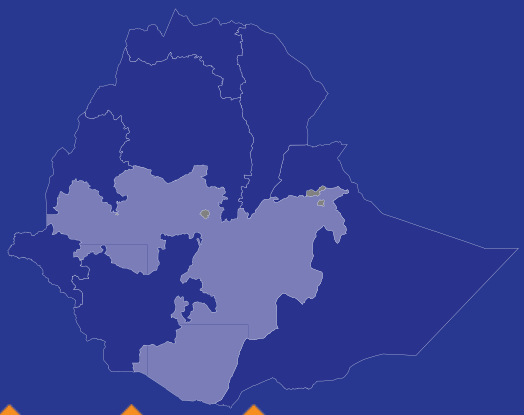
REGIONAL BRIEF



# HSFR/HFG End of Project Achievement Highlights - Oromia

*The USAID-funded HSFR/HFG project provides technical assistance to the Government of Ethiopia to implement and scale-up health care financing reforms across the country. The goal is to increase access to and utilization of health services through improved quality of health care and reduced financial barriers.*

*Project objectives are to:*

- *Improve the quality of health services*
- *Improve access to health services*
- *Improve governance of health insurance and health services*
- *Improve program learning*

June 2018

## THE REGIONAL CONTEXT

Oromia is the largest of Ethiopia's nine regional states, accounting for about 30 percent of the country's total land mass. The Ethiopian Central Statistics Agency estimates its population at 36.8 million, about 85 percent of whom reside in rural areas. Oromia is divided into 20 zonal administrations and 20 urban centers, and has 333 woredas.

About 20 years ago, service coverage and the quality of health services in Oromia was very low. There were only 21 public hospitals and 135 health centers in the region, which were not sufficient to meet the demand for the then 24.4 million residents. Today, there are 79 hospitals, 1,383 health centers, and 6,797 health posts in Oromia.

Like other regions in the county, the health care system in Oromia has faced many challenges:

- Limited budget allocation from the government to the health sector.
- Inefficient and inequitable use of health resources. Resources were allocated mostly to hospitals, which were geographically remote for the majority of the rural population and which focused on providing expensive curative services.
- Inequitable financing arrangements whereby people paid the same user fees irrespective of their ability to pay, and poor households were denied access due to prohibitive user fees.
- Burdensome, high out-of-pocket payments for health care by the majority of the population at the time of illness.
- Poor health service quality due to shortages of medical equipment, drugs, and medical supplies, and consequently, lack of modern and improved health care services.

To address health sector financing challenges, in 1998 the Federal Democratic Republic Government of Ethiopia approved a health care financing (HCF) strategy that calls for increasing financial resources available for the health sector. Following development of the national strategy, the Oromia regional government put in place the required legal frameworks to guide their implementation, including: Health Service Delivery and Administration (HSDA) Proclamation No.93/2005, HSDA Regulation No. 56/2005, and HSDA Directive No. 001/2007.

The Health Sector Finance Reform/Health Finance and Governance (HSFR/HFG) project has since 2013 provided technical support to the Oromia regional health bureau (RHB), Ethiopia Health Insurance Agency branch offices, woreda administrations, woreda health offices (WorHOs), community-based health insurance (CBHI) schemes, and health facilities in the design, legislation, implementation, and evidence generation of these reforms. Project support included: capacity building such as training the leadership and staff at various levels of the regional government; integrated supportive supervision and mentoring; assistance with adaptation and revision of legal frameworks and implementation guidelines; material support such as provision of motorcycles and computers to CBHI schemes; evidence generation through standardization of data collection instruments and collection, compilation, and analysis of data; and strengthening of governance and networking through review meetings, experience-sharing visits, and high-level conferences and workshops.

# MAJOR ACHIEVEMENTS

## Revenue retention and utilization

This reform allows hospitals and health centers to collect and retain revenue generated at the facility rather than remitting it to the government treasury, and to use this revenue to make improvements in provision of quality health services. Revenue sources include consultation fees, sales of drugs and medical supplies, fees for diagnostics and inpatient services, sale of used materials, cash and in-kind donations, and revenue from research and training services.

