

Health Care Financing Reform in Ethiopia: Improving Quality and Equity

Abstract

Ethiopia endorsed a health care financing strategy in 1998 that envisioned a wide range of reform initiatives. The implementation of these reform initiatives was legalized through regional legislations and operationalized in line with prototype implementation frameworks that were modified and aligned within specific regional contexts. In 2004, actual implementation was initiated in Amhara, Oromia, and Southern Nations, Nationalities, and People (SNNP) Regional States following ratification and endorsement of regional proclamations, regulations, and directives by the respective regional councils (Parliaments), regional executive Councils (Cabinets), and Regional Health Bureaus (RHBs). Currently, the reforms have expanded to the remaining regions, with the exception of Afar and Somali, which are still in the process of endorsing legal and operational frameworks. All other regions (Tigray, Benshangul-Gumuz, Gambella, Harari, Addis Ababa, and Dire Dawa) have already begun implementation.

The strategy recognized that health care should be financed through multiple financing mechanisms to ensure long-range sustainability. The reforms introduced include implementing revenue retention and use at health facility level, systematizing a fee-waiver system for the poor, standardizing exemption services, setting and revising user fees, introducing a private wing in public hospitals, outsourcing nonclinical services, and promoting health facility autonomy through the introduction of a governance system.

The purpose of this background paper is to provide a glimpse of these reforms, the major progress and achievements made through their implementation, and the role of USAID's continued technical and financial support in implementation of these reforms and related results.

BACKGROUND

HEALTH STATUS

Ethiopia is situated in the northeastern segment of the African continent, commonly known as the Horn of Africa, with a land mass of 1.14 million square kilometers. With a total population of more than 73.9 million in 2007, Ethiopia is the third most populous country in Africa, following Nigeria and Egypt.

More than 44 percent of the population is under the age of 15 years, and over half (52 percent) of the population is in the age range of 15 to 65 years. Preventable communicable diseases and nutritional disorders continue to be major health issues. The most recent vital health indicators (2007/08) show a life expectancy of 54 years (53.4 years for male and 55.4 for female), an infant mortality rate of 77/1000, and an under-five mortality rate of 123/1000. More than 90 percent of child deaths are due to pneumonia, diarrhea, malaria, neonatal problems, malnutrition, and HIV/AIDS, and often to a combination of these. The maternal mortality rate, at 673/100,000 (CSA et al. 2006), remains high. The major causes of maternal death are primarily pregnancy related and preventable: obstructed/prolonged labor (13 percent), ruptured uterus (12 percent), and severe pre-eclampsia/eclampsia (11 percent).

Six percent of all maternal deaths were attributable to complications from abortion. Malaria accounts for 9 percent of deaths. Shortages of skilled midwives, a weak referral system at health center levels, inadequate availability of basic emergency obstetric care and comprehensive emergency obstetric care equipment, and under-financing of key services were identified as major supply-side constraints that have hindered progress (FMOH 2010a).

RECENT HEALTH SYSTEM STRUCTURAL CHANGES

Ethiopia recently introduced a three-tier health care delivery system.

Level one: The woreda (district) includes a primary hospital (with population coverage of 100,000 people), health centers (1/25,000 population), and their satellite health posts (1/5,000 population) connected to each other by a referral system. Health centers and health posts form a primary health care unit with each health center having five satellite health posts.

Level two: A general hospital with population coverage of 1 million people.

Level three: A specialized hospital that covers a population of 5 million. The rapid expansion of the private-for-profit and nongovernmental organization (NGO) sectors is playing a significant role in expanding health service coverage and utilization of the Ethiopian Health Care System, thus enhancing the public/private/NGO partnerships in the delivery of health care services in the country.

Offices at different levels of the health sector, from the Federal Ministry of Health (FMOH) to RHBs and woreda health offices, share decision-making processes, powers, and duties where FMOH and the RHBs focus more on policy matters and technical support while woreda health offices focus on managing and coordinating the operation of a district health system that includes a primary hospital, health centers, and health posts under the woreda's jurisdiction.

