ETHIOPIA HEALTH SECTOR FINANCING REFORM /
HEALTH FINANCE AND GOVERNANCE (HSFR/HFG) PROJECT

END-OF-PROJECT REPORT

2013 – 2018

June 2018
This publication was produced for review by the United States Agency for International Development. It was prepared by Health Sector Financing Reform/Health Finance and Governance (HSFR/HFG) Project, a technical assistance program to support the Government of Ethiopia. HSFR/HFG is managed by Abt Associates. The project is funded by the United States Agency for International Development (USAID) under cooperative agreement AID-OAA-A-12-00080.

The Health Finance and Governance Project
USAID's Health Finance and Governance (HFG) project will improve health in developing countries by expanding people's access to health care. Led by Abt Associates, the project team will work with partner countries to increase their domestic resources for health, manage those precious resources more effectively, and make wise purchasing decisions. As a result, this five-year, $209 million global project will increase the use of both primary and priority health services, including HIV/AIDS, tuberculosis, malaria, and reproductive health services. Designed to fundamentally strengthen health systems, HFG will support countries as they navigate the economic transitions needed to achieve universal health care.

Cooperative Agreement No: AID-OAA-A-12-00080

Submitted to: Dr. Helina Worku
A/Team Leader for Health System Strengthening Team
United States Agency for International Development/Ethiopia

Subrata Routh
Senior Health Financing Advisor

Scott Stewart, AOR
Office of Health Systems
Bureau for Global Health

Recommended Citation: Ethiopia Health Sector Financing Reform/Health Finance and Governance Project. June 2018. *Ethiopia Health Sector Financing Reform/Health Finance and Governance (HSFR/HFG) Project: End-of-Project Report*. Rockville, MD: Health Finance and Governance Project, Abt Associates.

Photo credits:
Cover and pages 7, 12, 16, 17, 25, 26, 27b by Ayenew Haileselassie, HSFR/HFG project.
Pages 13, 24 by Habtamu Bogale, HSFR/HFG project.
Pages 1, 2, 5, 10, 18, 21, 23, 27a by Gonzalo Guajardo for Communication for Development Ltd.

Abt Associates Inc. | 6130 Executive Boulevard | Rockville, MD 20852
T: 301.347.5000 | F: 240.767.6178 | www.abtassociates.com

| Avenir Health | Broad Branch Associates | Development Alternatives Inc. (DAI)
| Johns Hopkins Bloomberg School of Public Health (JHSPH) | Results for Development Institute (R4D)
| RTI International | Training Resources Group, Inc. (TRG)

ETHIOPIA HEALTH SECTOR FINANCING REFORM/ HEALTH FINANCE AND GOVERNANCE (HSFR/HFG) PROJECT

END-OF-PROJECT REPORT

2013 – 2018

CONTENTS

ACRONYMS

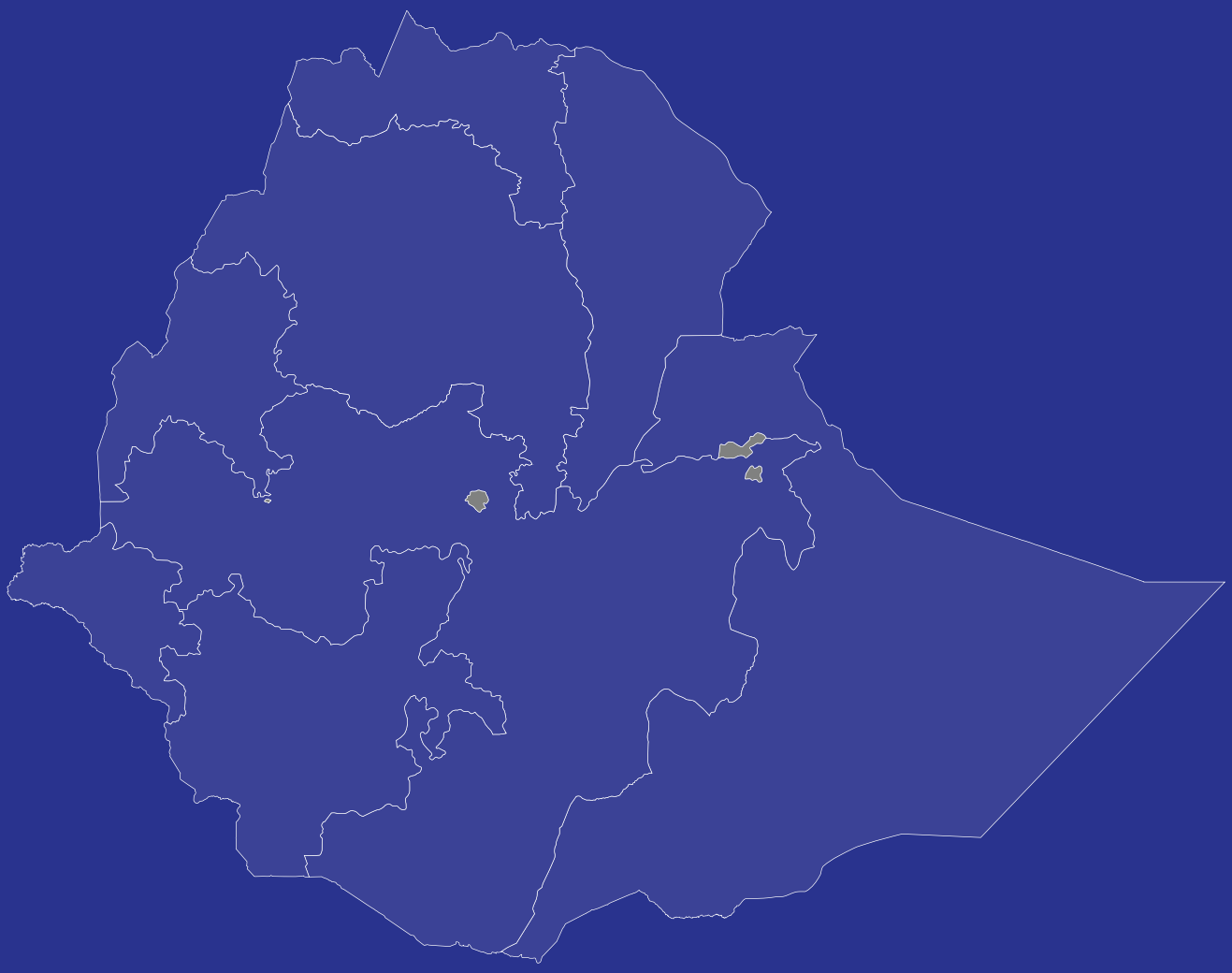
CBHI	Community-Based Health Insurance
COP	Chief of Party
DCOP	Deputy Chief of Party
DDCA	Dire Dawa City Administration
EHIA	Ethiopian Health Insurance Agency
FMOH	Federal Ministry of Health
GoE	Government of Ethiopia
HCF	Health Care Financing
HEFA	Health Economics and Financing Analysis
HSFR/HFG	Health Sector Financing Reform/Health Finance and Governance Project
M&E	Monitoring and Evaluation
RHB	Regional Health Bureau
RRU	Revenue Retention and Utilization
SHI	Social Health Insurance
SNNP	Southern Nations, Nationalities, and Peoples' Region
USAID	United States Agency for International Development
WorHO	Woreda Health Office

ACKNOWLEDGMENTS

This report describes the main results of the Ethiopia Health Sector Financing Reform/Health Finance and Governance (HSFR/HFG) project. HSFR/HFG appreciates the generous support, collaboration, and contributions of the many counterparts and stakeholders who contributed to project success. We gratefully acknowledge the financial support and technical leadership provided by the United States Agency for International Development (USAID) in Ethiopia, and in particular the USAID Health, AIDS, Population and Nutrition office's Health Systems Strengthening Team. The driving force behind HSFR/HFG achievements was the Government of Ethiopia and its Federal Ministry of Health, and we extend our thanks to government counterparts at the central, regional, zonal, woreda, and kebele levels. Also fundamentally important was the Ethiopian Ministry of Finance and Economic Cooperation, and we are grateful for their collaboration and contributions at all levels of the government system. Finally, we acknowledge the HSFR/HFG project site and home office teams for their expertise and professionalism.

