



Private Health Sector Forum

The Private Health Sector in Ethiopia at a Crossroads
Optimize, regulate and cement partnership with the private sector
For sustainable universal access

Forum Proceedings

March 26-27, 2014
Addis Ababa, Ethiopia



Table of Contents

Acronyms.....	i
Acknowledgements.....	ii
Executive Summary.....	1
Thematic Area: Public Private Partnership.....	1
Thematic Area: Health Regulations.....	2
Thematic Area: Health Care Financing.....	2
Summary Day 2 Group Discussions.....	4
Theme 1: Public Private Partnership.....	4
Theme 2: Health Regulation.....	4
Theme 3: Health Care Financing.....	5
Conclusion and Way Forward.....	5
I. Introduction and Speech.....	7
1. Plenary Session 1: Official Opening -Date and Time: March 26, 09: 00-09:45.....	7
a) Topic: Welcome and Purpose of the Forum.....	7
b) Topic: Keynote Remarks.....	7
c) Topic: Keynote Remarks.....	9
d) Topic: Keynote Address.....	10
e) Topic: Opening Speech.....	11
II. Main Highlights of the Presentations.....	12
2. Plenary Session 2: Public-Private Partnership in Health.....	12
2.1 State-of-the-Art Lecture: PPPH March 26, 11: 00-11:50.....	12
2.2 Questions and Answers: March 26, 11:50-12:00.....	15
3. Panel Session 1: Public-Private Partnership in Health.....	17
3.1 Presentations March 26, 13:00 – 14:45.....	17
a) Topic: State of PPPH in Ethiopia: Trends and Prospects.....	17
b) Topic: Legal Framework for PPP.....	18
c) Topic: The State of the Private Health Sector in Ethiopia.....	19
d) Topic: PPPH: The Case of South Africa-Successful Models and PPP in Non-Clinical Services.....	21
3.2 Discussion and Conclusion: March 26, 13:45-14:25.....	22
4. Panel Session 2: Health Regulations.....	23
4.1 Presentations: March 26, 14:35 – 16:00.....	23
a) Topic: State of Health Regulations in Ethiopia.....	23
b) Topic: Collaborative Public-Private Quality Improvement: Experiences from Jordan.....	24
c) Topic: The Essentials of Health Regulations in Resource Limited Countries.....	26
d) Topic: Self-Regulation in Health Care.....	28
4.2 Discussion and Conclusions: March 26, 15:20-15:55.....	31
5. Panel Session 3: Financing Universal Health Coverage.....	32
5.1 Presentations March 26, 16:20: 17:15.....	32
a) Topic: Current Practices and Prospects in Financing Health in Ethiopia.....	32
b) Topic: Models of Health Insurance for Universal Health Coverage.....	33
c) Topic: Private Health Sector Access to Finance: The African Experience.....	34
d) Topic: PPP for Low Cost Commercial Health Insurance: An Experience from Nigeria.....	35
e) Topic: The Role of the Private Sector in Health Care Financing.....	36
5.2 Discussions and Conclusions: March 27, 8:30-8:45.....	37
III. Next Steps: Recommendations for Follow Up.....	39

Acronyms

HSDP	Health Sector Development Program
FMHACA	Food, Medicine and Health Care Administration and Control Authority
FMOH	Federal Ministry of Health
M&E	Monitoring and Evaluation
MDG	Millennium Development Goal
MOFED	Ministry of Finance and Economic Development
NGO	Non-governmental Organization
NHIS	National Health Insurance Scheme
PATHS	Partnership for Transferring Health Systems
PEPFAR	President's Emergency Plan for AIDS Relief
PHSP	Private Health Sector Program
PPM	Public Private Mix
PPP	Public Private Partnership
PPPH	Public Private Partnership in Health
SHOPS	Strengthening Health Outcomes through the Private Sector
THE	Total Health Expenditure
USAID	United States Agency for International Development
WHO	World Health Organization

Acknowledgements

This document is a result of an initiative by the Private Health Sector Program of the United States Agency for International Development (USAID) to help build the capacity of the Federal Ministry of Health in Public-Private Partnerships (PPPs). The proceedings was prepared by ABH Services Plc, edited and augmented by PHSP senior staff with feedback from the Resource Mobilization Directorate in the Federal Ministry of Health, and the printing is made possible by the technical and financial assistance of USAID/PHSP.