Regions and districts have RHBs and district health offices to manage public health services at their levels. The devolution of power to regional governments has resulted in a shift of public service delivery, including health care, largely under the authority of the regions.

KEY HEALTH FINANCING ISSUES

The World Health Report of 2010 identified three interrelated problems that limit universal coverage: (1) limited availability of health resources, (2) over-reliance on direct payments at the time people need care, and (3) inefficient and inequitable use of resources (WHO 2010). The limited availability of resources for health in Ethiopia is very clear. The total health spending in Ethiopia increased from about US\$522 million in 2004/05 to about US\$1.2 billion in 2007/08. However, overall health is under-financed, both in absolute terms and when compared to the sub-Saharan Africa average, as evidenced by per capita health spending of US\$4.5 in 1995/96 (FMOH 2001) that reached only 16.10 in 2007/08 (FMOH 2007). On the demand side, cultural norms, distance to functioning health centers, and financial barriers were found to be the major causes for not seeking health services in health facilities (FMOH 2011).

The FMOH of Ethiopia developed a health care financing strategy in 1998 that was endorsed by the Council of Ministers and became a very important policy document for introduction of health financing reforms. The government recognized that health cannot be financed only by government and underscored the importance of promoting cost sharing in provision of health services.

WHY HEALTH FINANCING REFORM IN ETHIOPIA?

In the early 1990s, Ethiopia was recovering from a prolonged civil war, the health infrastructure had seriously deteriorated, and the health service system was dysfunctional. Physical access to health service providers was beyond the reach of the majority of the Ethiopian population, and even more difficult for the poorest segments of the population. The overall country budget was limited, resulting in inadequate financing of health care. In addition, health service delivery was inefficient and inequitable, and quality of health care was generally poor. For instance, in the 1995/96 Ethiopian Fiscal Year (EFY), the annual per capita spending on health in Ethiopia was only US\$4.09 – too small an amount to buy good basic health services (FMOH 2001).

The round-four National Health Account (NHA) reports revealed that per capita spending on health is steadily growing (see Figure 1). As stated, in EFY 1995/96, per capita spending on health was only US\$4.09, but increased steadily to US\$5.6, US\$7.14, and US\$16.1 in 1999/2000, 2004/05, and 2007/08, respectively. However, even at the relatively high level of current spending, spending on health is still far from adequate to buy good health care.

FIGURE 1: TRENDS IN ANNUAL PER CAPITA SPENDING IN HEALTH IN ETHIOPIA (IN US DOLLARS)



Source: FMOH: Ethiopia NHA Reports (FMOH 2001, 2003, 2006, and 2010b)

In those areas where limited human resources were available, diagnostic equipment was not functioning and essential drugs were not available, compromising quality of health care. A willingness-and-ability-to-pay study conducted in 2001 revealed that respondents found the services provided by public clinics and health centers and hospitals unsatisfactory and below average (30 percent and 47 percent, respectively).

HIGHLIGHTS OF HEALTH CARE FINANCING REFORM COMPONENTS

In 1998, the Ethiopian government developed and endorsed a health financing strategy (see strategy goals in Box 1) that directs resources for the health sector to be mobilized from different sources and permits government to provide health services through its health facilities by means of a cost-sharing arrangement with users. In order to operationalize the strategy, FMOH drafted a prototype legal framework and operational manuals that were adopted by regional governments.