In addition, we thank the following organizations and programs, which over five years of project implementation, provided collaboration and inputs that helped HSFR/HFG to realize its ambitious goals:

- Bill and Melinda Gates Foundation
- Breakthrough International Consultancy
- Clinton Health Access Initiative
- Development Alternatives Inc.
- John Snow Inc.
- Johns Hopkins University School of Public Health
- Management Sciences for Health
- Pathfinder International
- Results for Development
- The World Bank
- U.K. Department for International Development
- UNICEF
- World Health Organization



INTRODUCTION

The United States Agency for International Development (USAID) has supported the Government of Ethiopia (GoE) through the Federal Ministry of Health (FMOH) in the implementation of health care financing (HCF) reforms for two decades – ever since the FMOH developed its Health Care Financing Strategy (1998) to improve and diversify resource mobilization for health care, ensure equitable and efficient resource allocation and use, and secure financial protection for its citizens. The two most recent USAID projects have been the bilateral Health Sector Financing Reform (HSFR) project, which ended on July 30, 2013, and the Health Sector Financing Reform/Health Finance and Governance (HSFR/HFG) project, the subject of this end-of-project report. The continuation of HSFR through the HFG global project represented a continuation of USAID support for HCF reform in Ethiopia and was designed to build upon the success and lessons of earlier efforts. Its tenure is August 1, 2013–September 29, 2018; and it received $36,645,661 in committed funding across the life of the project.

This end-of-project report summarizes HSFR/HFG performance and results achieved with the collaboration of the GoE and local counterparts from project start in August 2013 through March 2018 (or most recently available data). The next section provides context about the challenges faced by the Ethiopian health sector, the GoE HCF reforms put into place in response, and HSRF/HFG goals, objectives, expected results, implementation strategies, and staffing and structure. Section 3 presents overall project performance against expected results, and results and achievements by project objective. The report closes with discussions of the challenges and lessons learned from five years of implementation, and how HSFR/HFG contributed to the sustainability of HCF reform.

CONTEXT

CHALLENGES

Over the last two decades, Ethiopia has made impressive progress in strengthening many aspects of its health system, including improving governance, increasing access to health services, strengthening HCF mechanisms, and increasing the availability of human resources for health.

These improvements have contributed to the country's remarkable progress in reducing infant and under-five mortality rates in recent years. The proportion of children who died before their first birthday decreased from 97 to 48 per 1,000 live births between 2000 and 2016. Similarly, the proportion of children who died before their fifth birthday decreased from 166 to 67 per 1,000 live births during the same time period.[1]

Despite these improvements, many challenges remain. When HSFR/HFG began in 2013, life expectancy was one of the lowest in the world and communicable diseases and nutrition-related disorders were major health burdens. In addition, although declining, maternal and under-five mortality rates were high.

Another challenge was health financing. Per capita health spending in 2010/11 was only $20.77 per year, about one-third of which was out-of-pocket expenditure. The high out-of-pocket costs often made care seeking prohibitive for households, or proved catastrophic or impoverishing for those who did access health services. In addition, health facilities had inadequate budgets, leading to a lack of diagnostic equipment, drug shortages, and facilities in need of repair. These problems contributed to the low quality, availability, and utilization of health services.

[1] *Central Statistical Agency (CSA) [Ethiopia] and ICF. 2016. Ethiopia Demographic and Health Survey 2016: Key Indicators Report. Addis Ababa, Ethiopia, and Rockville, Maryland, USA.*

Ethiopia's Health Care Financing Reforms

- **Revenue retention and utilization:** Allows public hospitals and health centers to use the fees they collect from patients and other sources of revenue to improve the quality of services, rather than remitting the revenue to the treasury. The increased funding at the health facility level allows for improvements in areas such as infrastructure, utilities, and the procurement of medical equipment, supplies, and medicine.
- **Facility governance:** Establishes and operationalizes governing boards in hospitals and management committees in health centers to provide overall direction and oversight of health facilities. 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, effectively, and economically. Board/committee members represent local government agencies, facility management, health workers, and the community.
- **Establishment of a private wing in public hospitals:** Allows public hospitals in most regions and at the federal level to open and operate a private wing to generate revenue from patients who are willing to pay higher, or relatively close to market rates for health services. The primary objective of this revenue, some of which is paid to hospital physicians, is to improve health worker retention. The reform also provides alternatives and choices to private health service users and generates additional income for health facilities to use for service delivery improvements.
- **Outsourcing of non-clinical services:** Encourages public hospitals to outsource non-clinical services such as laundry, security, and catering by contracting with local vendors that have a comparative advantage in providing these services. The goal is to improve hospital efficiency and reduce the burden on hospital management teams.
- **Systematizing fee waiver system and standardizing the package of exempted services:** Minimizes financial barriers and ensures that the poorest segments of the population have access to the full range of health services offered through the public system. Ethiopia institutionalized mechanisms to provide services to the poor free of charge through a fee waiver system and to all citizens through exemptions from fees for certain critical public health services (health education and treatment of tuberculosis patients, immunization of children under the age of five). The reform includes systematizing the fee waiver system, including the identification and certification of those who are eligible, to reduce inequities in access to health care across regions. The package of exempted public health services is standardized to prevent variation among facilities and enhance equity in access.
- **Introducing and expanding health insurance:** To address the issues of high out-of-pocket spending for health services and financial barriers to care, and to generate more resources for the health sector over the long run, the GoE piloted and is scaling up CBHI for citizens in the agricultural and informal sectors, and is undertaking preparatory activities to launch payroll-based SHI for Ethiopians working in the formal sector.

CHANGE

To address these challenges, the GoE introduced a range of HCF reforms aimed at increasing the availability of resources for health as well as protecting the population from prohibitive user fees or catastrophic spending at time of sickness. Reform design and initial implementation began before 2013; however, two regions and new health facilities in the starter regions, had yet to start implementing reforms. There was a need to strengthen and expand implementation across the seven regions and two city administrations already implementing reforms and to expand reforms into the Afar and Somali regions.

HSFR/HFG GOAL, OBJECTIVES, AND EXPECTED RESULTS

Since 2013, HSFR/HFG has assisted the GoE and other partners to address these pressing challenges and to further expand and improve implementation of HCF reforms across the country. HSFR/HFG was designed with the overall goal of increasing access to and utilization of health care services by providing technical assistance to HCF reforms and interventions that improve the governance and quality of health services and reduce financial barriers. Specific project objectives were:

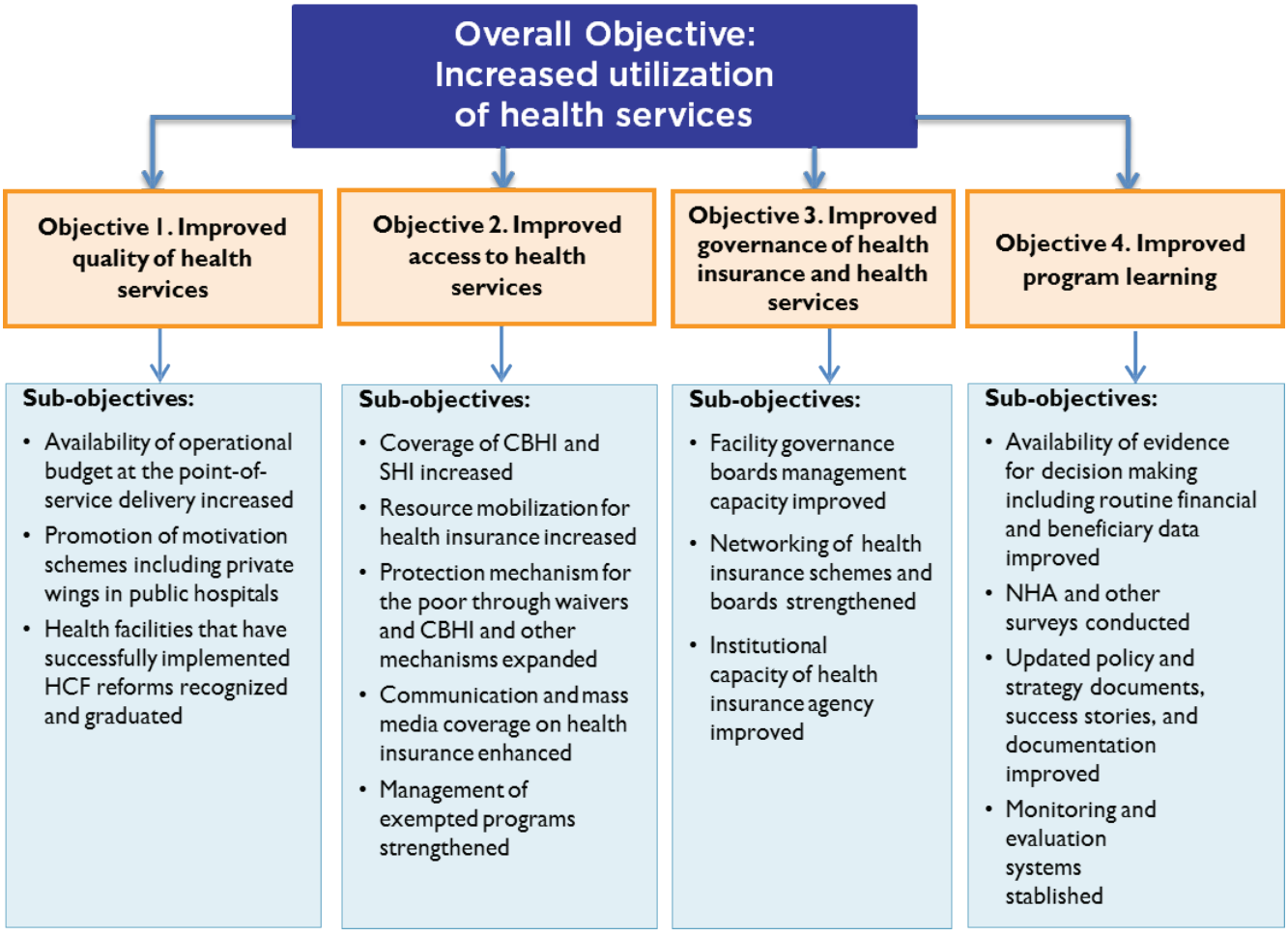
- Improved quality of health services;
- Improved access to health services;
- Improved governance of health insurance and health services; and
- Improved program learning.