HSFR/HFG technical support to local stakeholders in implementing this reform included: revising the HSDA directive in areas such as fixing the meeting frequency of health facility governing bodies, systematizing in-kind community contributions to maternal services, and limiting the number of health facilities a governing board could supervise; advocating for and supporting the government in putting in place the required structure for health facilities to have finance and procurement departments and in recruiting key finance staff for health facilities; technical assistance to health facilities and WorHOs in the revenue retention and utilization (RRU) planning and budgeting process; training more than 600 health facility key finance staff on financial management; and on-site technical support during supportive supervision visits. Moreover, HSFR/HFG contributed to institutionalization of reform by supporting integration

**Shashemene Referral Hospital uses retained revenue to improve quality of health services and achieve 96 percent drug availability**

Shashemene Hospital used retained revenue to ensure it had a reliable alternative water supply to the frequently interrupted municipal water. The hospital spent over 100,000 birr on labor and materials to lay pipes to access water from a spring 11 kilometers away and install water tanks. The now-reliable water supply has improved hospital sanitation and hygiene. The hospital also allocated 4 million birr to co-finance the construction of a new building for a surgical ward and to buy equipment such as operating tables, oxygen concentrators, and suction machines. It used 456,000 birr of retained revenue to equip a pediatric ward with 30 new beds, an infant weight scale, a pediatric weight scale, and incubators. Drugs and medical supplies typically consume 70 percent of the hospital's retained revenue. By using retained revenue to purchase the drugs it needs, the hospital has achieved 96 percent drug availability in the hospital dispensary (see picture).

of the RRU processes within government finance rules and procedures, by advocating for the creation of budget codes for health facilities, which promotes transparency in budget allocations (in contrast to former lump-sum budget allocations to facilities, enabling those with more information and capacity to consume the bulk of the budget and leaving others underfunded), and advocating for regular auditing of facilities by the woreda finance and economic development office.

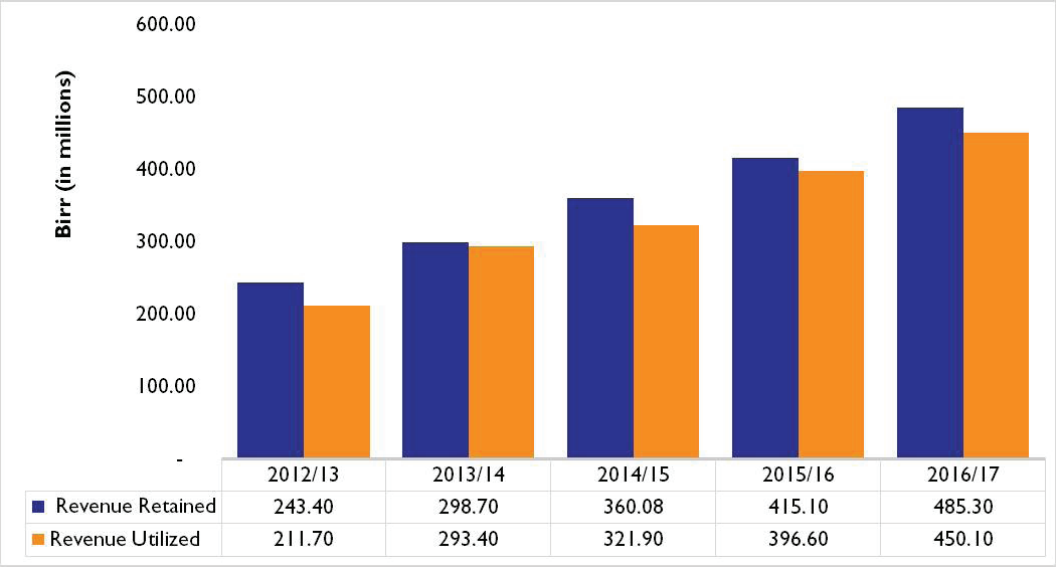
The percentage of health facilities implementing the RRU reform increased from 90 percent at the beginning of HSFR/HFG in 2013 to 100 percent at the project end in 2018..

