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Health Facility Governance in the Ethiopian Health System

Abstract

Health governance – one of the pillars of a health system – has received appreciable attention from the Ethiopian health sector over the past decade. Through the leadership of the Federal Ministry of Health (FMOH), the health sector has various coordinating mechanisms at the federal, regional, and woreda (district) levels, although the performance of the coordinating mechanisms weakens as one goes from the federal to the woreda level. To make facilities responsive to local needs and mitigate administrative complexities, the government initiated health facility governance reform by introducing boards for hospitals and governing bodies/management committees for health centers. Boards are now well established in most health facilities. They facilitate linkage with the community, and are used to advocate for increased resource mobilization for facilities. In addition, these governance structures serve as the major monitoring and decision-making bodies, and currently all reform efforts, including health care financing, very much depend on their functioning.

BACKGROUND

Prior to 1991, Ethiopia was a centralized country with a unitary form of government. Decisions were made at the center with little or no accountability to the needs of the communities. Ethiopia now is a federal country administratively divided into nine regional states and two city administrations. Each of the nine regions is divided into zones and each zone into lower administrative units called woredas, or districts. Each woreda is subdivided into the lowest administrative unit, called a kebele. The two city administrations (Addis Ababa and Dire Dawa) are also divided into subcity administrations and woredas.

One of the world's oldest civilizations, Ethiopia is also one of the world's poorest countries. The country's per capita income of US$380 is much lower than the sub-Saharan African average of US$1,165 (World Bank 2010). Over the past two decades the government has been implementing comprehensive social and economic reforms. A key feature of reform has been the government's strong commitment to shift its spending to sectors such as health, education, road infrastructure, agriculture, and rural development that, if strengthened, will reduce poverty.

The past eight years have been particularly transformational for Ethiopia's health sector – an improved policy environment and shift in government priorities toward human resource development have significantly improved access to and quality of health services. Health infrastructure and the health extension program expanded significantly under the Health Sector Development Program III (HSDP III). As of 2010/11, the health service coverage reached more than 90 percent of the population (FMOH 2011). HSDP IV aims to consolidate the expansion with a focus on maternal and newborn health and quality of health services.

Ethiopia has been successful in improving certain health indicators: According to the Ethiopia Demographic and Health Survey (DHS) 2011 preliminary report, family planning coverage has reached 29 percent and infant mortality has decreased by 23 percent, from 77 to 59 deaths per 1,000 live births, while under five mortality has decreased by 28 percent, from 123 to 88 per 1,000 births (Central Statistical Agency and ICF Macro 2011). In addition, 10 percent of births were delivered in health facilities, doubling the level reported in the 2005 DHS. Nevertheless, Ethiopia's population still faces a high morbidity and mortality rate and overall health status remains relatively poor (HSDP IV). Overall, 24 percent of Ethiopian children are fully vaccinated, while 15 percent have not received any vaccination. Life expectancy in 2007/08 was 54 years (53.4 years for men and 55.4 for women). Preventable communicable diseases and nutritional disorders, including anemia, continue to be the major health problems in the country.

RATIONALE FOR FACILITY GOVERNANCE REFORM

Since 1995 Ethiopia has been decentralizing functions, resources, and authority to the local level. A more decentralized health care system has been part of this movement. The first wave of decentralization resulted in the FMOH, Regional Health Bureaus (RHBs), and woreda health offices sharing the decision-making about the design, development, and implementation of the health system. The FMOH and the RHBs were expected to make policy, provide technical support, and manage hospitals, woreda health offices to manage and coordinate the operation of primary health care services at the woreda level.

Even under decentralizaion, health care facilities, hospitals in particular, were directly accountable to the RHBs, and no mechanism existed to make the hospitals responsive to the needs of their local communities. Communities were not involved in making decisions about strengthening facilities to improve service quality or resource allocation and prioritization of activities based on local realities.

HSDP I (1998) therefore proposed the following governance structure for the Ethiopian health system (FMOH 1998):

- The Central Joint Steering Committee (CJSC), Joint Core Coordinating Committee (JCCC), and FMOH-development partners (DPs) Joint Consultative Meeting (JCM); and Annual Review Meeting (ARM) at the federal level;
- The Regional Joint Steering Committee (RJSC) at the regional level;
- Woreda joint steering committees at woreda level; and
- Kebele HIV and health committees at the community level.

These various committees at all levels of the health system were to serve as coordination mechanisms to plan, implement, and monitor and evaluate programs and projects in the health sector.

However, evaluation of HSDP I and II disclosed that the subnational steering committees were not functioning properly. In fact, in many regions, committees were not established. Where committees existed, they met only irregularly. Most importantly, there was a clear weakness in ensuring transparent and accountable management of health facilities, especially in their responsiveness to community needs for access to quality health services.