The HSFR/HFG results framework, maps the project's objectives and sub-objectives.

In addition HSFR/HFG was designed to contribute to the achievement of five expected results by the end of the project:

- Health service utilization increased in 174 (13 pilot and 161 second phase) CBHI woredas (districts) from the current 0.3 to 0.6.
- Health facilities managed with boards where communities are represented increased to 90 percent.
- Public health facilities retaining and using their revenue increased to 90 percent.
- Share of out-of-pocket expenditures in CBHI pilot woredas to total health spending reduced from the baseline of 37 percent to 30 percent.
- Proportion of people enrolled in health insurance increased from one percent to 20 percent.

HSFR/HFG Project Results Framework



IMPLEMENTATION STRATEGIES

The key implementation strategies that HSFR/HFG used to achieve its objectives and expected results were as follows:

- Work through established public sector structures and build local institutional capacity.
- Hold ongoing policy dialogue and engage stakeholders in implementation of HCF reforms and prioritization of HCF interventions.
- Build the capacity of health sector finance personnel and other key stakeholders at all levels, along with Ethiopia Health Insurance Agency (EHIA) and CBHI schemes.
- Update and customize training materials, including curriculum, in collaboration with the FMOH, regional health bureaus (RHBs), universities, and training institutions.
- Bring international expertise, from the HFG partnership and beyond, to the provision of technical support for health insurance.
- Provide systematic program learning for policy development, through evidence generation and use.
- Partner with other donor-funded health sector partners and projects to create synergy and to leverage resources.
- Networking and experience sharing among providers and insurance scheme representatives.
- Work to transition project activities to GoE counterparts to oversee and implement.

STRUCTURE AND STAFFING

Project organization

HSFR/HFG was organized to facilitate work in Ethiopia's decentralized health system. Its significant in-country presence provided support at all levels of the health system through a central project office, four regional offices, and seven satellite offices:

- The central office, located in Addis Ababa, provided overall project management and oversight, and technical support to all regions. It supported the FMOH, EHIA, and other federal agencies in federal-level policy-making processes and implementation of HCF reforms in federal referral and teaching hospitals. It also implemented the project work in the Afar and Somali regions, and Addis Ababa City Administration.

Each regional office had a regional director as well as technical and operations staff to provide an ongoing regional presence to work closely with regional and woreda-level counterparts.

- The Oromia regional office (co-located with the central office) covered the Oromia and Harari regions and Dire Dawa City Administration.
- The Bahir Dar (Amhara) regional office covered the Amhara and Benishangul-Gumuz regions.
- The Hawassa (SNNP) regional office covered the SNNP and Gambella regions.
- The Mekelle (Tigray) regional office covered the Tigray region.

Seven satellite offices further deepened HSFR/HFG's program presence. They were located in Nekemte and Shashemene (Oromia region), Dessie (Amhara), Wolkite (SNNP), Assosa (Benishangul-Gumuz), Gambella (Gambella), and Samara (Afar).

Human resources

At the height of implementation, HSFR/HFG had an average of 90 technical and support staff in Ethiopia. About half of the team were specialists in health insurance, insurance communications, HCF, and planning, working out of the central office or deployed to the regional and satellite offices. Seven additional technical staff were embedded within the GoE structure – one senior health insurance communication advisor and one planning and program expert seconded to EHIA headquarters; three regional health insurance communication specialists seconded to EHIA branch offices in Oromia, Dire Dawa, Amhara, and Tigray; and one HCF specialist seconded to the FMOH's Resource Mobilization Directorate (recently renamed the Resource Mobilization Case Team).

KEY ACHIEVEMENTS AND RESULTS

Building and strengthening local capacity through technical assistance, training, and institutionalization efforts were integral parts of the HSFR/HFG strategy. We provided technical support to and worked collaboratively with GoE counterparts at the federal, regional, woreda, and health facility levels, to refine, implement, scale-up, and further institutionalize HCF reforms.

Building on work begun under earlier projects, we helped:

- Expand and strengthen implementation of HCF reforms in regions where it had started (in Amhara, Benishangul-Gumuz, Gambella, Oromia, SNNP, and Tigray regions and the Addis Ababa and Dire Dawa city administrations) and initiate reforms in the Afar and Somali regions;
- Scale up CBHI in Amhara, Oromia, SNNP, and Tigray and roll it out to Benishangul-Gumuz and Harari regions and Addis Ababa and Dire Dawa city administrations; and
- Engage in technical and policy consultations and advance preparatory measures for SHI.

Key counterparts included the FMOH, EHIA, RHBs, bureaus of finance and economic development (BoFEDs), woreda administrations, woreda health offices (WorHOs), and health facilities. By March 2018, HSFR/HFG had achieved the following key cumulative results, accomplished in collaboration and partnership with local counterparts.

PERFORMANCE AGAINST EXPECTED RESULTS

The following list shows HSFR/HFG's five expected results and then actual end of project achievements:

- Health service utilization increased in 174 (13 pilot and 161 second phase) CBHI woredas from the current 0.3 to 0.6.
  - HSFR/HFG assistance helped increase health service utilization in 318 (13 pilot and 305 expansion) CBHI woredas from **0.3 to 0.67.**[1]
- Health facilities managed with boards where communities are represented increased to 90 percent.
  - HSFR/HFG support helped increase the percentage of health facilities with governing boards to **99 percent of hospitals and 98 percent of health centers** in the country. All governing boards have a community representative.
- Public health facilities retaining and using their revenue increased to 90 percent.
  - HSFR/HFG helped increase the number of public health facilities retaining and using their revenue to **96 percent in hospitals** and **92 percent of health centers**.
- Share of out-of-pocket expenditures in CBHI pilot woredas to total health spending reduced from the baseline of 37 percent to 30 percent.
  - HSFR/HFG assistance contributed to a reduction in the share of out-of-pocket expenditures in health spending for the total population **from 37 percent to 33 percent**.[2]
- Proportion of people enrolled in health insurance increased from one percent to 20 percent.
  - HSFR/HFG support to the CBHI program helped increase the proportion of people enrolled in health insurance **from one to 18 percent**.

Challenges addressed

- High out-of-pocket spending
- Inadequate health facility budgets
- Low quality and availability of health services
- Poor utilization of health services

HSFR/HFG impact, in collaboration with local counterparts

- More Ethiopians are far less likely to have high out-of-pocket medical expenses
- Increased use of health care services
- Improved access to better-quality health care

[1] *Seyoum Aklilu. May 2018. Community-Based Health Insurance Performance and Implementation Challenges:A Study of Data from Sample Schemes, Kebeles, and Health Facilities. Rockville, MD: Health Finance and Governance Project, Abt Associates Inc. (performance).*

[2] *FMOH. April 2014. Ethiopia's Fifth National Health Accounts 2010/2011. Addis Ababa, Ethiopia (baseline); FMOH. August 2017. Ethiopia Health Accounts 2013/14. Addis Ababa, Ethiopia (performance).*

KEY ACHIEVEMENTS AND RESULTS BY OBJECTIVE

OBJECTIVE 1: IMPROVED QUALITY OF HEALTH SERVICES

Improved and expanded retained revenue and utilization (RRU) reform implementation, and increased budgets available at facilities to make quality improvements

RRU is the HCF reform that allows health facilities to keep the fees they collect from patients, rather than remitting them to the treasury, and use that revenue to improve the quality of services. The reform necessitated improvements in the financial management system and capacities at health facilities to help ensure increased efficiency in financial resource utilization, and hence the effectiveness of RRU reform implementation.

HSFR/HFG built hospital and health center capacity to retain and use revenue, and manage revenues and expenditures responsibly:

- To improve and institutionalize financial management systems, advocated and worked with RHBs and health facilities in defining key financial management positions and facilitated filling these positions with qualified personnel.
- Provided technical assistance to regional governments in customizing financial management manuals that were aligned with government financial management requirements and HCF reforms.
- In collaboration with RHBs and regional BoFEDs, trained 2,062 health facility finance staff on financial management. They now have the capacity to plan for and budget the use of retained revenue and manage financial transactions.
- Facilitated monitoring and auditing practices, an important part of public financial management.