Box 1: Health Care Financing Reform Goals

- Identify and obtain resources that can be dedicated to preventive, promotive, curative, and rehabilitative health services
- Increase absolute resources to the health sector
- Increase efficiency in the use of available resources
- Promote sustainability of health care financing and improve the quality and coverage of health services

In line with the health care financing strategy and based on the approved legal frameworks, a wide range of health care financing reforms have been implemented. Initially implemented in the three largest regions (Amhara, Oromia, and SNNP) in 2005–2006, these reforms are now being scaled up all over the country. In the last three years, the health care financing reforms have been expanded to Tigray, Benshangul-Gumuz, and Harari Regional States, as well as Addis Ababa and Dire Dawa city administrations. The necessary legal and operational frameworks are in place in Somali and Afar regions, and these regions are expected to embark on full-fledged implementation of the reforms soon.

HCF REFORM COMPONENTS

Revenue retention and utilization: Ethiopia has a tradition of paying for health services, that dates back to the introduction of the modern health service delivery system. Ethiopia follows a consolidated revenue collection and budgeting system in which all public institutions that are collecting revenue are supposed to channel their revenue to the central treasury and receive their operational funding in the form of a government budget. Similarly, in the health sector, health facilities were channeling all revenue that they had been generating internally to the treasury. This caused a lack of sense of ownership by health facility staff and health facilities, and the amount of money health facilities had been collecting and channeling to the treasury was rather insignificant. On the other hand, health facilities faced a serious shortage of resources to cover their operational costs, and, in most cases, their non-salary operational budget was being depleted by the end of the first quarter causing inefficient use of scarce resources and poor quality of health care. In response to this problem, the health care financing strategy, followed by the respective regional and federal laws, allowed health facilities to retain and use their revenue for health service quality improvements. Hospitals and health centers in Amhara, Oromia, and SNNP Regional States started to retain revenue in 2005 and 2006.

Systematizing fee waiver system: Ethiopia institutionalized mechanisms for providing services to the poor free of charge through a fee-waiver system, as well as through free provision of selected public health services (through exemption) such as health education and treatment of tuberculosis patients, and through services targeting selected groups (e.g., immunization of children under the age of five). However, a strong need existed to systematize and standardize these services. For instance, local authorities had been issuing (and is still issuing in some regions) fee waiver certificates to the poor as verified through local social justice systems at the time of sickness. This resulted in cumbersome procedures that caused delays in the poor's ability to access care. This was not the case for individuals in higher income categories, and the system therefore created health care inequities.

Standardizing exemption services: In the Ethiopian health system, some public health services have been provided to all citizens free of charge regardless of level of income. This has occurred because of the nature of these activities and because of the need to promote use of certain health care services. Although exemption services were more standardized across regions, some services needed standardization by government. Services that were provided free of charge in some public health facilities were not free in others. In addition, there was no clear distinction between the financing and service provision. Health facilities were providing free services without budgetary/funding support for these activities.

Outsourcing of nonclinical services in public hospitals: Hospital management was spending considerable time and resources on routine administration and management of human and material resources that are meant for provision of supportive services for these health facilities. When managed by hospitals, these services tend to be inefficient and expensive. This includes services such as catering, laundry, cleaning, gardening, security, and maintenance. In view of this, the health care financing strategy considered outsourcing nonclinical services to improve efficiency, reduce spending, and reduce the burden on hospital management.

User fee setting and revision: In the Ethiopian public health system, health facilities have been collecting revenue in the form of user fees for more than half a century. However, these fees have never been systematically revised and no longer reflect the cost of providing services, nor have the fees been adjusted based on the user's ability to pay for them. The health care financing strategy clearly stipulated that user fees needed to be revised to reflect the costs of delivering health care services, but also underscored that individuals should be charged according to their ability to pay. Cost sharing between the government and users was one of the principles of the health care financing strategy.

