilities, the fees charged by public health facilities are affordable and relatively cheaper when compared to the private health facilities. This clearly shows that there is some sort of subsidy even for some that may have the ability to pay for services. This could have been better utilized for other priority services in the facility.

Imbalance between federal function and expenditure assignment for health needs may lead to inadequate funding for exempted services: As shown in previous section, external resources have financed about 50% of the total health expenditure. The major driver of this cost is cost of commodities for exempted services. With expected decline of external aid and Ethiopia moving to advancing to middle-income, it is expected that the country should take increasing responsibility of financing these commodities. Most of these exempted services, according to the responsibility expenditure assignment of different levels in Ethiopia, fall under primary care, and hence a woreda function. The big question therefore is will woredas be able to finance these commodities in case of shortfalls. The data from regions and woredas show that a majority of government funding goes to salaries and there is limited room for increasing operational funding. Analysing the fiscal space in the country shows about 60% of total resources are allocated and used at the federal level (Figure 8.1). This clearly reflects the need to revisit and potentially include the high cost of commodities for exempted services in the expenditure function at the federal level (where centralized procurement may make sense) or some other arrangement to assure adequate financing of these services.

Figure 8.1: Annual Fiscal Space by Level of Government in Ethiopia



Source: MOFED (2014b)

There is divergence between HCF proclamations, regulations and guidelines and actual implementation of the HCF strategy. The exempted services provided currently not only differ from the list provided in the laws but also have significant equity issues as some woredas benefit from such services from donor funded services while other do not. There are also cases where retained fees are used outside the positive list described in the HCF manuals. For instance, Debre Tabor Hospital is directed to pay education expenses of the CEO,

and 300-birr position allowance for 16 management members, and other related expenses. This is likely to affect the financial capacity of the hospital. Health posts in Benishangul-Gumuz provide not only preventive care but also some clinical services as well and charge fees. However, revenue collected in these health posts is not retained, it is deposited with the WOFEDs.

Fee retention at federal level hospitals is a recent development. In general, tertiary hospitals have more capacity to generate resources and become self-financing compared to lower levels health facilities. Based on this assumption, the HCF strategy sets out a clear strategy stating that FMOH will "explore alternative options for financing health service delivery and efficiency improvements in urban areas like Addis Ababa in order to improve the quality of health care and to release government resources to ameliorate primary health care services within the administration" (FMOH, 1998). Some regional hospitals like Felege Hiwot have stated that they can now generate 50% of their running cost and are venturing towards innovative income generating services such as outsourcing of curative care services and expanding their diagnostic services even to the private sector to generate more income. Unfortunately, until recently the health financing reforms that have been implemented in tertiary hospitals does not go beyond establishing private wings. The issue has been raised in various review documents (mid term review (MTRs), and joint review mission (JRMs)) and so far there is very little push to get the HCF strategy reforms implemented. The EFY 2007 federal government budget states that they will now retain fees. However, the mechanisms to implement this reform are still unclear.

8.3 Progress in Implementing CBHI and SHI

The delay in the implementation of the SHI: The introduction of SHI is expected to have positive contribution not only to risk protection, but also for increasing resources to the sector. While indeed the necessary systems and guidelines pre-requite for good functioning of the SHI in Ethiopia, the plan to launch it has been repeatedly delayed.

Low enrolment rates and weak premium collection of CBHI schemes: The CBHI evaluation report (HFG/HSFR, 2014) clearly show that there is very low enrolment rates in some woredas and the collection of premiums for all woredas is a challenge due to lack of operational structures and incentive mechanisms for local collectors. This has a negative impact on resource mobilization at the community level.