RRU implementation results in the largest regions, over the life of HSFR/HFG

Amhara

- Expanded the number of health facilities implementing the retained revenue and utilization reform from 91% to nearly 97%
- Increased the amount of revenue retained at health facilities from 197 million to over 800 million birr ($10.6 million to over $34.6 million)

Oromia

- Expanded the number of health facilities implementing the RRU reform from 90% to 100%
- More than doubled the amount of health facility retained revenue spending for drugs and medical supplies from 211 million to over 450 million birr ($11.3 million to over $19.5 million)
- Doubled total appropriated retained revenue from about 243 million to more than 485 million birr (about $13.1 million to more than $20.9 million)

SNNP

- Expanded the number of health facilities implementing the RRU reform from nearly 87% to 97%
- Increased retained revenue more than fivefold, from 178 million to over 986 million birr ($9.6 million to over $42.7 million)

Tigray

- Expanded the number of health facilities implementing the RRU reform from 52% to 100%
- More than doubled health facilities' utilization of retained revenue from 93 million to over 201 million birr ($5.0 million to over $8.7 million)
- Increased health facilities' spending of retained revenue for drugs and medical supplies from 66 million to more than 141 million birr ($3.5 million to more than $6.1 million)

*Based on available data through March 2018

As a result of these interventions, between 2013 and 2017, the number of health centers implementing RRU grew from 1,442 to 3,332, and the number of hospitals from 103 to 267 – in other words, an additional 2,054 health facilities began implementing the RRU reform under HSFR/HFG. Today, 3,599 facilities – almost all public hospitals (96 percent) and health centers (92 percent) and in all regions and city administrations are implementing the RRU reform.

On average, the amount of revenue health facilities collected and retained has more than tripled for both health centers and hospitals since the project started. This reflects both the number of health facilities adopting the reform but also improvements in facility capacity to collect revenue. Revenue retained by health facilities now accounts for around 22 percent of total health facility budgets, up from about 15 percent in 2013.

Because the retained revenue is additive to the regular government budget, health facilities now have more financial resources to invest in service quality. Improvements – such as renovating and expanding facilities; procuring medical equipment, supplies, and medicines; making utilities such as water and electricity available; and investing in part-time or contract-based specialist care – are enhancing the quality of delivery of clinical services and increasing health service utilization. Furthermore, before reform, health centers did not have public financial management structures and hospitals financial management needed to be strengthened. Now, health facilities must have public financial management structures in place and employ health facility finance staff. As a result, facilities can now manage both retained revenue and their regular government budget allocation.

According to the findings of supportive supervision conducted in 2016/17, 74.9 percent of health centers' and 93 percent of hospitals' retained revenue was used to keep an adequate and continuous stock of appropriate drugs and medical supplies on hand.

RRU improved drug availability at health facilities

- Debre-Zeit Health Center in Benishangul-Gumuz region supports 5 health posts in its cluster with drugs and medical supplies purchased with retained revenue.
- The drug availability rate is 95% in the Felege Hiwot Referral Hospital dispensary and 97% in Bishoftu General Hospital, where about 70% of the retained revenue is earmarked to procure drugs and medical supplies.
- Drugs and medical supplies typically consume 70% of Shashemene Hospital's retained revenue. By using retained revenue to purchase the drugs it needs, the hospital achieved 96% drug availability in the hospital dispensary.

An additional 2,054 health facilities began implementing RRU under HSFR/HFG. To build capacity, 2,062 health facility finance staff were trained on financial management and 1,797 health facility staff, woreda administration officials, and other officials were trained on the fundamentals of the HCF reform strategy, legal and implementation frameworks, and HCF reform components.

Outsourcing non-clinical services at public hospitals

By assisting 127 (about half of all) public hospitals to outsource non-clinical services, HSFR/HFG facilitated increased efficiency and cost savings within these hospitals. Managers and clinicians at public hospitals can now focus on their core function of delivering high-quality clinical care, while specialized companies handle ancillary services such as laundry, security, and catering.

HSFR/HFG provided technical assistance in revising the outsourcing legal framework and building capacity through trainings of hospital staff and board members in implementing the reform. Support was also provided in supportive supervision, and conducting meetings with key partners and health facilities to review hospital performance in implementing the reform. Although uptake started slowly, 127 of the functional public hospitals in Ethiopia had outsourced at least one non-clinical service by 2017. This is a significant increase from only 58 hospitals in 2013 and 2014. The increase is attributable to increased interest in and capacity to outsource, but also to the number of functional hospitals, which more than doubled over the five-year period.

Establishing private wings in public hospitals

HSFR/HFG provided technical assistance to RHBs and public hospitals in implementing the private wing HCF reform, resulting in higher retention of key health facility staff. Retaining clinical staff is critical to enable the public health system to provide high-quality health services. The reform has helped public hospitals address high attrition rates, particularly for specialists like surgeons, orthopedists, and gynecologists.

When implementing the private wing reform, public hospitals are providing patients an alternative to the use of private hospital services, and generating additional revenue from these patients, who are able to pay higher rates for health services out of pocket and through private insurance or other form of third-party payment. Patients in private wings benefit from shorter waiting times than in the public wards, and the option to choose their preferred physician. A percentage of the fees generated from the private wings goes directly to health staff, motivating them to continue working at the public hospital.

HSFR/HFG provided training to hospital management and RHBs on concepts and rationales for private wings; roles and responsibilities of different bodies including the RHB, hospital board, and hospital management; preconditions for establishing private wings (e.g., availability of rooms, willingness of hospital staff, and having a hospital governing board); and expected benefits and implementation challenges.

> At Ayder Comprehensive Specialized Hospital in the Tigray region, a new private wing has contributed to the overall success of the hospital. The hospital has implemented a variety of HCF reforms, and is now providing advanced health care services for patients. According to Dr. Amanuel Haile, Chief Clinical Director, the hospital used revenue from the private wing to make improvements in the quality of health service delivery and for bonuses that have enhanced staff retention. The hospital now has more specialists who are able to provide high-quality care in both the general ward and private wings.

We also assisted in developing implementation guidelines that set forth health facility revenue-sharing criteria, user fee schedules, staff assignment requirements, and how the private wing functions in relation to the general ward. Sixty hospitals – in Amhara, Addis Ababa, Benishangul-Gumuz, Oromia, and Tigray regions, including federal and teaching hospitals – now have private wings or rooms that are generating revenue to help retain health workers in the public health system. Over the life of project, HSFR/HFG helped establish 15 of the private wings, a 33 percent increase from when the project started, and provided technical assistance to all 60 hospitals with private wings, to support their implementation of the reform.

Empowering Women through CBHI

In many Ethiopian communities, as in other traditional societies, men are the primary income earners and often make all financial decisions for the family, including spending on health care.

For families without health insurance, the biggest roadblock to adequate health care is money. In systems where payment is required at the time of care, some avoid or delay seeking treatment, fearing catastrophic and impoverishing costs. With no health insurance and no financial autonomy, women are often unable to access care on their own. For women and their families in Ethiopia, however, this is changing.

Ethiopia has made great strides in recent years to provide access to health care and financial protection for its citizens through government-supported health insurance. Thanks to CBHI, supported by the USAID-funded HSFR/HFG project, women in Ethiopia are more empowered and better able to independently access essential health care services.

Health insurance can improve access to health care for all citizens by establishing financial protection in an equitable and sustainable manner. This can benefit in particular vulnerable groups such as mothers, newborns, and children, and the poorest of the poor/indigent, who are covered through government targeted subsidies.

In 2013, HSFR/HFG evaluated the CBHI pilot program and found that households that were enrolled in CBHI had increased health service utilization. In addition, female-headed households were more likely to join CBHI than male-headed households. A more recent HSFR/HFG study, conducted 2017, examined utilization at 28 health centers and found that in regions where CBHI coverage rates are higher, health services utilization among insured women and children is higher (children on average by 14.0 percent, women by 47.5 percent) than among noninsured. This suggests that CBHI empowers women to make health service utilization decisions for themselves and their children and, therefore, that CBHI can improve maternal health and child survival outcomes. Women are able to access care for themselves and their children at time of need without requesting money from male heads of household because, as a CBHI member, no payment is required at the time of service.

"Before CBHI was started in our woreda, we had to sell whatever we had, even our precious cattle, when one of us got sick. But now, because of our CBHI membership, we can get appropriate health services when a family member gets sick. Some people in our village got treatment for their serious illnesses through surgery as they were referred to hospitals. Had it not been for CBHI, it would have been unthinkable to get such kinds of services without impoverishing ourselves."