Initiation of health insurance: As previously mentioned, out-of-pocket spending accounts for a significant proportion of health sector spending. In 2007/08, out-of-pocket spending accounted for 37

percent of the total spending in health (FMOH 2010b). Direct payment at the time of sickness is considered “unsuited,” because it could inhibit access, especially for the poor, and because of “the risk of impoverishment or destitution,” according to the World Health Organization (WHO) (2010). WHO further stated that “... when the reliance on direct payments falls to less than 15–20 percent of the total health expenditures then the incidence of financial catastrophe routinely falls to negligible levels” (WHO 2010). Direct payments are inequitable as they are regressive, allowing the rich to pay the same amount as the poor for services. The WHO report also revealed that if households are spending more than 40 percent of their disposable income, they could become impoverished. Given the poverty level of nearly one-half of the population in Ethiopia, it is likely that households who decide to use health services could easily slip into poverty. Health spending also accounts for a significant proportion of household disposable income, and this level of spending could be prohibitive for accessing health care services. Thus, the Ethiopian government is in the process of initiating health insurance schemes, social health insurance for the formal sector, and community-based health insurance for citizens in the informal and agriculture sectors.

Establishment of a private wing in public hospitals:

In most regions and at the federal level, public hospitals are allowed to open and operationalize a private wing with the primary objective of improving health workers’ retention, providing alternatives and choices to private health service users, and generating additional income for health facilities.

Health facility autonomy through establishment of governing bodies: Before the introduction of health financing reform, Ethiopian health facilities experienced cumbersome and ill-timed communications regarding major executive decisions from RHBs and woreda health offices. These decision makers were also physically detached from the health facilities and were not responsive to day-to-day client health service needs. The need for health facility autonomy through establishment of a health facility governing body was critical, as was involving appropriate representatives from the local administration, the health facility, and the local community.

HEALTH FINANCING REFORM ACHIEVEMENTS

Based on the health financing strategy, prototype legal frameworks and operational manuals were developed at the federal level with continuous technical assistance from subsequent USAID bilateral projects, Essential Services for Health in Ethiopia (ESHE-I and ESHE-II), 2001–08, and the current Health Sector Financing Reform (HSFR) project. Between 2001 and 2003, Ethiopia conducted activities to prepare for launching the various reforms (see Boxes 2 and 3 below). Activities contributing to this included the following:

- Experience-sharing visits to learn from experiences
- Training and capacity-building events
- Establishment of prototype legal and operational documents
- Workshops on policy advocacy and consultation.

In 2004 and 2005, the regional governments of Amhara, Oromia, and SNNP Regional States adopted the legal and operational frameworks with technical support from the ESHE-II project. The prototype legal frameworks and operational guides such as Health Care Financing Implementation Manual, Outsourcing of Non-Clinical Services and Establishment of a Private Wing, Financial Management Manual, Revenue Retention and Utilization Guide, and other operational guides were adopted by the respective regional governments and RHBs. Implementation of these financing reforms first started in Amhara, Oromia, and SNNP Regional States by endorsing legal frameworks and adopting the operational guides to their regional contexts in 2004–2006. The legal frameworks and operational manuals were further adopted by the RHBs of Tigray, Benshangul-Gumuz, Gambella, Harari, Addis Ababa, and Dire Dawa. The Somali and Afar regions are also in the process of finalizing ratification of the legal frameworks, and they are expected to adopt the operational manuals very soon. Government authorities at all levels have reported that these operational frameworks and guidelines are very useful for properly implementing the various reform components. Training of trainers and actual roll-out trainings were organized for FMOH, RHB, Zonal Health Departments (ZHDs), Woreda Health Offices (WorHO) and health facility staff in all regions