8.4 External aid mobilization and utilization

There are challenges of knowing the resources that are being implemented outside the knowledge of the government system (Channel 3). External aid mobilization and utilization that are channelled through the implementing partners and should have been consolidated as part of annual planning process does not happen as shown in Section 6.2. Of the total resources mobilized, only 39% are on budget. This is specifically the case we go down from federal to woreda levels. Both RHB and WorHO acknowledge that they receive development assistance from various implementing partners (IPs), but they have not consolidated the amount of the external resource flows and their utilization in their own health sector planning using the EBP approach. This results in planning based on partial analysis of available resources. It will be important to strengthen EBP and national planning with better data on off budget external funding. As the level of these funds changes, it is important to incorporate in planning and management the contribution of IPs and DPs at the regional and woreda levels and resource gaps and challenges associated with external resource use.

8.5 Efficiency and effectiveness

Efficiency and effectiveness: Gaps still exist in the monitoring and evaluation (M&E) system at the woreda level to ensure that health centres are properly collecting, planning and using their internal revenues. While BOFEDs are expected to regularly audit the use of the retained fees, there is a weak link between WorHO and WoFED. Auditing is not in their annual program and neither do they have adequate personnel, particularly financial auditors or accountants that are meant to regularly audit HCs and make the necessary corrective measures to circumvent possible leakages or misuse. Anecdotal evidence shows lack of understanding of the working procedures and fear of accountability had led to some Health facilities reluctant to use the revenue that has been retained. This demonstrates efficiency loss in the health service delivery.

In hospitals where private wings operate, there are emerging tendencies of moral hazards by professionals. These are manifested in a number of ways: patients at regular time being pushed to the private wing; patients pushed to take unnecessary laboratory; and number of patients per physician in the private wing is much higher than that of the regular service where there are higher flow of patients. As the quality of services improved relatively available with lower fee as compared to the private sectors' services there is risk of crowding out private health facilities by the private wing. The impact of the private ward/wing on the performance of on the regular services within the facilities and the private sector around the catchment population has not been assessed.

The current budget allocation is line item or input based. Such allocation does not link resource allocation or input with expected outputs as does performance based financing. Neither does such allocation create sense of accountability for outputs and meeting targets by health practitioners or health managers. There is room for gain in efficiency and effectiveness with the implementation of result based financing whereby health practitioners/teams are held accountable for delivering a certain target of outputs by linking it directly with the amount of resource they are allocated.

8.6 Equity

There is limited evidence documenting the effective functioning of the health sector reforms that aims at protecting the poor. Under-coverage of the poor in waivers in all regions is high. There is variation in the implementation of the waiver program across and within regions. Amhara for instance — the best performing region in terms of waivers-covered about 7% of the regional population and account for 82% percent of the total fee waiver beneficiaries in the country (FWBs) (FMOH, 2014b). Covering 7% percent of the regional population is very low compared to the estimated number of households living below poverty line i.e. 30.5% (MOFED, 2012). Other regions are not doing that well. In some regions, like Oromiya, it has not been implemented in all the woredas. Overall this inadequate coverage is the result of inadequate resources available by the woreda to finance such expenditures. There are also woredas that default their obligation of paying to health facilities due to budget shortages.

The fee waiver program is not working effectively for different reasons. Although the list of FWBs was supposed to be revised in every three years, this does not happen always, leading to potential leakage and under coverage. Despite the involvement of the community during selection, there are still some complaints about the fairness of the selection of FWBs in some woredas. It is reported in many woredas that people who have a capacity to pay have benefited from the program while some who did not benefit. The design of waiver reimbursement systems is inappropriate for referral hospitals as it is difficult for them to chase every woreda to pay for the cost and neither has the woredas allocated budget for referral in the first place. In some woredas, health facilities reported that local authorities issue fee waiver certificates to the poor at the time of sickness without allocating budget for the program. The facility waiver reimbursements are not made on time or sometimes difficult to get. There is no adequate and strong administrative accountability mechanisms in the fee waiver guideline to ensure woredas do not default on payment to health facilities.

There are a number of problems in the implementation of the exempted services policies, which affect equity. The list of exempted services provided in health facilities does not match with the regional exempted services list as there are additional services being offered in some woredas where there are programs providing special support to enable the services to be provided free of charge. There are instances where some of the exempted services, which are supported by program drugs, are interrupted due to irregular supply of commodities. Facilities reported that exempted service take up some of the facilities resources, as they do not which is not fully covered by the third party. However, they do not know the breakdown of the details of resources. There are also some services like diabetics that have to be included in the exempted services. All of these experiences result in differentials in access and quality between woredas and regions.