– CBHI beneficiary

OBJECTIVE 2: IMPROVED ACCESS TO HEALTH SERVICES

Evaluated and scaled-up CBHI coverage

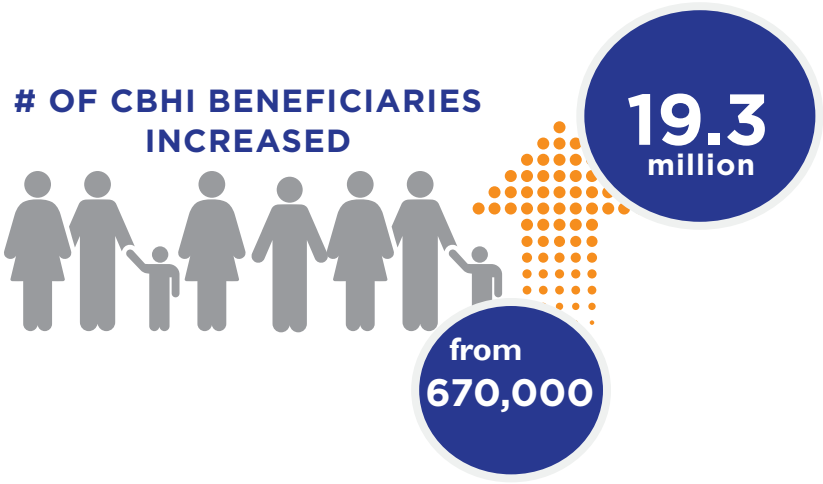
Under the HSFR bilateral project, the GoE piloted CBHI in 13 woredas in Amhara, Oromia, SNNP, and Tigray from 2011 to 2013. HSFR/HFG evaluated the CBHI pilot to assess the extent to which the pilot schemes were achieving desired results. Specifically, we measured improvements in enrollment, utilization of health services, quality of health services, financial protection of households from catastrophic out-of-pocket expenses, and financial sustainability of the schemes. Findings showed that health services utilization increased among CBHI-enrolled members to almost double the national average. In addition, CBHI members were 26 percent more likely than non-members to seek care when they were sick. CBHI members were less likely to be impoverished due to health expenditure.

Grounded in findings and lessons from the pilot, HSFR/HFG's technical assistance supported the GoE in designing and implementing its national CBHI Scale-up Strategy that targets 80 percent of Ethiopia's population in the informal sector. The strategy calls for phased geographical expansion; it also projects the financing requirements of expansion and described the organizational structures and human resources needed. It identified important initiatives to streamline the CBHI program, including harmonization of important design features such as contribution amount, benefit package, definition of specific registration and renewal periods, and establishment of higher-level pooling.

Under a phased approach, CBHI scale-up occurred first in the Amhara, Oromia, SNNP, and Tigray pioneer regions. More recently, it has expanded into Benishangul-Gumuz, Gambella, and Harari regions and Addis Ababa and Dire Dawa city administrations.

HSFR/HFG technical assistance significantly helped CBHI to expand, ensuring that more Ethiopians will be able to access critical health services. With support from the project, EHIA, and RHBs, the GoE:

- Extended CBHI to more geographic areas of the country, from 13 woredas in 2013 to 512 in 2018 (196 in Oromia, 156 in Amhara, 98 in SNNP, 36 in Tigray, 10 in Addis Ababa City Administration, 9 in Harari; 3 in Benishangul-Gumuz; 3 in Gambella, and 1 in Dire Dawa City Administration). These are over half of the woredas in the country.[1]
- Increased the number of CBHI beneficiaries from about 670,000 to 19.3 million.



Built CBHI implementation capacity of key stakeholders at all levels of the health system

To support the scale-up of CBHI, we provided training for over 4,051 health facility staff on the CBHI directive, scheme contractual agreements, audits, reimbursement mechanisms, and provider payment mechanisms. Training was also provided for more than 20,598 federal, regional, zonal, woreda, and kebele officials on the CBHI program. Regional and zonal-level CBHI review meetings to share experiences and discuss performance on enrollment, contribution collection, health service utilization, reimbursement of health facilities, and indigent selection were supported by HSFR/HFG, and the project supported development of the CBHI training and medical audit manuals.

Increased domestic resources mobilized through CBHI

Expansion of the CBHI program has resulted in more domestic financial resources for the Ethiopian health sector. CBHI schemes have collected more than 1.48 billion birr ($66.7 million) from registration fees and contributions since 2013.[2] The Ethiopian government has contributed an additional 385 million birr ($17.3 million) in the form of general and targeted subsidies, including the expected general subsidy for the current year, which is due in July 2018.

Breaking this down further:

- The amount of CBHI membership contributions collected by schemes from paying households alone increased more than tenfold between 2013/14 and 2017/18 (from 41.4 million birr to nearly 515.8 million birr, or around $2.1 million to $18.9 million).
- The volume of resources mobilized by CBHI schemes is increasing significantly as more and more woredas launch the program and households enroll and renew. The total amount mobilized through CBHI in 2016/17 exceeded 710 million birr (US$30.7 million), more than double the amount of the previous year and more than a twelvefold increase over the last four years.

[1] Of the 512 CBHI-implementing woredas, 318 schemes were fully established and providing benefit packages for beneficiaries by March 2018. The remaining woredas were conducting preparatory activities such as community mobilization, membership enrollment, contribution collection, indigent selection, and other relevant activities.

[2] Historical exchange rates are used throughout this report. An average of historical rates is used for cumulative figures.

CBHI implementation results in the largest regions, over the life of HSFR/HFG

Amhara

- Expanded CBHI from 3 to 156 woredas
- Increased CBHI member households from around 50,000 to over 1.7 million
- Increased indigent household members from about 9,600 to more than 337,000
- Increased resources mobilized from contributions from 2.4 million to 290 million birr ($129,000 to $12.6 million)
- Increased number of visits CBHI beneficiaries made to health facilities from nearly 174,000 to 2.7 million visits
- Increased the amount reimbursed to CBHI-contracted health facilities from about 5.2 million to 116.7 million birr ($279,600 to $5.1 million)

Oromia

- Expanded CBHI from 4 to 196 woredas
- Increased CBHI member households from about 21,500 to more than 1 million
- Increased indigent household members from around 2,700 to nearly 400,000
- Increased resources mobilized from contributions from 1.6 million to more than 32 million birr ($86,000 to more than $1.4 million)
- Increased the number of visits CBHI beneficiaries made to health facilities from about 53,400 million to 1.2 million
- Increased the amount reimbursed to CBHI-contracted health facilities from 2 million to nearly 2 9 million birr ($108,000 to around $1.2 million)

SNNP

- Expanded CBHI from 3 to 98 woredas
- Increased CBHI member households from almost 20,000 to more than 820,000
- Increased indigent household members from about 1,200 to 83,000
- Increased resources mobilized from contributions and subsidies from 2 million to152 million birr ($ 107.5 to $6.6 million)
- Increased the number of visits CBHI beneficiaries made to health facilities from about 73,000 to more than 1.1 million
- Increased the amount reimbursed to CBHI-contracted health facilities from nearly 1.8 million to over 42.8 million birr ($97,000 to over $1.8 million)

Tigray

- Expanded CBHI from 3 to 36 woredas
- Increased CBHI member households from about 35,600 to 272,000
- Increased indigent household members from around 8,650 to more than 62,000
- Increased the number of visits CBHI beneficiaries made to health facilities from nearly 60,000 to over 650,000
- Increased the amount reimbursed to CBHI-contracted health facilities increased from almost 2.4 million to 28.7 million birr (around $129,000 to $1.2 million)

*Based on available data through March 2018

Increased access to and utilization of health services

The main purpose of CBHI is to improve access to health care by reducing the financial burden of obtaining it. CBHI beneficiaries are entitled to access a package of basic curative health services free of charge (no co-payment) at the time of service in public facilities.

With HSFR/HFG technical support, CBHI has contributed to an increase in the utilization of modern health care services. The number of visits made by CBHI beneficiaries in the four pioneer regions (Amhara, Oromia, Tigray, and SNNP) increased eightfold, from about half a million in 2013/14 to more than 4.2 million in 2016/17. A recent HSFR/HFG study that examined utilization at 28 health centers found that the utilization rate for CBHI beneficiaries has reached 0.67 visits per year while the rate for non-members is 0.39.[3] This means that the CBHI-insured population is 1.7 times more likely to visit health facilities than the non-insured. Anecdotal evidence indicates that many people who have lived with untreated illness or conditions for years have visited facilities and benefited from health care after enrolling in CBHI.

Raised CBHI awareness through media

HSFR/HFG held workshops on the concept and benefits of health insurance for journalists and other members of the media so that they had the knowledge and information needed to produce effective health insurance promotion programs. In collaboration with regional mass media agencies in Amhara and SNNP, media visits to 14 woredas were conducted during the life of project. After the visit, journalists disseminated CBHI successes on regional television and radio programming.