Figure 1 shows the amount of birr retained and used by health facilities in Oromia over the last five years. There has been a steady increase in the amount of both variables, with 1.8 billion birr collected and 1.67 birr billion utilized over the period. The amount of revenue that health facilities retained doubled from 2013/14 to 2016/17, and the amount they used more than doubled. The annual utilization rate of retained revenue by health facilities is about 93 percent

Retained revenue is being used in Oromia to improve the quality of health care service delivery:

- Data from the region's Bureau of Finance and Economic Cooperation indicates that about 70 percent is used to improve the availability of drugs, medical equipment, and supplies.
- Many health facilities are using retained revenue to purchase modern medical equipment, procure and install generators to ensure sustained power supply, and develop infrastructure such as constructing new examination rooms or improving water supply.
- Health management information systems are being strengthened in some hospitals by using retained revenue to purchase computers or pay for internet connectivity.
- Within the scope of the HSDA directive of the region, retained revenue is being used to finance operational costs because the budget allocated from treasury usually covers little more than salaries, especially in the case of health centers.
- Retained revenue is playing a role in the region's and the nation's effort to achieve universal health coverage through primary health care. It strengthens the capacity of health posts, which focus on delivering preventive and promotive health services. Each health center supports 4–5 health posts by supplying educational materials, essential kits and medical supplies, and inputs to sustain the cold-chain system of the health posts.

## Figure 1. Trend in retained revenue collection and utilization




| | 2012/13 | 2013/14 | 2014/15 | 2015/16 | 2016/17 |
|---|---|---|---|---|---|
| Revenue Retained | 243.40 | 298.70 | 360.08 | 415.10 | 485.30 |
| Revenue Utilized | 211.70 | 293.40 | 321.90 | 396.60 | 450.10 |

## Health facility governance

The Ministry of Health's health facility governance reform allows for increased health facility autonomy through the establishment of governing bodies at health facilities to contribute to the proper and timely use of facility resources and respond to client needs. Called "governing boards" at hospitals and "management committees" at health centers, these governing bodies are mandated and authorized to ensure that facilities are fully implementing HCF reforms, are offering the best patient care possible, and are functioning efficiently and effectively. This reform is considered critical because its implementation impacts the proper implementation of the other reforms, including RRU, which is intended to improve quality of services.

HSFR/HFG supported Oromia regional government efforts to implement governance reform. This included advocating to all stakeholders on the importance of the governing bodies, and providing training on the objectives, implementation procedures, and monitoring and review mechanisms of the reform in order to strengthen governing body capacity.

Since HSFR/HFG began, the number of health facilities with functional governing bodies has increased from about 46 to 79 boards in hospitals and from 1,220 to 1,383 management committees in health centers (i.e., to all the region's facilities). It has provided training for more than 1,700 board members on the concept and rationale of HCF reforms, on the main provisions of the law (HSDA proclamation, regulation, directive, and manuals), and on the roles and responsibilities of board members.

The project has actively supported the regional government in revising the HSDA directive to include new developments/ changes such as defining the number of health facilities that are under the stewardship of a board, defining the frequency of meetings required from a board, and other measures needed for effective operation of the board.

### Health Services in Bishoftu Hospital

Bishoftu Hospital is a general hospital located about 47 kms from Addis Ababa. The hospital serves about 1.2 million people. It was once known for its poor management, and lack of major laboratory and other essential diagnostic services. These resulted in public demonstrations against the hospital in 2007, during which the community requested the hospital to either provide proper services or shut down. The hospital began implementing HCF reforms in 2008 and put in place a governing board with representatives from relevant government offices and from the community.

Building on the work and momentum of earlier USAID-funded projects, HSFR/HFG provided technical supports to Bishoftu Hospital over the last five years. This included: training governing board members on HCF reforms and their duties and responsibilities as board members; training hospital finance staff on financial management; supporting the hospital to enter into a contract agreement to provide services to CBHI beneficiaries; and facilitating review meetings with the CBHI schemes.