Box 2: Highlights of Major Activities Implemented

- Momentum for the reform was influenced by advocacy workshops in all regions. More than 1,100 people from RHBs, regional finance bureaus, zonal health departments, woreda health offices, hospitals, and health centers participated.
- Reform process was influenced by studies conducted in health care finance-related areas.
- Study tours were conducted on cost recovery (Zambia), public-private collaboration (South Africa), and health insurance and government-NGO collaboration (Bangladesh and Thailand).
- Plan of Action for implementation of the reform agenda, detailing required policy intervention was prepared, presented, and discussed (annual review meeting 2001 in Nazareth).
- Designed Special Pharmacy (SP) Project and 150 SPs (120 in health centers, 30 in hospitals) established with detailed operational and management guidelines in June 2001. Later the special pharmacies were opened in more than 450 health facilities.
- Developed prototype draft proclamations and regulations for implementing health care finance reforms; shared with decision makers.
- Health Service Delivery, Administration, and Management proclamation were ratified by the regional governments of SNNP, Oromia, Amhara, Tigray, Benshangulk-Gumuz, Gambella, Afar, Somali, and Harari regions, as well as Addis Ababa and Dire Dawa City Administrations, following a series of consultations at technical and policymaking levels.
- The prototype health care finance implementation manual was developed, and adopted by the regions. The manual provides detailed guidance on the steps to follow, formats to use, and a timeline for performing the tasks to implement HCF reforms.
- Health care finance baseline surveys were conducted in the three largest regions (Oromia, SNNP, and Amhara) in 2003 and 2004 by ESHE-II project and in most other regions by HSFR project in 2008–2009.
- HCF reform training of trainers (TOT) and roll-out training provided in all regions.
- Four NHA surveys were conducted based on data of 1995/96, 1999/2000, 2004/05, and 2007/08 spending.
- Study tours on health insurance were conducted in Ghana, Mexico, Rwanda, and Senegal.
- Final strategic framework document and proclamation on health insurance were developed.
- Monitoring and evaluation framework was developed for health care finance.
- SP impact assessment conducted; report prepared.
- At the federal level, final draft proclamation incorporated in the health service proclamation and directive on HCF reform prepared.

(hospitals and health centers) were introduced to the financing reforms.

Health facility-based revenue retention and utilization: Following ratification of the required legal frameworks and adoption of operational guides, health facilities (hospitals and health centers) in Amhara, Oromia, and SNNP Regional States were able to retain and use their internally generated revenue as additive to their regular government budget. In the last two to three years, all the remaining regions approved the legal and operational frameworks and introduced retention with the exception of Somali and Afar regions. These regions

are still in the process of approving legal frameworks and adoption of operational guides (see Table 1). In the regions that are already implementing the reform, only the new health centers have not yet started retention as they need to complete necessary planning, which includes recruiting finance management staff. The health facility-level retained revenue is being used for quality improvement, as defined in the respective legal and operational frameworks of the regions.

In 2009/10, data collected from Amhara, Oromia, and SNNP Regional States through supportive supervision

Box 3: List of Study and Working Paper Reports

- Assessing willingness and ability to pay for health care in Ethiopia
- Assessing willingness to pay for medical care in SNNP Regional State: research results and analysis
- Ethiopian health care delineation
- Health insurance and prepayment: principles, concepts, and features in developing countries, prospects for Ethiopia
- Improving the quality of services and adjusting user fees at Ethiopian government health facilities: estimating the potential impacts of implementing various options
- National baseline on drug supply and use
- Private expenditure trends in Ethiopia and implications for health systems financing
- Private health expenditure review
- NGO involvement in the health sector: facts, challenges, and suggestions for collaborative environment
- SPs in Ethiopia: opportunities, challenges, and the way forward
- The policy of fee retention and its implementation in SNNPR: the experience of government hospitals
- Ethiopia: contracting government services in the health sector
- Health services delivery and financing options for the pastoral areas
- Ensuring financial sustainability under the Health Sector Development Program
- Three health care finance baseline surveys conducted, in 2003 in SNNP and in 2004 in Oromia and Amhara regions
- Four NHA surveys conducted based on data of 1995/96, 1999/2000, 2004/05, and 2007/08.
- SP impact assessment
- Health care finance implementation progress assessment conducted in selected woredas in SNNP, Amhara, and Oromia regions