In addition, the health sector effectiveness was constrained by an inefficient procurement system. Facility managers lacked the skills and authority needed to do effective planning. Inability to make good decisions at the point of service delivery made procurement of medicines, supplies, and services very complex and lengthy, because the facilities had to go through the bureaucratic channels of woreda health offices, zonal health departments, and RHBs.

Toward the end of HSDP II, the FMOH and Health Population and Nutrition (HPN), revamped their efforts to improve harmonization and alignment in the health sector. This renewed commitment led to (1) the joint development of HSDP III, (2) signing of the 2005 Code of Conduct, (3) establishment of the Technical Assistance a Pooled Fund, (4) joint development of the HSDP Harmonization Manual, and (5) introduction of woreda-based planning. Furthermore, the federal-level governance structure established by the HSDP I was modified in the following ways:

- Establishment of the FMOH-RHB Joint Steering Committee;
- Abolition of the CJSC; and
- Reorganization of the JCM into the Joint Consultative Forum (JCF).

This has resulted in progressively improved dialogue and deliberation in the health sector (FMOH 2009).

In addition, to improve the governance structure at points of service delivery, the government introduced facility governance boards as part of the broader health care financing reform. The boards were intended to address the following four issues: (1) lack of health facility autonomy and existence of administrative complexities, (2) lack of responsiveness to community needs, (3) lack of an accountable administrative system at health facilities, and (4) lack of concern for improved resource mobilization through local decision making. Each of these issues is discussed below.

Lack of autonomy and existence of administrative complexities: Even with the decentralization of activities to the regional and woreda levels, hospitals were accountable to RHBs, and primary health care units were accountable to woredas. As a result, strategic decisions were being made centrally with little or no consultation with facility managers. Often, facility managers did not have the authority to decide important issues, and strategic decisions were under the jurisdiction of high-level officials. Important decisions such as procurement of medicines, supplies, and equipment were made centrally without considering the needs of facilities.

Lack of responsiveness to community needs: A centralized system of governance made the facilities very bureaucratic and unresponsive to the communities, because no mechanism was in place to hear community voices. In addition, no mechanisms were available to address community grievances. A further problem was that poor target setting and monitoring mechanisms were attempting to respond to community demands for improving the quality of services.

Lack of an accountable administrative system at health facilities: With the centralized management system, the accountability of facility managers was unclear. Facility managers did not take the initiative to implement innovative practices to improve service delivery because they did not feel a sense of ownership for their work or facilities. Because health centers were not been cost centers, managers did not have the opportunity to plan, defend, and prioritize their budgets; therefore, there was little or no opportunity to account for whether or not funds were utilized as per the set priorities.

Lack of concern for improved resource mobilization through local decision making: Because the health sector was chronically underfunded, facilities often ran out of funds budgeted for operational activities and therefore had to limit the quantity and/or

quality of services they provided. Facility management was not directly involved in the planning and budgeting process, and managers never had the leverage to make their case for increased funding – and therefore increased quality – of services.

FACILITY GOVERNANCE REFORM INITIATIVE

Generally health governance is defined as the process of "competently directing health system resources, performance, and stakeholder participation toward the goal of saving lives and doing so in ways that are open, transparent, accountable, equitable, and responsive to the needs of the people" (Health Systems 20/20, forthcoming 2012). Governance in the context of the Ethiopian health sector presupposes how the development and implementation of the health sector plan is organized, managed, and communicated. This is not only about government – citizens, NGOs, and development partners also have a role to play. To achieve this, facility-level governance structures were introduced to deepen the decentralization process and ensure that service delivery points respond to clients' needs.

In Ethiopia almost all regions have endorsed the legal frameworks to introduce hospital boards and health center governing bodies/management committees. As per the regional laws, hospital boards are accountable to RHBs or zonal health offices, depending on the level of the hospital. Health center management committees are accountable to woreda administrations. See Box 1 for a full description of board governance responsibilities.

Box 1: Major Duties and Responsibilities of Hospital Boards and Health Center Governing Bodies

- Examine and approve the strategic and annual plans of the facility
- Manage and follow up on the overall activities of the facility
- Review and approve activity reports of facilities
- Devise mechanisms to enhance the resource mobilization of the hospitals
- Determine services that are contractually outsourced to third parties

Hospital boards usually comprise seven or eight members. The mayor or senior zonal official (usually zonal administrator) chairs the body; other members come from other sector offices, and there is one representative from the communities. The hospitals in a regional capital have a regional official as chairperson. Health center governing bodies or management committees usually have five to seven members, including the woreda administrator, sector office heads, and one representative from the communities. Woreda administrators serve as committee chairpersons for these governing bodies.