Overall, despite the marked achievement on the supply side toward enhancing the PHC through accelerated expansion of PHCU, given the poverty level in the country and the limited coverage and implementation of the fee-waiver and health insurance scheme; the equity objective of the HCF reform is far from met as households still finance 34% of total health expenditure (as per NHA) and this puts a great burden of ill health in poor households. Hence, major work is required on the demand side to make health care to provide equitable and acceptable standards of service for all segments of the population. On the supply side, in addition to improving access it is also important to review the service availability and functionality of the PHCUs.

8.7 Capacity Development for HCF

Inadequate Institutional capacity for implementing health care financing: Capacities in knowledge and skills at federal, regional and woreda level are limited for planning, implementing, and monitoring health financing. At the national level, there is inadequate capacity to develop and implement HCF, which requires investment in training of FMOH and EHIA staff on health economics and financing. If FRM to steward the separation between FMOH and EHIA, then more capacity is needed to perform this function effectively. The management of different channels of funding is complex and challenging and will continue to fragment the financing channels unless strategies are devised over the long term to pool these resources into a consolidated mechanism-government public health funding and insurance. Health financing planning and monitoring capacities can be further strengthened at regional level to prepare for their increasing role in the future.

At lower levels**,** there have been a number of trainings on the HCF strategy reforms to woreda administrations, WOFEDs and WorHO and governance boards when the reform is initiated in each woreda and facility. However, lack of awareness in the woreda level administration and inadequate capacity at the facility level remains to be one of the challenges in the implementation process. Our assessment shows that, on the average, less than 50 percent Health facilities have personnel that have been trained on HCF strategy. There is high staff turnover mainly because of transfer to other areas or left their jobs due to own personal reasons, especially among facility heads. There are instances where health facility board members do not meet as scheduled. A health center management committee that is supposed to meet every month did not have any meeting for over six months, despite incentive payments of75 birr per meeting day for all members and 100 birr for the chair. This has hampered the effectiveness of leadership and community ownership. Well-trained staff does not back collection of internal revenue in some facilities. It is reported that due to lack of incentive to the administrative staffs and narrow organizational structures of the Health facilities, the Health facilities could not retain and hire the required number of staffs that goes to the expansion of services. As a result, in some HCs the woreda administration assisted HCs by transferring some staff form other sectors. There is also high turnover of health facilities board members.

9. Recommendations Based on This Review for Ethiopia's Future Health Care Financing Strategies with Links to Relevant Global Experience

1. The government should update and develop a strategic vision and strategy for health financing over the next GTP period, with short (5 years), medium (10 years) and longer-term (20 years) perspectives. Ethiopia's health system has experienced much positive development but is also becoming more complex and diverse. This vision and strategy can incorporate estimates of possible resource mobilization scenarios over this period reflecting the effects of economic growth and social development and possible changes in the external resource mobilization scenario in the future. Attention should also be paid to changing organizational structures, such as the development of the Health Insurance Agency and it role in guiding new resource pooling arrangements as well as the structures in place that current handle Channel 2 and 3 resources at national and subnational levels. Guidance for the development and updating of payment and purchasing arrangements will also be more pressing in the future.

Box 9.1: Experience to Review and Develop Health Finance Strategies

WHO's 2010 World Health Report urges member states to assess their health financing arrangements and develop strategic planning for health financing. International organizations including the World Bank, GFATM, and GAVI are scaling up their efforts to assist countries in this endeavor.

Many lower and lower-middle income countries do not prepare very specific health financing strategies and plans, especially with quantitative estimates over the medium and longer-term range. In collaboration with development partners, more countries have prepared "medium term expenditure frameworks" (MTEF) for prospective period up to five years, in order to plan better the linkage between domestic and external resources.