We worked with EHIA on print and broadcast media campaigns to raise community and stakeholder awareness about health insurance programs and to encourage CBHI enrollment and renewal. This led to the production of over 35,500 informative brochures and posters, and the nationwide broadcasting of about170 television and 5,000 radio public service announcements in four local languages with targeted messages that explained the CBHI and SHI initiatives and encouraged CBHI enrollment and membership renewal. Informational videos on health insurance were also produced and aired in health facility waiting rooms.

Increased financial risk protection for the poor by supporting fee waiver implementation

HSFR/HFG assisted the government in implementing its fee waiver program, which is removing financial barriers to health care access for the poorest Ethiopians. With our technical support, advocacy, and implementation follow-up, more than 1.5 million households – approximate 7 million individual beneficiaries – have been certified to access a comprehensive package of health services free of charge. More poor Ethiopians now have better access to the full range of services offered through the public health system.

[3] *Seyoum Aklilu. May 2018. Community-Based Health Insurance Performance and Implementation Challenges: A Study of Data from Sample Schemes, Kebeles, and Health Facilities. Rockville, MD: Health Finance and Governance Project, Abt Associates Inc.*

Tirunesh's story

Tirunesh Ambo, a 70-year-old widow, is one of the fee waiver beneficiaries served at Mizan Amman Hospital, located in a remote area in the SNNP region. With only a meagre income from picking coffee during peak harvesting season, Tirunesh found it almost impossible to pay for the health care she needed. Now she is able to use the fee waivers to access health services free of charge. "I no longer dread the health complications that old age has brought since I am now able to get free services," she said.

We provided training, mentoring, and supportive supervision to woreda administrators, WorHO staff, and RHB HCF focal persons to implement the fee waiver program in woredas where CBHI is not available. Enabling selection committees in kebeles (the lowest-level governmental administrative unit) to identify and enroll poor households annually has helped to mitigate bias and favoritism in the allocation of fee waiver benefits, and allowed those most in need to receive services when they seek care. With HSFR/HFG's support, woreda administrations are now setting aside resources to reimburse health facilities (based on the user fee rates) for providing services to fee waiver beneficiaries. In regions where standardization of the fee waiver system has been successfully accomplished, access to health care services by the poor has improved.

Revised user fees

Ethiopian public health facilities have been collecting user fees for certain curative services for over half a century. However, like the package of exempted services, application of user fees was neither standardized nor transparent, nor did the fees reflect the actual costs of providing these services. HSFR/HFG facilitated user fee revision studies to inform regional-level discussions on setting of standard user fees, and it conducted costing exercises in some regions using a simplified cost analysis tool developed under the project. An important outcome of this activity was the mandate that facilities clearly post these fees to inform users of the financial liabilities associated with each service.

Standardized package of exempted services

To strengthen GoE management of exempted programs, HSFR/HFG assisted the GoE in standardizing a package of free preventive and promotive health care services in all regions. Activities supported Ethiopia's HCF strategy, which calls for regions to standardize a package of critical public health services that will be provided free of charge to the entire population, including maternal health, immunization, tuberculosis treatment, and HIV/AIDS diagnosis and treatment services.

Previously, there was variation in exempted services being provided across facilities. As a result, patients were often unaware of what they would be charged for services, which discouraged care seeking. Now, health facilities are required to provide clear information on exempted services, including posting a list of services in appropriate locations in health facilities. HSFR/HFG supported the government to make sure the lists were clearly defined, funded, and posted where they can be easily seen and read by patients and visitors. To reinforce compliance with the provision of exempted services, we made sure facility staff understood the requirement and checked for the list of services during supportive supervision visits at health facilities.

Before:

Non-standardized package of exempted health care services

- Different services available in each region
- Patients unaware of what they would be charged for services

After:

Standardized package of exempted health care services

- Access to priority public health services in all regions
- List of standardized services posted for people to see
- Public health facility users more likely to access health care services

This ensures that health service users (clients) have clear information about which services require payment and which are provided free of charge – making users more likely to utilize the health care services they need. Standardization can also allow regions and woredas to plan and budget more accurately for service provision and hold facilities accountable for achieving coverage targets. HSFR/HFG also generated evidence on the magnitude and the financial burden of providing exempted services, and facilitated dialogue between health facilities and the GoE to increase the budget allocation for exempted services. Standardization has also allowed regions and woredas to plan and budget more accurately for service provision and hold facilities accountable for achieving coverage targets.

Assisted EHIA to plan for and conduct preparatory activities for SHI

HSFR/HFG assisted EHIA in conducting preparatory work to launch its payroll-based SHI program for Ethiopian citizens working in the formal sector. Technical assistance was provided to develop the SHI legal and operational frameworks for federal and regional use, and to develop training curriculum. Over 60 EHIA staff were trained on the legal frameworks as well as on provider payment mechanisms.

The team also collaborated with EHIA on an assessment of 26 health centers to identify contract-eligible facilities, and another assessment of the feasibility of user fees set by EHIA. Results revealed a need to revise the fee-for-service mechanism before entering into contractual agreement with providers. Support also included consultative design of the contracting and provider payment systems and orientation for providers and facility managers in accounting, claims management, and administration of SHI at the facility level. The team assisted EHIA in conducting SHI awareness-raising meetings with regional cabinet members and senior management of various sector offices to discuss the SHI legal framework and implementation steps to launch and implement SHI. HSFR/HFG attended these meetings as technical resources who provided information and advice, and answered questions related to SHI. The GoE had originally planned to launch SHI during the HSFR/HFG period of performance; however, it postponed doing so in order to conduct these additional preparatory activities and engage in further discussions about whether and how to revise the SHI legal framework in order to address stakeholder questions.

OBJECTIVE 3: IMPROVED GOVERNANCE OF HEALTH INSURANCE AND HEALTH SERVICES

Expanded implementation of the governing board reform and improved implementation

Allowing health facility autonomy through the introduction of health facility governing boards in hospitals and management committees in health centers is a GoE reform that contributes to proper and timely use of resources. HSFR/HFG supported the GoE in expanding the number of facilities implementing the reform as well as their capacity to do so.

We provided training in HCF reform and facility governance for about 4,730 health facility governance board members and health facility management committees. This strengthened boards' capacity to manage their facilities and implement HCF reforms, including prioritizing the use of retained revenue, and fostered greater autonomy and decentralization of facility-level planning, management, and decision making, resulting in more local input and control over resources.

All regions are now implementing this governance reform. Of all health facilities in Ethiopia, 3,552 health centers (98 percent) and 264 hospitals (99 percent) now have established boards actively involved in providing overall direction and oversight of health facilities. This compares with 83 percent of health facilities implementing the governing board reform and having an established board at the beginning of the HSFR/HFG project. By strengthening governing boards, the HSFR/HFG team fostered greater autonomy and decentralization of facility-level planning, management, and decision making, resulting in more local input and control over resources. It also ensured that health centers and hospitals use their budget allocations and retained revenue to respond to client needs to provide the best patient care possible in accordance with standards and guidelines.

Mekelle Health Center Management Committee helps improve service delivery

Mekelle Health Center in Tigray is one of many health facilities in the region that have benefited from having a fully functional management committee. The committee provides proper leadership for the implementation of various government reforms. This includes the RRU reform aimed at improving the quality of service delivery at health facilities.

HSFR/HFG strengthened the capacity of the management committee by training committee members on the objectives of the health facility governing board reform and their roles and responsibilities in its implementation. This strengthened their capacity to make informed, strategic decisions. The project also provided training in financial management procedures to key finance staff at the health facility, which enabled the management committee to work with the health facility management team to implement appropriate financial management practices required under the reform.

Decisions taken by the management committee to use retained revenue have improved service delivery, which in turn has increased patient flow and mobilized even more revenue at the facility every year for the past five years. The health center's retained revenue increased from 0.85 million birr in 2013/14 to 1.4 million birr (around $43,600 to $51,500) in just the first three quarters of 2017/18. This provided more budget for the committee to decide how to prioritize and spend. The committee decided to improve availability of drugs and medical supplies; to build walkways, two additional blocks for maternal and child health services, and one documentation room; to purchase medical equipment; and to carry out other quality improvement initiatives.

Nearly all of Ethiopia's health facilities now have governing boards with improved capacity to oversee health care financing reform implementation.

Supported performance review meetings for strengthened implementation

HSFR/HFG provided technical support at zonal-level CBHI review meetings, where participants from woreda, regional, and zonal administrations and EHIA branch offices, and CBHI schemes discuss performance and implementation challenges, and identify and assign specific action steps in implementation. At the subsequent meeting, they review progress against the assigned action items, along with the other agenda items. These meetings, which are held two to three times per year, proved to be critical in tracking performance and holding stakeholders accountable for agreed-to action steps.