TABLE 1: HEALTH FACILITIES IMPLEMENTING HEALTH FINANCING REFORMS BY REGION

N/S	Administrative region/city	Number of health facilities		Number of facilities implementing the reform		Percentage of facilities implementing the reform	
		Hospitals	HCs	Hospitals	HCs	Hospitals	HCs
1	SNNP	16	578	16	546	100	94
2	Amhara	16	745	16	358	100	48
3	Oromia	35	1053	35	1053	100	100
4	Tigray	12	211	12	118	100	56
5	B/ Gumuz	2	29	2	21	100	72
6	Harari	2	8	2	8	100	100
7	Dire Dawa	1	15	1	15	100	100
8	Gambella	1	18	1	1	100	6
9	Addis Ababa	5	31	5	31	100	100
10	Afar	4	40	0	0	0	0
11	Somali	8	62	0	0	0	0
	Total	102	2,790	90	2,151	88	77

Source: USAID (2010)

showed that out of 299 health centers, nearly 84.6 percent (253) have had an appropriated budget for EFY 2009/10. The average amount of appropriated budget for the health centers from the retained revenue in EFY 2009/10 was 208,930.00 Ethiopian Birr (ETB). Health centers utilized nearly 73 percent of their appropriated budget from their retained revenue per quarter. Only 17 hospitals (81 percent) provided data on the total amount in their appropriated budget for the same fiscal year. The average annual appropriated budget per hospital was 1,647,821.08 ETB. Although the amount varies from health facility to health facility, generally the retained amount is large enough to contribute to improving the quality of health services in health facilities.

Major achievements of revenue retention and use were the following:

- Availability of essential medicines increased:** The baseline surveys conducted in 2003 and 2004 revealed that in most health facilities, the drug budget was enough to cover only one-quarter of the year, and health facilities were experiencing stock-out of essential drugs for most of the year. Since then stock-outs of essential drugs have been substantially reduced, and when they do occur, it is mainly because of shortages at the wholesaler level. In 2009/10, supportive supervision data revealed that 42 percent of total expenditure from retained revenue was used for procurement of drugs and medical supplies and 8 percent was used to transport drugs and medical supplies, and fuel and lubricant for facilities with vehicles.
- Diagnostic capacity of health facilities improved:** Many health facilities procured essential diagnostic and health service delivery equipment.



Diagnostic equipment procured using health facility retained revenue.

The 2009/10, supervision data showed that more than 6 percent of retained revenue was used for procurement of essential equipment.

- Continual quality of care maintained:** Health facilities that have had non-functioning diagnostic equipment and vehicles because of budget shortages managed to maintain and operationalize their equipment and vehicles using their retained revenue.
- Water supply and electricity to health facilities improved:** Regular and continuous supply of water and electricity is critical for provision of health facilities. Many health centers that did not have a water supply or had an unpredictable or dysfunctional water system spent part of their retained revenue to



New water tank and generator installed at Wolaitta Sodo Health Center.



establish or maintain the supply system. Some centers and hospitals bought generators to ensure availability of electricity.

- **Operational costs including paying utility bills covered.** Before introduction of revenue retention and utilization, health centers and hospitals reported that they did not have an adequate budget to cover operational expenses, including to obtain fuel for their vehicles, pay their bills, and buy essential medical and nonmedical supplies. About 6 percent of retained revenue was used for improving the facility's health management information system. Other expenditure items such as office supplies, printing services, per diem, and loading and unloading account for 3 percent each, and other items account for 1 percent to 2 percent each.
- **Health infrastructure improved:** Some health facilities renovated their buildings and constructed additional blocks. In 2009/10, the three regions used about 7 percent of retained revenue for renovation and maintenance of health facility buildings.

Systematizing fee waiver and exemption systems:

In the Amhara region, where the new fee waiver system is fully implemented, an increasing number of poor households experienced better access to health services. A total of 1,319,114 indigents were selected through community participation and benefited from free health care services. The average number of fee waiver beneficiaries was 7,946 and the government budget allocation for waiver reimbursement per district was 20,791 ETB. A great proportion of the health facilities (53.3 percent) were reimbursed on the basis of fee for service and 43.8 percent were reimbursed on capitation. In other regions, the full implementation of the new fee waiver system is not yet complete. In districts where the new fee waiver system is functioning, a recognizable number of those at the poverty level were able to access free health care.