Gottret and Schieber (2008) reviewed experiences of "good practice" in health financing in 9 countries that achieved progress in coverage. Successful health financing involves planning for pluralistic financing arrangements including government and non-government sectors and strategic plans to gradually expand coverage through both direct funding and subsidy arrangements. The report emphasize the following "enabling conditions":

- Robust economic growth during the bulk of the reform period;
- Long-term government environment;
- Strong institutional and policy environment;
- High population literacy levels;
- Rural focus;
- Coverage expansions accompanied by carefully sequenced and significant delivery systems (including human resources for health) and provider payment changes;
- Flexibility and mid-course corrections;
- Strong and explicit primary care focus; and
- Strong fiscal commitment to cover the poor.

Several countries are notable for having put in place strong strategic frameworks. Thailand and Mexico are two examples of strong progress towards UHC. South Africa has also recently developed a financing strategy with specific steps towards coverage expansion

2. Different resource mobilization strategies for strengthening domestic financing for health need in depth exploration and testing. Mobilizing a large amount of resources in the Ethiopian context will be very challenging in view of the limited fiscal space in the country and given the fact that health spending must compete with other uses of government resources. Government should examine options for increasing domestic budgets for health both through increased government resource mobilization overall and increasing the share of government spending to health, innovative financing mechanisms, and more detailed planning regarding the contributions to increasing government resources that could emerge from SHI and CBHI.

Box 9.2: Experience in Resource Mobilization Strategies

Increasing government budgets for health. Recent work by Tandon and Cashin (2010) and WHO (2010) explored in some detail the potential for increasing the "fiscal space" for health in the regular government budget. Strategies can include increasing tax efficiency; give higher priority to health in resource allocation decisions; increasing external resource flows; and efficiency gains.

As noted in Box 10.1, success in increasing the overall government resource envelope often depends on positive enabling conditions, many of which are present in Ethiopia.

Innovative Financing. Experiences from other countries shows that there is potential to generate additional resources by identifying new income sources, which can be specifically earmarked for health. Some possible sources could be excise tax or the so-call 'sin-tax' on chat, cigarette, alcohol, etc. Directing certain proportion of VAT to the health sector could be another option. A notable example is Ghana's allocation of a fixed percentage of VAT to support their national health insurance scheme.

Also, levying a certain percentage of tax on gross interest earning from saving deposits or dividend earning could be another source. The government could also consider levying tax on companies that do not meet certain level of emission standards according to emissions tests. This could meet multiples objectives such as improving environmental sustainability, creating a sense of social responsibility, making companies/individuals responsible for the health problems they create, and increasing resources for health at the same time.

However, experience around innovative financing mechanisms in lower-income countries is not very encouraging as a vehicle for raising sizable funds. A recent analysis in Kenya looking at potential new financing mechanisms to offset the possible decline in HIV/AIDS funding found that potential innovative financing mechanisms could contribute but not fully compensate fully the resource needs for that disease.

3. Need to strengthen pre-payment and risk pooling mechanisms to reduce OOPs. There is a need to reduce the OOPs at point of use in Ethiopia, and should be primarily driven by the social health and community based health insurance schemes. The CBHI pilot evaluation identified major gaps and recommendations for scaling-up the insurance scheme in order to move towards UHC by providing health insurance coverage to the informal sector. The implementation of design-related recommendations (e.g., establishing higher-level pools) is important to ensure the financial sustainability of CBHI. The government is finalizing the preparatory phase of implementing the social health insurance scheme. At this time, it is necessary to implement these two schemes separately until they are found to viable and the necessary systems are in place to integrate these two insurance schemes into one.

4. Ethiopia should strengthen its capacities to analyse health-financing requirements, implement new strategies, and monitor and evaluate progress in improving health financing. As noted above, the current institutional environment for work on health financing is complex, involving different departments within the FMOH and a number of committees engaging with both national and regional authorities. Much of the work to implement change falls on regional and woreda staff that may not have similar dedicated staff and capacities in this area. The recent development of the Health Insurance Agency, with sizable regional offices, has added further structure and also new requirements for capacity strengthening.