Improved EHIA's institutional capacity

With HSFR/HFG's support, the GoE strengthened the capacity of the FMOH's EHIA, thereby furthering the institutionalization of health insurance in Ethiopia. We successfully supported the government to implement insurance reforms and activities, while also building EHIA capacity.

HSFR/HFG assisted the government in refining the agency structure and functions, and in developing legislation and operational frameworks. We supported the EHIA's institutional systems and capabilities to administer insurance programs. We also assisted in developing job descriptions for EHIA staff, and in recruiting, hiring, and training EHIA staff on provider payment mechanisms, insurance scheme management, and other topics relevant to health insurance.

Five technical experts were seconded to EHIA headquarters and branch offices to address technical gaps in health insurance planning, programming, and communications. In addition, we provided technical support to develop and refine insurance-related operational manuals and guides. With this assistance, EHIA has now assumed responsibility for leading and operationalizing health insurance.

OBJECTIVE 4: IMPROVED PROGRAM LEARNING

Several issues challenge the financial sustainability of Ethiopia's health system. These include ensuring adequate government financing for the fee waiver system, exempted services, and CBHI subsidies; and developing efficient and effective institutional arrangements to support implementation of the HCF reforms. Therefore, HSFR/HFG carried out a rich learning agenda over the course of program that informed and facilitated the GoE's ability to make evidence-based policy decisions as it pursues HCF reforms.

Supportive supervision provided data and monitoring

To monitor and support reform implementation, HSFR/HFG regularly conducted supportive supervision visits with the participation of government counterparts from the federal, regional, zonal, and woreda levels. Over the life of project, we conducted supportive supervision visits at 2,703 health facilities (260 hospitals and 2,443 health centers) and 1,126 CBHI schemes. During visits, supervisors provided on-the-spot technical support, collected data on overall progress and performance in implementing CBHI and HCF reforms, and identified best practices and implementation challenges.

Supportive supervision generated valuable data that the project and government counterparts used as input for periodic review of the health sector at different levels. They were consistently used, for example, to identify where (geographic and/or health system level) and what type of technical assistance was needed, after which HSFR/HFG worked with the GoE to address the identified needs and gaps.

HSFR/HFG produced an annual synthesis report that consolidated supportive supervision data and included key findings and recommendations. The FMOH and regional and woreda authorities use these reports as data sources and to guide HCF reform implementation strategies and corrective actions. We also participated in FMOH/RHB-led integrated supportive supervision visits in several regions, including Addis Ababa and federal hospitals, as part of an RHB-HSFR/HFG collaboration. The team visited zonal health departments, WorHOs, hospitals, and health centers, and assessed the status of HCF reform implementation, identified strengths and bottlenecks, and recommended feasible solutions.

Steps toward HCF reform M&E systems development

HSFR/HFG provided technical assistance to develop a CBHI data management manual that was rolled out to regions along with training for scheme staff in its use. We also successfully advocated for the incorporation of HCF indicators into Ethiopia's national health management information system, as well as onto the integrated supportive supervision checklist used by the FMOH and RHBs.

Supported generation and use of evidence in health financing decision making through Health Accounts

Health Accounts is a globally recognized health expenditure tracking framework used to measure the amount of health expenditures and resource flows in health systems. Health Accounts findings provide evidence to gauge health sector performance, and information that can support accelerated investment in health and redirection of resources to priority health areas.

HSFR/HFG helped the FMOH generate and use Health Accounts evidence to make important HCF decisions. With our support, the FMOH successfully increased resources for the health sector and used data to inform key strategies for improving the health status of Ethiopians.

We provided technical support for Ethiopia's fifth and sixth round of Health Accounts, using the WHO System of Health Accounts 2011 methodology. In addition to the general Health Accounts, the exercises included subaccounts for HIV/AIDS, reproductive health, child health, malaria, tuberculosis, and health information systems that provide evidence on health expenditures in these areas. Data were collected from a wide range of institutions, and through representative surveys. In addition to this technical assistance, our support included conducting a household health expenditure survey and a survey of people living with HIV/AIDS to obtain evidence on where people go for their health care, why, and how much they spend.

The FMOH used Health Accounts findings to stimulate budget negotiations that resulted in increased resources for the health sector. For example, data on the percentage of household expenditures going to health provided the FMOH with solid evidence to support the design and introduction of CBHI. Health Accounts findings showed that Ethiopians had high out-of-pocket spending on health care, important evidence to support the government's policy to address the problem and improve access to health care. The FMOH used the data to inform its CBHI Scale-up Strategy and the GoE's Health Sector Transformation Plan.

To foster sustainability, with technical support from HSFR/HFG, the FMOH institutionalized the Health Accounts practice by establishing the Health Economics and Financing Analysis (HEFA) Case Team. The HEFA team is responsible for Health Accounts resource tracking and health finance analysis. HSFR/HFG supported the FMOH in establishing the team. The HEFA team fully owned and led the sixth Health Accounts exercise, and worked alongside HSFR/HFG to strengthen capacities in data collection, analysis, and report writing. Recently, the FMOH reiterated its commitment to strengthen/create resource mobilization units in the regions.

Policy and strategy documents, technical reports, success stories, and other products improved implementation and knowledge

Over the course of the project, HSFR/HFG produced technical reports and briefs, strategy documents, legal and operational frameworks, and guidelines that contributed to implementation and program learning. We conducted a study on the performance and implementation challenges of data from sample CBHI schemes, kebeles, and health facilities, and helped the FMOH to develop and revise its HCF Strategy and to design the CBHI Scale-up Strategy. Other examples include financial management, audit, and CBHI legal frameworks; and financial accounting, CBHI training, and private wing operations manuals. Under a portfolio of communications activities, we documented and shared information and experiences through success stories, newsletters, and short format videos.

We are at the page to own the health care financing program ourselves. We have all of the proclamations, all of the regulations and manuals in place…We started a journey. I'm very optimistic that we can make it to the point of universal health care coverage. You have to commit everything that at you have; including your time, including your finances, including your energy.

- Dr. Mengistu Bekele, Deputy Head of the Oromia RHB

CHALLENGES

HSFR/HFG faced the following implementation challenges over the course of project implementation and worked to address them through various activities:

- Uneven commitment and leadership of government at all levels – regional, zonal, woreda, and kebele – affects their support for planning, budgeting, oversight, approvals, communication with constituencies, and overall HCF reform implementation. This, in turn, affects the pace and effectiveness of HSFR/HFG program activities. It also affects the project's performance against objectives. We provided government counterparts with technical input to help strengthen their commitment to and leadership of reform, and advocate for needed changes to address these issues as they arise.
- HSFR/HFG's approach was built around supporting the GoE's roll-out and implementation of HCF reforms. The speed at which the GoE wanted to undertake an initiative (e.g., scale-up of CBHI) may not have always been aligned with the targets that were attainable within HSFR/HFG's available resources or capacities.
- Inadequate readiness of health facilities (including poor drug availability, human resource availability and capacity, and diagnostic services) impeded achievement of HSFR/HFG CBHI and health service utilization targets. As demand for services increases through enrollment in health insurance, the supply side must ensure the quality and availability of services. Without the medications, supplies, and personnel required for treatment, CBHI members may not renew their membership or attempt to access services a second time. HSFR/HFG advocated to RHBs and the Pharmaceuticals Fund and Supply Agency to acquire the required supplies and advised them to pursue all available options to obtain essential drugs.
- High turnover rates among public sector health personnel such as trained key finance staff and facility board members required HSFR/HFG to train and re-train on a constant basis.
- Security concerns, particularly over the last two years, affected implementation in some regions.

LESSONS LEARNED

Government ownership and leadership should be at the forefront of reform development and implementation

Strong GoE ownership and leadership helped HSFR/HFG to put in place the necessary legal and operational frameworks, institutions, structures, and staffing that supported HCF reform implementation as well as institutionalization within the health system.

Adaptive learning is key to refining implementation

The project put in place mechanisms, such as supportive supervision and assessments, to monitor and learn, and then used that information to adjust implementation. For example, key findings and recommendations from the CBHI pilot evaluation conducted early in the project informed the national CBHI Scale-up Strategy. The type of technical assistance, the level(s) of the health system where it should be provided, and the geographic locations where it was most needed, were continuously identified through the data, while gaps were identified through supportive supervision. Based on findings, the government took action to address the gaps in order to get facilities ready and facilitate implementation of the CBHI program. Evidence also was used to create consensus and support for the implementation of reforms and to increase the literacy of government officials regarding the importance of investing in health and the significant role health plays in the socio-economic development of the country.

Sharing lessons learned facilitates implementation

Because the implementation of HCF reforms was an incremental process, regions that started later or that experienced performance challenges were able to learn from more advanced regions through experience-sharing platforms supported by HSFR/HFG.