Standardization of exempted health care services:

In line with their regional legal frameworks, health facilities are implementing exempted services that include immunization, antenatal care, postnatal care, delivery at

primary health care unit, treatment of tuberculosis, and other public health services. Health facilities are posting lists of exempted services and this is helping to educate users about these services, including which ones are free. The 2009/10 the USAID Bilateral Health Sector Financing Reform (HSFR) project supportive supervision synthesis data showed that, overall, 59 percent (179) of health centers and 38.1 percent (8) of hospitals visited in the reporting year posted the list of exempted health services on their notice boards. Of these, 52.5 percent (94) of health centers were in Amhara, 32.4 percent (58) in Oromia, and 15.1 percent (27) in the SNNP, and all hospitals were from the Amhara region. The major problems encountered while providing exempted health services included shortage of drugs and medical supplies, absence of clear guidance on whether to fully or partially charge for services, additional costs incurred for the provision of exempted health services, and inadequate support both from the government and NGOs for the provision of these services. As a result, some facilities charge for delivery-related services and supplies such as laboratory services, gloves, glucose, and some drugs.



New buildings constructed to replace old ones



Establishment of a private wing in public hospitals:

Some of the federal and regional hospitals established private wings to generate additional income for health professionals and health facilities. The private wings offer more choices to users while also addressing improvements in health worker retention and income generation for the facilities.

Health facility autonomy through establishment of governing bodies:

Health centers and hospitals in health care finance reform starter regions established governing bodies, and regions where reforms are being expanded are following the same steps. Governance is one of the six building blocks of countries' health systems (WHO 2010). HSFR project's supportive supervision synthesis report revealed that out of 320 health facilities visited in Amhara, Oromia, and SNNP regions, 96.3 percent (288) of health centers and all 21 hospitals established a health facility governing body/board at the time of supervision visits in 2009/10. Only 3.5 percent (10) of health centers in the SNNP reported that they had not yet established a governing body. Of those that established a governing body/board, nearly 83 percent (269 health facilities) indicated the frequency of governing body/board meetings as well as procedures followed such as recording minutes. Facilities listed major health care finance-related decisions made by the governing body/board. These included approval of the health facility workplan and budget utilization of retained revenue, use of retained revenue for procurement of drugs and medical supplies, evaluation of the overall performance of the health facility, and oversight of the implementation of the new fee-waiver system. This coincides perfectly with their duties and responsibilities in the legal framework.

Some operational challenges were observed in the governance of health facilities. Most facilities noted a high turnover of governing body/board members as a result of their busy work schedules and absence of incentive mechanisms as their major challenges or constraints. Measures taken to overcome these challenges included continuous discussion and communication with the woreda administration and woreda health office to address replacement or substitution of nonactive members, scheduling meetings at more convenient times for board members, and submitting recommendations

to the respective woreda administrations for approval of financial incentives to be paid to governing body/board members.

Outsourcing of nonclinical services in public hospitals:

The purpose of outsourcing is to improve efficiency, reduce costs, and enable health facilities to focus on their core clinical services. The HSFR project 2009/10 supervision report showed that among all hospitals covered during supportive supervision, three hospitals in Amhara region – Enat, Debre Birhan, and Felege Hiwot – outsourced nonclinical services such as supply of food items (bread, *injera*, and *wat* [stew]).