Much of the work carried out to date has also relied on externally-financed contractors — for example the excellent work done to produce a time series of national health accounts, or the technical support for the implementation of some of the strategies under the 1998 Health Care and Financing Strategy.

The FMOH should consider alternative mechanisms for developing these capacities in a sustainable institutional model that would support the FMOH going forward with concurrent efforts in regions. This could be a consolidated function within the FMOH, a quasi-government body affiliated with the FMOH, or a partnership with a university or institute outside government. It could be linked with broader health systems and policy functions of which financing plays a part. Support from an external partner could be mobilized for initial investment with a transition plan.

Box 9.3: Experience in Health Financial Analysis Capacity

There is no single model for carrying out these functions that stands out as uniquely successful. There are examples of strong health planning and policy departments within ministries of health, collaborations with universities and think tanks, and effective government contracting out of these functions under government supervision.

Some principles to consider include:

- Are employment conditions within government sufficiently attractive to recruit and maintain technically qualified staff that would specialize and gain experience in these areas?
- Can a capacity building plan be implemented over time that would provide both senior and junior staff?
- How can domestic capacities to train and upgrade staff be developed — should there be a health financing training function within government and affiliated institutions?
- Can some degree of independence be assured so that sounds and objective analysis is available?

5. Improve use of financial and non-financial incentives to improve efficiency, equity, and quality in health care delivery. Ethiopia's scale-up in health care delivery capacity has benefitted from a disciplined and committed public sector workforce. Under the 1998 strategy there have been some moves towards introducing flexible approaches to payment for services that encourage better productivity and quality. These include the retained revenues at health facilities, the paying wards in public hospitals, and the balanced scorecard mechanisms under business process re-engineering (BPR). Social Health Insurance and CBHI may also introduce new mechanisms and there have been on-going discussions about how Ethiopia should approach results-based financing methods in terms of possible compensation to individuals, facilities, woredas, and possibly even regions.

Box 9.4: Experience in Financial and Non-Financial Incentives

There has been growing interest in results-based financing (RBF) mechanisms for health programs led in part by the World Bank's Health Results Innovations Trust Fund. A significant number of countries around the world are experimenting with RBF-type innovations and carrying out evaluations. The World Bank maintains an excellent website with technical guidance and results of this work (**www.rbfhealth.org**).

RBF (and related terms like performance-based financing (PBF), pay-for-performance (P4P), etc.) cover a wide-range of different types of interventions. These can include both financial and non-financial incentives. They can include incentives to individuals, facilities, and administrative units of government. Generally financial incentives are built into a mixed payment model, with base levels of compensation supplemented by additional compensation based on achievement of agreed upon targets of output or outcome. Non-financial incentives can also be important, related to future study opportunities, transfers, etc.

There is evidence that RBF-type incentives can have a significant positive impact on productivity, efficiency, quality, and equity when properly designed and implemented. Overall, the evidence is somewhat mixed, with some positive results and some not so positive, which suggests that the impact depends on design, implementation, and context. Concerns about cost-effectiveness, sustainability, and consequences exist for other health program activities and general government staff performance.

Experience suggests that RBF can play a positive role in improving health services, but that attention should be paid to:

- Overall institutional context
- Organizational setting of health care delivery and effects of incentives on other health workers and staff
- Fiscal implications
- Need for strong and often external monitoring and evaluation

6. Defining Public private partnership. Although work is still occurring around how to define a clear PPP in Ethiopia, here we will highlight some of the most important preliminary recommendations from the PPP case study report produced by FMOH and HEPCAPS II (2015) that is still in draft form. First, it is critical to develop a clear standard operating procedure to guide PPPs in health. Second, the MOFED must prepare a national PPP legal framework, and to get it approved by the Government. Third, partnerships between government and private-for-profit facilities on specific programs, particularly HIV/ART and TB need to be structured, systematized, and fully led by government for sustained impact. Fourth, build strong structures from federal to woreda levels, and establish a unit dedicated to PPP at national, regional and possibly at woreda levels. Lastly, Government and stakeholders need to invest in building capacity of the private sector and government sector offices on PPP with particular attention to the design, management, monitoring, evaluation and review of contractual agreements and other types of public-private modalities.