Learning from other countries' experiences helps in the design and execution of health reforms

GoE leadership and technical personnel that participated in study tours to Ghana and Rwanda returned to Ethiopia with a deeper knowledge base and, perhaps more importantly, with more of a "can do" spirit. Upon return they provided better follow-up, and they realized that reform work they previously thought might be challenging to implement in Ethiopia was perhaps indeed possible because they had observed it elsewhere.

CONTRIBUTIONS TO SUSTAINABILITY

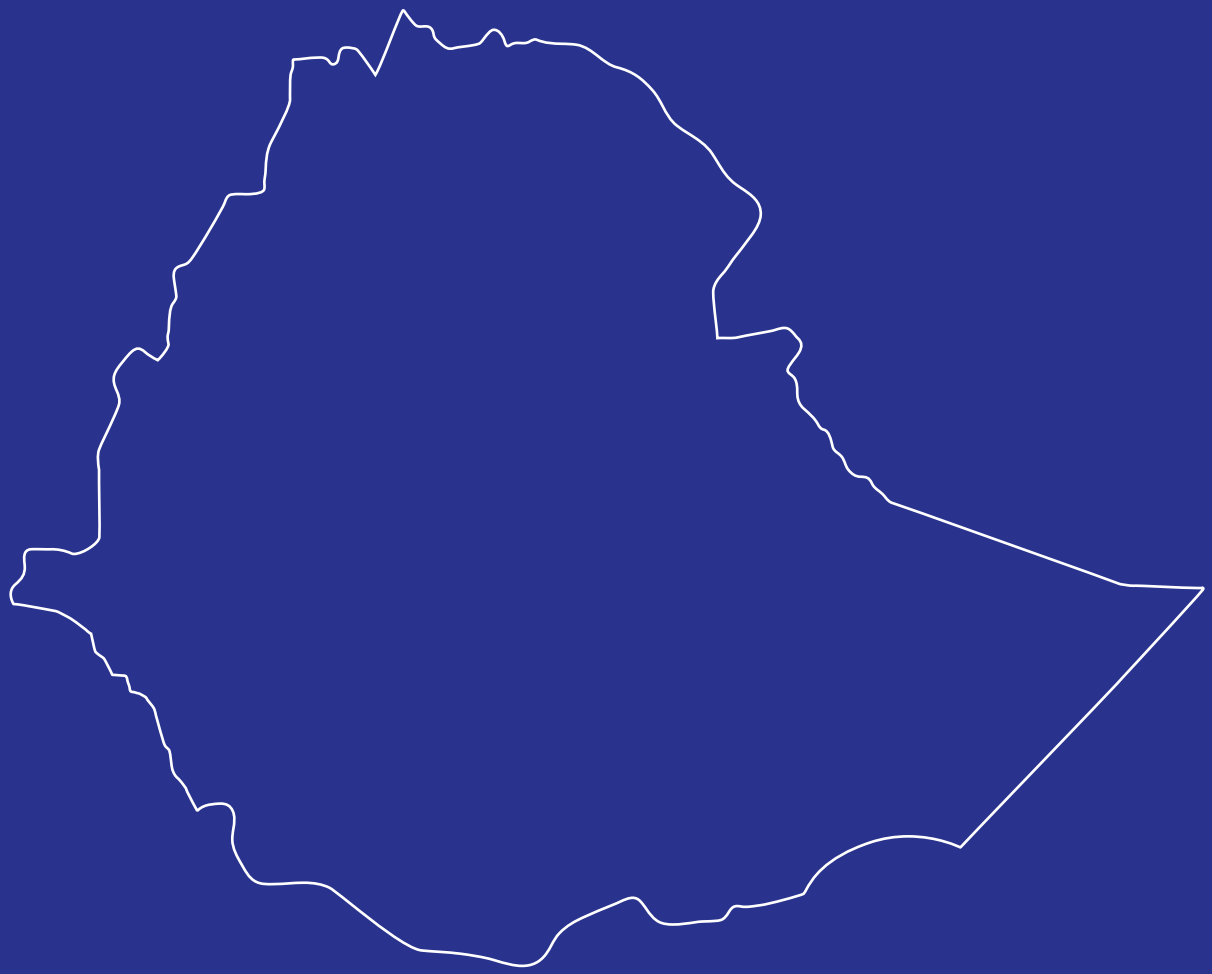
The HCF reform described in this report will make a lasting impact on Ethiopia's health system. To foster sustainability, HSFR/HFG worked collaboratively throughout the project, engaging and supporting the GoE to refine and implement HCF reform and CBHI. We contributed to the sustainability of reforms in a variety of ways:

- Kept the government in the driver's seat – the GoE owned and led the reform process, with HSFR/HFG providing a supportive, advisory, and capacity-building technical role.
- Required organizational structure, staffing, and capacity be in place at different levels of the health system to support reforms. We helped establish public financial management structures in health facilities and woredas to recruit key finance and procurement personnel for health facilities. We also provided training on financial management in collaboration with RHBs and regional BoFEDs.
- Strengthened capabilities within EHIA to lead and coordinate health insurance. EHIA now has 23 branch offices and more than 1,000 staff throughout Ethiopia.
- Supported the GoE in institutionalizing resource tracking and health finance analysis for the FMOH's policy decision making by supporting the FMOH in establishing the HEFA Case Team.
- Put in place legal and operational frameworks. HSFR/HFG leaves behind a legacy of legal and policy documents, guidelines, manuals, and supportive supervision checklists. These support the FMOH's work to institutionalize and operationalize HCF reforms, and are important mechanisms for sustaining implementation.
- Included HCF in national policy documents and strategic plans. Reforms are being implemented under comprehensive strategies and policy documents, including the Health Sector Transformation Plan (2015-2020), the Health Care Financing Strategy (2015-2025), and the CBHI Scale-up Strategy (2015). These documents are guiding the continuing reform process.
- Incorporated health financing into the integrated supportive supervision process of the FMOH and RHBs, enabling the government to monitor reform progress and performance. HCF performance data collection, analysis, and use are now conducted through this system. EHIA has taken responsibility for supervising and collecting data from CBHI schemes.

- Worked with local counterparts to identify local universities and training institutions that have the potential to provide training, with the goal of transitioning HCF, CBHI, and public financial management training from the project to the GoE. Consultation forums held by EHIA, FMOH, RHBs, and HSFR/HFG identified 15 universities/training institutions as capable of providing CBHI training. Of these, five expressed interest in providing the training. EHIA and RHBs will take the lead in signing memoranda of understanding with these institutions and moving the process forward. Since regions are now implementing HCF reforms without significant project support (especially with respect to the RRU and governing board reforms), at the national level, we approached the FMOH to include HCF and public financial management training in their in-service training program.
- Although at different stages of maturity, many HCF reforms have transitioned from project support to the GoE in the majority of regions and the two city administrations. HSFR/HFG worked to ensure that the FMOH has the capacities and systems that will enable it to continue supporting health facilities, regions, and woredas in implementing HCF reforms and health insurance programs heretofore supported by the project.

Clinical audits are critical for ensuring standard health services to CBHI beneficiaries. Zebiba Mussa, Health Officer at the Kutaber Woreda CBHI scheme has the primary duty of conducting clinical audits before the scheme approves health facility reimbursement requests for services rendered to CBHI beneficiaries.

To build capacity, HSFR/HFG trained health facility finance staff on financial management and health facility staff, woreda administration officials, and other officials on the fundamentals of the HCF reform strategy, legal and implementation frameworks, and HCF reform components.



ABOUT THE HEALTH FINANCE AND GOVERNANCE PROJECT 2013 - 2018

The Health Finance and Governance (HFG) Project works to address some of the greatest challenges facing health systems today. Drawing on the latest research, the project implements strategies to help countries increase their domestic resources for health, manage those precious resources more effectively, and make wise purchasing decisions. The project also assists countries in developing robust governance systems to ensure that financial investments for health achieve their intended results.

With activities in more than 40 countries, HFG collaborates with health stakeholders to protect families from catastrophic health care costs, expand access to priority services – such as maternal and child health care – and ensure equitable population coverage through:

- Improving financing by mobilizing domestic resources, reducing financial barriers, expanding health insurance, and implementing provider payment systems;
- Enhancing governance for better health system management and greater accountability and transparency;
- Improving management and operations systems to advance the delivery and effectiveness of health care, for example, through mobile money and public financial management; and
- Advancing techniques to measure progress in health systems performance, especially around universal health coverage.

The HFG project (2012-2018) is funded by the U.S. Agency for International Development (USAID) and is led by Abt Associates in collaboration with Avenir Health, Broad Branch Associates, Development Alternatives Inc., the Johns Hopkins Bloomberg School of Public Health, Results for Development Institute, RTI International, and Training Resources Group, Inc.

The project is funded under USAID cooperative agreement AID-OAA-A-12-00080.

To learn more, visit www.hfgproject.org


HSFR
HFG
Health Sector
Financing Reform
Health Finance
& Governance
Expanding Access. Improving Health