*Bishoftu Hospital's new 80-bed ward constructed with retained revenue*

Under the strong leadership of its board, Bishoftu Hospital has made significant achievements in implementing HCF reforms and improving the quality of its service delivery. The board oversees health services and decides on the sequencing and implementation of reforms, such as using retained revenue, establishing private rooms, and outsourcing non-clinical services.

The hospital was able to retain and use an average of about 7.9 million birr per year over the last five years, increasing from 5.8 million birr in 2013 to 9.6 million birr in 2017. The hospital spends more than 70 percent of its retained revenue to improve availability of drugs, medical supplies, and medical equipment. The hospital improved its pharmacy and drug availability, and purchased operating room tables, an automated physiotherapy machine, laundry machines, and a generator. Additionally, it improved the water supply, and built a multi-purpose meeting hall, a library, and a new ward with 80-bed capacity.

# Community-based health insurance

To address high out-of-pocket spending for health services, a major financial barrier to care seeking, and to generate more resources for the health sector in the long term, the Ethiopian government piloted and scaled up CBHI for citizens in the agricultural and informal sectors.

HSFR/HFG supported the regional government in developing and adapting the CBHI directive, manuals and bylaws. It also provided training to RHB, woreda administration, WorHO, and CBHI scheme staff, and to woreda and kebele cabinet members on: the concepts and principles of CBHI, the design parameters of CBHI, implementation procedures and practices, CBHI financial management, and program monitoring, review, and reporting requirements. Further, the project supported the RHB in organizing high-level conferences that were important for advocating for CBHI to key stakeholders in the region. Project engagement with regional media and community mobilization initiatives helped explain and build membership in CBHI. Supportive supervision also helped build implementation capacity and track performance.

HSFR/HFG supported the regional government and woreda administrations to mobilize eligible households to enroll as paying households or by government subsidy, and health facilities to enter into contract agreements with CBHI schemes to provide health services to CBHI beneficiaries.

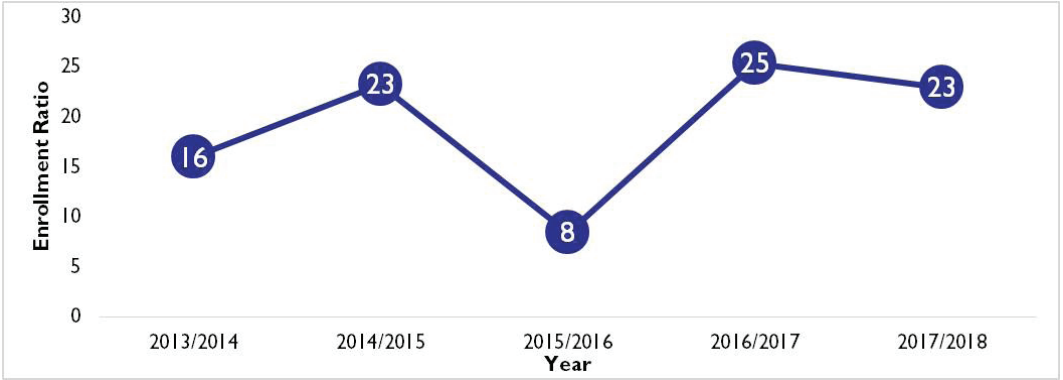
## POPULATION COVERAGE

The implementation of CBHI in Oromia started in 2011 in four pilot woredas: Deder Gimbichu, Kuyu, and Limo Kosa. Based on the findings of the pilot evaluation conducted by HSFR/HFG, the project supported the regional government to scale up CBHI to about 197 woredas by 2018. CBHI now reaches 59 percent of the woredas in the region. The Ethiopian government's Health Sector Transformation Plan sets forth a target of covering 80 percent of the woredas by 2020. With 197 of its 333 woredas currently covered by CBHI, the region is working towards achieving this target.