Box 9.5: Experience with Public Private Partnerships

The potential for engaging the non-government sector in support of public goals in health has long been recognized and a focus of debate. Extensive resources on this subject can be found at HANSHEP (**www.hanshep.org**), Strengthening Health Outcomes through the Private Sector (**http://www.shopsproject.org/resource-center**) — USAID's flagship private sector in health project — and the Results for Development Institute's Center for Health Market Innovations (**http://r4d.org/focus-areas/center-health-market-innovations**).

While some oppose using government resources to finance the non-government sector on ideological grounds, the general consensus is that public-private partnerships can make useful contributions to access, quality, and equity when designed and managed well. There are many examples of different approaches such as:

- Contracting (government procurement of services from non-government actors through formal legal agreements), both to strengthen the functioning of government facilities (sometimes called "contracting in") as well as to augment government service delivery capacity or in some cases substitute for it (sometimes called "contracting out");
- Transactional arrangements to enable private financing and management of health services such as "build, operate, transfer" agreements;
- Social marketing (commodities) and social franchising (services) to increase access to desired inputs or interventions;
- Demand-side financing of non-government providers through mechanisms like vouchers.

(As reviewed by the HEPCAPS2 project, a number of examples of these can be found operating today in Ethiopia.)

One clear theme from international experience is that "the devil is in the details" when it comes to developing and managing successful PPPs — with success defined as having a net positive outcome on desirable public sector goals such as access, quality, and efficiency of services and overall outcomes in terms of health, financial protection, and patient satisfaction.

Sound design and implementation depends on:

- Good understanding of the dynamics of the supply and demand factors in markets for services identified for PPP approaches;
- Sufficient evidence on service costs and determinants of demand and utilization to design arrangements with non-government actors that are likely to be feasible and to produce positive results;
- Legal and regulatory foundations and technical capabilities in government agencies to design contracts, negotiate agreements, and monitor processes and results;
- Well-written contracts and agreements that enable non-government actors to make good use of their innovative capabilities to achieve results without overly intrusive conditions which can make them less effective;
- Flexibility to modify agreements and strategies as market conditions and government needs and capabilities evolve

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11. Annex 1: Details of Data Sources and Collection Method

Method of data collection	KII	FGD	Secondary data collection
Regional level	Heads of RHB/ Head of (Health Finance) Reform Core Process Head of BOFED Head, BOLSA Partners' Forum		BOFED RHB
	Grand Total = 21 Oromiya = 3 Amhara = 3 Addis Ababa = 3 B-Gumuz = 3 Afar = 3 SNNPR = 3 Tigray = 3		Grand Total = 14 Oromiya = 3 Tigray = 3 Addis Ababa = 3 B-Gumuz = 3 Somali = 3 SNNPR = 3 Amhara = 3
Woreda Level	Head of WorHO Head of WOFED	Community members –general Community members – fee waiver beneficiaries	WOFED WorHO
	Grand Total = 36 Oromiya = 6x2 = 12 Amhara= 6X2 =12 Addis Ababa = 2X2 = 4 B-Gumuz = 2X2 = 4 Afar= 2X2 = 4	Grand Total = 36 Oromiya = 6x2 = 12 Amhara = 6X2 = 12 Addis Ababa = 2X2 = 4 B-Gumuz = 2X2 = 4 Afar = 2X2 = 4	Grand Total = 36 Oromiya = 6x2 = 12 Amhara = 6X2 = 12 Addis Ababa = 2X2 = 4 B-Gumuz = 2X2 = 4 Afar = 2X2 = 4
Hospitals	CEO/GM	Management Board, Hospitals	CEO/GM (EHSP list) Finance and Administration Dept
	Grand Total = 21 Oromiya = 6x1 = 6 Tigray = 4x1 = 4 Addis Ababa = 3X1 = 3 B-Gumuz = 3x1 = 3 Somali = 3x1 = 3 Federal = 2x1 = 2	Grand Total = 21 Oromiya = 6x1 = 6 Tigray = 4x1 = 4 Addis Ababa = 3X1 = 3 B-Gumuz = 3x1 = 3 Somali = 3x1 = 3 Federal = 2x1 = 2	Grand Total = 42 Oromiya = 6x2 = 12 Tigray = 4x2 = 8 Addis Ababa = 3X2 = 6 B-Gumuz = 3x2 = 6 Somali = 3x2 = 6 Federal = 2x2 = 4
HC	Head	Management Committee	HC Head (EHSP list) Finance and Administration Dept
	Grand Total = 36 Oromiya = 12 Amhara = 12 Addis Ababa = 4 B-Gumuz = 4 Afar = 2	Grand Total = 36 Oromiya = 12 Amhara = 12 Addis Ababa = 4 B-Gumuz = 4 Afar = 2	Grand Total = 36 Oromiya = 12 Amhara = 12 Addis Ababa = 4 B-Gumuz = 4 Afar = 2
HP	HEW in charge		HEW in charge (EHSP list)
	Grand Total = 32 Oromiya = 12 Amhara = 12 Addis Ababa = 0 B-Gumuz = 4 Afar =4		Grand Total = 32 Oromiya = 12 Amhara = 12 Addis Ababa = 0 B-Gumuz = 4 Afar =4