The Southern Nations, Nationalities and Peoples (SNNP) region established a governance board in 2006, followed by Amhara and Oromia regions. More recently, other regions such as Tigray have also established governance boards. The structure of the boards across the regions is similar, but there is some variation in board composition. In Tigray, board members come largely from civic organizations or associations such as women's and youth associations; there is also a representative from hospital workers, a representative from the business community, and one member from the community (Tigray National Regional State Council 2006).

In Amhara, regional law provides that "the board of each and every hospital shall have at least five, but not more than seven members according to the circumstances of the case. Regard should also be made in the course of the designation to gender balance and professional expertise" (Amhara National Regional State Council 2006). The board has a community representative and a representative from hospital workers.

The situation in SNNP is similar to that in Amhara, but in SNNP representatives from government offices are to be head of offices (SNNP Regional State Council 2005).

In summary, Amhara stressed professional composition to ensure board effectiveness, while Tigray gave emphasizes representation by different social groups. SNNP did not explicitly address the issue of professional expertise; it gave preference to representatives with political influence over professional expertise.

In Tigray, the lack of an appropriate skill mix on the boards has prevented health center governing bodies

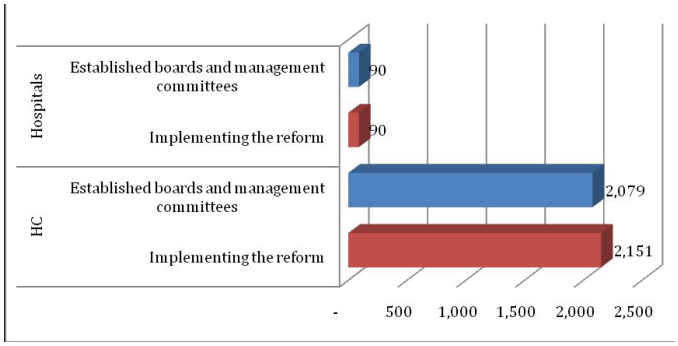
from discharging their duties and responsibilities effectively. Recently the RHB amended board composition; although the aforementioned organizations can sit on the board, their representatives are expected to be educated (i.e., have at least a diploma) so that they can assist in the governance of the hospital or health center to which they are assigned.

Whatever the board membership, before assuming their position, members must attend a two-day orientation on the roles and responsibilities of facility governance boards as set out in the regional legal frameworks.

RESULTS TO DATE

In the implementation of health care financing reform, the government emphasized establishing health facility governance, as boards play a vital role in providing the leadership necessary to ensure that hospitals offer the best patient care possible while functioning efficiently, effectively, and economically. Nearly all public hospitals and a substantial number of health centers in Ethiopia have established governing boards and governing bodies (Figure 1).

FIGURE 1. NUMBER OF BOARDS AND MANAGEMENT COMMITTEES ESTABLISHED IN ETHIOPIA TO DATE



Substantial improvements have been observed since regions started implementing the health care financing reform program in 2005/06. Revenue retention and utilization was the first component to be implemented. This component was given priority because the government's goal was to increase the amount of local discretionary resources available at the facility level to improve the quality of care. In conjunction with the revenue retention component, the RHBs established the boards, which have become operational during the last seven years.

As per the regional laws, hospital board and health center management committee meetings should be held quarterly, but, like the composition of the boards, the frequency of meetings varies by region and facility. According to the various supportive supervision reports conducted by Health Sector Financing Reform project, there are three principal areas that indicate the importance of governance structures in enhancing the performance of health facilities:

1. Boards/governing bodies are facilitating linkage to the community: The establishment of boards has sent a strong signal to the communities that they are increasingly taking ownership of the facilities. This is illustrated by examining the board composition of Debre Birhan Hospital, presented in Table 1.

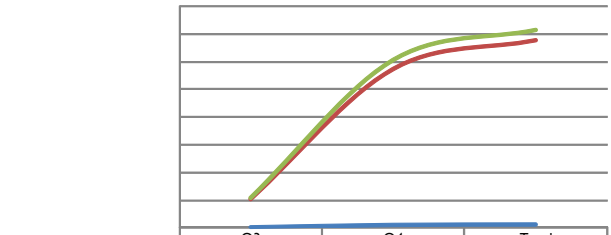
TABLE 1: COMPOSITION OF DEBRE BIRHAN HOSPITAL BOARD

Responsibility in Government Office	Responsibility in the Board
North Shoa zonal administrator	Chairperson
Debre Birhan city mayor	Deputy chairperson
Zonal health department head	Member
Women and children affairs head	Member
Medical director of the hospital	Member
Representative of hospital staff	Member
Representative of the community	Member
Debre Birhan University president	Member

One popular community board member is vocal in expressing the interest of the communities, and all board members bring the community's complaints concerning service delivery to the meetings. The board also discusses community concerns and tries to resolve problems accordingly. Board members communicate to the communities the improvements that the hospital is making. As a result of this interaction between the hospital and the community through the board, community complaints about the hospital have decreased. Outpatient client satisfaction currently stands at 86 percent (Debre Birhan Hospital EFY 2003). This is a dramatic improvement

compared with the virtually zero client satisfaction prior to the reform. The two consecutive quarters in 2010/11 for which data are available for key performance indicators appear to show substantial improvement in the hospital's performance (Figure 2).