In terms of uptake by the community, CBHI membership in the region has increased nearly fivefold over the past five years, from 21,478 households in 2013/14 to about 1 million people in 2017/18. Figure 2 shows the trend in the enrollment ratio in the region's CBHI-implementing woredas. CBHI enrollment increased except in 2015/16 due to political and security instability in the region, high turnover of government officials, and lack of awareness about the benefits of the program and about their roles and responsibilities related to CBHI, particularly by lower-level leadership in the region.

The highest average enrollment rate of 25 percent, in 2016/17, is far less than the minimum target of 60 percent set for the region in the regional plan. The total number of CBHI beneficiaries in 2017/18 are estimated to be over 4.8 million, 15 percent of Oromia's entire population, which also is behind the target of enrolling 80 percent of the population by 2020. On average, 67 percent of enrolled households are paying members and the rest are the poorest of the poor/ indigents who are covered under the program by a targeted subsidy. While the proportion of indigent households appears to be high, this imbalance is due to the low number of paying households enrolled.

Figure 2. Regional CBHI enrollment rate by year



## RESOURCE MOBILIZATION

The major sources of revenue for the CBHI schemes as outlined in the regional directive include contribution from households, the targeted subsidy from the woreda administration for poor households, and the general subsidy from the federal government for the CBHI schemes. The magnitude of resources mobilized through CBHI schemes has increased significantly with more woredas implementing the program and an increasing number of households enrolling in schemes.

Figure 3 shows the amount and trend of resources mobilized from member contributions and the general and targeted subsidies transferred from government. Since 2013/14, the total amount of resources mobilized increased from CBHI schemes in Oromia increased from 6.2 million birr in 2013/14 to 221.0 million birr in 2016/17. This represents a 360 percent increase mainly because of the significant increase in the number of woredas implementing the program. In the first nine months of 2017/18, the amount of resources mobilized is only 7.02 million birr. This amount is expected to increase significantly as the community mobilization work has been extended to compensate for time lost to political instability and security problems that the region has experienced since 2015/16.

Out of the total CBHI resources mobilized over the past five years, the contribution collected from paying members was about 255.07 million birr while total allocations from regional and woreda administrations in the form of targeted subsidy was about 171.6 million birr. The general subsidy, which is a matching contribution by the federal government to schemes, was about 40.3 million birr. This is expected to increase when the general subsidy for 2017/18 due in July 2018 is released to CBHI schemes.

Of the total revenue mobilized, member contributions account for 54 percent and targeted subsidy and general subsidy for 37 percent and 9 percent, respectively (Figure 4).

Figure 3. Number and percentage of CBHI woredas

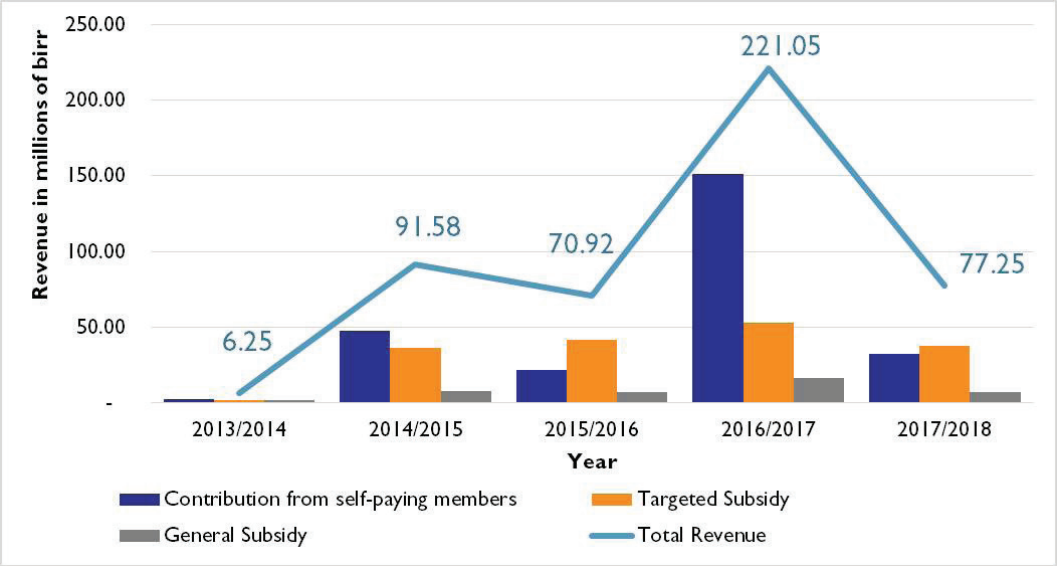
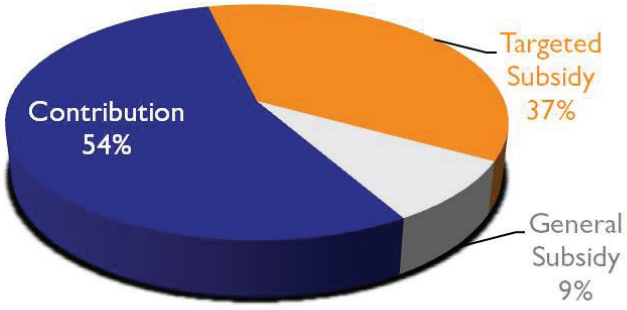