12. Annex 2: List of Background Researches and Studies Conducted Before Launching HCFR

No.	Publication year	Publisher/Author	Title/Topic
1	2000, November	Jan Valdelin, Netsanet Walelign and Alan Fairbank	Private Expenditure Trends in Ethiopia and Implications for Health systems Financing (working paper 1)
2	2001, April	FMOH, HCF Secretariat	Estimating Willingness to Pay for Health Care in Ethiopia: research results and analysis (study report 3)
3	2001, September	Alan Fairbank	Improving the quality of Service and Adjusting User Fees at Ethiopian Government Health Facilities: estimating the potential impacts of implementing various options (working paper 3)
4		FMOH, HCF Secretariat	Health Care Delineation Study
5		WHO and FMOH, HCF Secretariat	Contracting in Ethiopia
6	2002, January	Netsanet Walelign and Yasmin Yusuf	Special Pharmacies: Opportunities, Challenges, and the Way forward (working paper 2)
7	2003, March	FMOH, HCF Secretariat	NGO Involvement in the Ethiopian Health Sector: facts, challenges and suggestions for collaborative environment (study no. 8)
8	2003, June	FMOH, HCF Secretariat and Health Finance Team, ESHE Project	Targeting Health Services in Ethiopia: a proposal for improving fee waiver and exemption systems
9	2003	FMOH, JSI and Abt Associates Inc	The Role of Increased Financing for Improving Quality of Health Care: evidences from multi-dimensional HCF studies in Ethiopia
10	2003	Netsanet Walelign and Yasmin Yusuf	Special pharmacy: Successes and Challenges
11		FMOH, HCF Secretariat and Health Finance Team, ESHE Project	Pre-feasibility of CBHI
12		FMOH, HCF Secretariat and Health Finance Team, ESHE Project	Experience of Revenue Retention among hospitals in SNNPR
13		FMOH, HCF Secretariat and Health Finance Team, ESHE Project	Unit Costing of Services as a background to user fee revision
14		FMOH, HCF Secretariat and Health Finance Team, ESHE Project	A discussion paper reviewing the concepts and principles of health insurance and prepayment in developing countries
15		FMOH, HCF Secretariat and Health Finance Team, ESHE Project	In-depth survey of current patterns in the supply, distribution, prescription, dispensing, and use of drugs;
16		FMOH, HCF Secretariat and Health Finance Team, ESHE Project	Assessment of the private for profit sector in financing and delivery of health service

[1]Resources channelled from DPs through NGOs, plus some of the USG's implementing partners' activities, are not on-plan.