FIGURE 2. DEBRE BIRHAN HOSPITAL: KEY PERFORMANCE INDICATORS, 2010/11



	Q3	Q4	Total
inpatient admissions	878	6538	7416
outpatient attendance	20514	112721	133235
Deliveries	315	2085	2400

2. Boards have become strong advocates for increased resource mobilization for facilities. Facility governance board members have become strong advocates of increased budget allocation and additional resource mobilization for facilities. This has been facilitated by the implementation of health care financing reforms. Again, Debre Birhan Hospital is an example. Unlike in past years, when it would have been very difficult for the hospital to make its case for increased resources, now the hospital has strong backing to push for a greater budget allocation. Unfortunately, the hospital board did not succeed in getting the RHB to increase the budget allocation in 2011/12; rather, the board increased the internal revenue budget allocation from 3.3 million birr in 2010/11 to 7 million birr for 2011/12. The hospital CEO explained that the board has strongly supported the idea of enhancing staff morale and currently has allocated 2.9 million birr from this internal revenue budget to purchase residential houses for staff. In addition, the mayor is planning to acquire space adjacent to the hospital so that the hospital can expand its services. According to the hospital CEO, "Had it not been for the board, all these would not have been possible."

3. Facility boards are the major monitoring and decision-making bodies. In a recent supportive supervision report on 298 health facilities, facility heads mentioned major areas that are the prime concern of facility boards as being the: "approval of the health facilities work plan and budget including utilization of retained revenue, evaluation of the performance of health facility and oversight of the implementation of the new fee waiver system." (USAID/Health Sector Financing Reform Project 2011). In their monitoring and decision-making functions, facility boards focus on improvements in overall hospital operations. They also create strong awareness of health needs through communication to higher-level decision makers and they strive to solve problems locally. Once again, Debre Birhan Hospital serves as an example. The hospital's board normally does quarterly performance evaluations in which the emphasis is on addressing strategic problems. The board also convenes short, monthly meetings to exchange ideas on issues that need urgent attention. As a matter of routine, the hospital board spot checks hospital activities once a week and this has helped improve service delivery and change the image of the hospital dramatically. The hospital board has managed to outsource day-to-day operational issues such as the security service, gardening, dietary, and laundry services, which helpes the senior management to focus on its core duties.

The board has also allocated internal revenues by looking at the key performance indicators. For example, in 2011/12, the board allocated funds to expand the tuberculosis (TB) ward to improve performance related to TB indicators. Another critical area is ensuring drug availability. Of the 7 million birr appropriated as internal revenue, the hospital board allocated 3.5 million birr to ensure availability of drugs. In addition, the operating room is in use 24 hours daily, and waiting time has been reduced from 70 days to an average of 22 days. The hospital has also introduced a shift system for nursing care that has brought about changes in the delivery of services. These practices at Debre Birhan Hospital have been taken as a model for all hospitals in the country, and the FMOH is planning to replicate the model as a best practice to emulate.

CONCLUSION AND LESSONS LEARNED

The above discussion, while based on anecdotal evidence, shows that decentralized health governance is essential for improved service delivery in the Ethiopian health system. All reform efforts, including health care financing, are dependent on a well-functioning board structure. If a health facility has a strong board, the facility will show improved performance every year. The converse is also true in facilities where there is no functioning board structure. The board composition is also important since it can create the positive environment needed to provide professional and political support to the facilities.

A number of important lessons have been learned in the operation of facility governance boards:

- Boards and governing bodies are instrumental in improving health facility performance. Whenever strong board structures exist, facilities have improved performance in terms of providing quality health services, and recently this has become very clear in that some partners in the health sector are striving to strengthen the board structures.
- The composition of board members must reflect both professional and political considerations. Professional composition is important if the board members are to support the facility management in planning, budgeting, monitoring, and evaluation and in making strategic decisions that are critical for the performance of the facilities. Lacking this type of professional composition, board members may be unable to make any meaningful contribution to the effective governance of facilities.
- A "sitting allowance" (token compensation) has to be paid for board members. Facility governance entities are entitled to receive a "sitting allowance," and this has to be put into effect in all regions and facilities if the governance structures are to have the incentive needed to discharge their collective and individual responsibilities.
- The governance structures need continuous capacity building. For boards to be effective, they need to have continuous capacity building regarding their roles and responsibilities. They also need to be continually updated on the health system as a whole so that they can provide concrete support to the facility management.

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