Figure 4. Total CBHI revenue moblized by source



## HEALTH SERVICE UTILIZATION

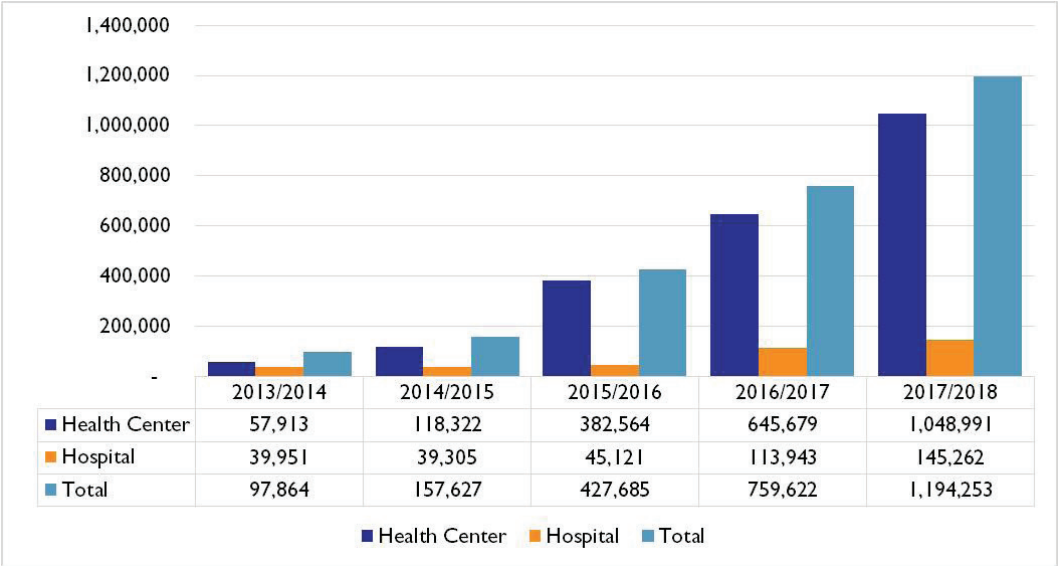
A primary goal of CBHI is to increase people's utilization of health services. To facilitate this, CBHI schemes enter into contractual agreements with public hospitals and health centers. Schemes make reimbursement to the contracted health facilities on a quarterly basis.

With respect to the CBHI goal of increasing utilization, the trend in total number of visits has been positive. As Figure 5 shows, the number of facility visits made by CBHI beneficiaries increased from 97,864 in 2013/14 to about 1.2 million thus far in 2017/18. This represents an a more than 12-fold increase, mainly due to the increased number of CBHI beneficiaries following scale-up to many woredas in the region.

Most of the increase in health visits (85 percent) has been to health centers; the remaining 15 percent was at hospitals. This ratio is in line with Ethiopia's prevention-focused health policy that requires all first-time visits to be at the primary health care level.