User fee setting and revision: The health care financing policy of the government promotes cost sharing between the government and users as one of the key principles of the health care financing strategy. The regional laws vary in terms of mandating the user fee revision and setting. For instance, in Amhara and Oromia, this mandate is given to the regional government, while SNNP health facilities are given the responsibility of setting and revising user fees taking into consideration the community's willingness and ability to pay as well as cost of services. However, a recent user fee revision study conducted by the HSFR project showed that there are discrepancies in adherence of regional legislation. For instance, in Amhara region, although the regional law gave the mandate of user fee revision to the regional council, of the 12 health centers and six hospitals covered in the study, nine health centers and four hospitals revised user fees on their own.

Initiation of health insurance: The Ethiopian government is in the process of initiating health insurance schemes, social health insurance (SHI) for the formal sector, and community-based health insurance (CBHI) for citizens in the informal and agriculture sectors. The necessary legal frameworks are already in place for the piloting of CBHI schemes as well as for initiation of the SHI program. The SHI agency has already been established and is being staffed with required professionals. SHI is expected to be operational for civil servants beginning in July 2012. It will gradually expand to cover all formal sector employees. Since 2011, CBHI schemes have been piloted in 13 districts in Amhara, Oromia, SNNP Regional

States, and Tigray Regional States. The HSFR project monitoring reports showed that health service utilization by CBHI pilot scheme members has substantially increased in the pilot districts. Patient load in the public facilities that are providing services for CBHI members has also increased.

CONCLUSION AND LESSONS LEARNED

Health care financing reforms, together with a wide range of reforms, has positively transformed the health sector. Revenue retention and use improved quality that in turn improved citizens' perceptions of health services, improved the performance and satisfaction of health professionals, and enhanced overall functioning and performance of the health system. A functioning governance system is critical to ensure health facility autonomy and accountability, timely and responsive decision making through representation, and active participation of health sector actors, including the community. Although much remains to be done and progress varies from region to region, implementation of the new fee waiver system and standardization of the exemption system are enhancing health service equity and promotion and use of public health services.

LESSONS LEARNED

- **Government ownership and commitment:** The Ethiopian health care finance reform is mostly government owned and led at various levels. The FMOH and RHBs, as well as the Ministry of Finance, Bureaus of Finance, and administrators at various levels have been supporters of the reforms. Legal and operational frameworks were developed and endorsed at each level by legislators and government authorities.
- **Relatively long-term technical assistance is critical:** The initiation and implementation of HCF reform was made possible thanks to the continued technical and financial support from USAID. The support has continued for more than 10 years and it is bearing fruits. The bilateral projects supported development of legal frameworks and operational guidelines, supported generation and use of evidence, and provided capacity-building supports including training, supervision, and on-the-spot technical support. The US Government reaffirmed its commitment to continue supporting the various health care financing reform initiatives as clearly stipulated in its Ethiopia Global Health Initiative Strategy.
- **Timing of initiation and implementation of the reform:** During initiation of the reform, Ethiopia was emerging from a long, protracted civil war that had substantially eroded the health services in the country. The government recognized that financing of health care was one of the major bottlenecks and needed immediate attention.
- **Partnering with major stakeholders:** All health stakeholders shared in the health care finance reform in Ethiopia. This sharing in return resulted in strong support from major development partners in Ethiopia including the World Bank, the United Nation specialized agencies, and other bilateral development partners.
- **Timely generation and dissemination of relevant health financing evidence is critical:** The health care financing reform was supported through timely generation and use of evidence. The studies conducted at the beginning of the reform, including the NHA estimations, generated valuable evidence that was critical for policy dialogue and advocacy with policymakers at all levels.
- **Capacity building and experience sharing:** The initiation of health care finance reform in Ethiopia was preceded by experience-sharing visits to selected Asian and African countries. Health financing policymakers and technicians received training in health financing both in-country and abroad. In the last five years, health care finance reform manuals were developed and became operational. They were also used for training of FMOH, RHB, WorHO, and health facility staff. Moreover, administrators and finance officials at different levels have been trained and are now leading successful implementation of the health care finance reforms. Health facility governance members received training focused on their roles and working relations with health facility management.

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