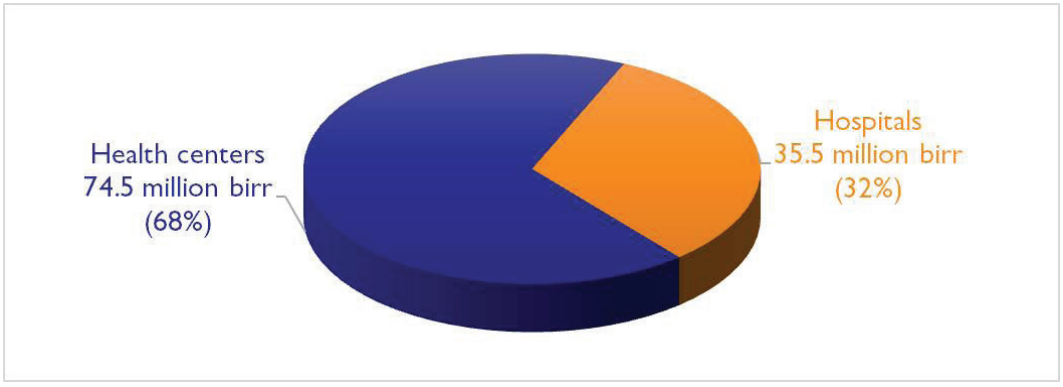
Figure 6 breaks down the resource flow by type of facility over the five-year period. As shown, higher-level facilities (hospitals) get nearly 32 percent of the reimbursements (35.5 million birr). Given the high cost of hospital services, this proportion of resource flow relative to the proportion of visits is acceptable. The remaining 68 percent of resources (74.5 million birr) was reimbursed to health centers.

### Figure 5: Number of CBHI visits by year and facility type




| | 2013/2014 | 2014/2015 | 2015/2016 | 2016/2017 | 2017/2018 |
|---|---|---|---|---|---|
| Health Center | 57,913 | 118,322 | 382,564 | 645,679 | 1,048,991 |
| Hospital | 39,951 | 39,305 | 45,121 | 113,943 | 145,262 |
| Total | 97,864 | 157,627 | 427,685 | 759,622 | 1,194,253 |

### Figure 6. Proportion of CBHI reimbursements by facility type



# LESSONS LEARNED

Key lessons learned from the implementation of HCF reforms in Oromia are as follows:

- Political commitment and strong leadership is the major driver of successful reform implementation. The Gimbichu CBHI scheme, one of the most successful CBHI schemes in the region, is a good example of this. The woreda administration provides strong support to the CBHI program by integrating community mobilization efforts into the woreda planning process and including CBHI in the supervision checklist used by woreda officials. The woreda CBHI board regularly reviews scheme performance. There is good distribution of CBHI identification cards to most members and particularly the indigent, As a result, CBHI enrollment and re-enrollment levels are high: the woreda has been able to sustain a nearly 70 percent CBHI enrollment ratio, above the minimum threshold required by the regional directive.
- Active community inclusion and involvement in the reform process is essential to build community ownership of the program. Community representation on health facility governing boards and management committees, and in the CBHI general assembly (the highest level of the CBHI governing structure; the general assembly approves scheme plan and performance reports) is vital to improving the accountability of schemes to communities and to enhancing sustainability.
- As health facilities mobilize and control greater and greater amounts of financial resources, attention needs to be given to how those resources are used.
- Focused technical support to enhance the capacity of implementers at regional, zonal, woreda, and kebele levels is required to ensure continuity of the results gained so far. Given the number of health facilities in Oromia, the frequent turnover of staff, and the relative newness of the CBHI program, it is important to continue supporting the regional government in HCF reform implementation.

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A flagship project of USAID's Office of Health Systems, the Health Finance and Governance (HFG) Project supports its partners in low- and middle-income countries to strengthen the health finance and governance functions of their health systems, expanding access to life-saving health services.
The HFG project is a six-year (2012-2018), $209 million global health project. The project builds on the achievements of the Health Systems 20/20 project. To learn more, please visit www.hfgproject.org.
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