The forum focused on three thematic areas: Public Private Partnership, Health Regulations and Health Financing and had taken full advantage of local and international expert participants to explore ways on how best to harness the full potential of the private health sector. The Ministry has greatly benefitted and appreciated the technical exchanges with a number of representatives from both public and private institutions in Ethiopia, including representatives from the Federal Ministry of Health, Regional Health Bureaus, Private sector, International NGOs, Health Associations and others

Mr. Abduljelil Reshad
Director, Resource Mobilization Directorate
Federal Ministry of Health

Executive Summary

The two-day forum entitled “The Private Health Sector in Ethiopia at a Crossroads,” was held from March 26-27, 2014 in Addis Ababa. This brought together a wide range of organizations from the public and private sectors to create increased awareness on the contribution and value of the private health sector. The three thematic areas that shaped the agenda for the two days were Public Private Partnership, Health Regulations, and Health Care Financing.

The key objectives of the forum were:

- To share experiences on successful models of the private health sector in other African countries and develop standard Public Private Partnership in Health (PPPH) legislative actions/policies, guidelines and models
- To discuss on how to maximize the potential of the private health sector in Ethiopia and to explore the best regulatory mechanism for the sector
- To reflect on how best to finance universal access to health care
- To emphasize the importance of Public Private Partnership (PPP) for high quality universal access to health care
- To create a dialogue between the Government and the private health sector
- To present the current state of the private health sector in Ethiopia

The forum was expected to facilitate the identification of a series of priorities and recommendations related to strengthening PPP, regulatory systems of the health sector and financing universal access of health care. The keynote addresses and remarks emphasizing the relevance and objectives of the forum were addressed by representatives from the Federal Ministry of Health (FMOH), the private sector, International Non-governmental Organizations (NGOs), and representatives of health associations. The forum was started with a presentation on the state-of-the-art lecture on PPPH and was followed by a series of presentations on the three thematic areas.

Thematic Area: Public Private Partnership

The first presentation of this panel was on the “State of PPPH in Ethiopia: Trends and Prospects.” It focused on the past and present health policy in Ethiopia, current public-private collaborations and partnerships in the health sector, and the work accomplished to create an enabling environment for PPPH.

The speaker pointed out that the current health policy and the various programs and directives of the Government have created an enabling environment for the active participation of the private sector in the provision of healthcare services. The development of a strategic framework for PPPH and the establishment of a PPP unit by the FMOH illustrated that the right steps are being taken to foster PPPH. Furthermore, policy guidelines and national frameworks for PPP are under development and are expected to further enhance PPP in the future.

The topic of the second presentation titled “Legal Framework for PPP,” focused on the need for a legal framework, policies, general PPP laws, and sectoral PPP laws and regulations, and major issues that impact PPPH in Ethiopia. The speaker recommended that the government needs to have a comprehensive PPP policy, which would serve as a springboard for the formulation of general/specific PPP laws. Furthermore, in order to ensure the application in practice of the PPP mechanisms, relevant new legislation should be developed and adopted, and existing laws amended whenever necessary.

“The State of the Private Health Sector in Ethiopia” was the topic of the third presentation that provided a focus on the policy environment for the private health sector in Ethiopia, i.e., the size, scope and contribution of the private health sector, the legal framework and financing of the private health sector, and the way forward to enhance PPP. The speaker clearly showed the need for both the private sector and the Government to exert extra efforts to benefit from PPPH. The private health sector in Ethiopia needed to establish a representative organization and have meaningful interaction and dialogue with the Government, banks, and other relevant institutions. The private health sector should: build its capacity towards self-regulation, strengthen its capabilities in business management, and attract investors. The Government of Ethiopia needs to translate policy statements into concrete and workable actions, formalize interaction and dialogue with the private health sector towards PPP, and establish a structure within the FMOH and Regional Health Bureaus (RHBS) to deal with issues related to the private health sector and PPPH. The private health sector should also be engaged and included in regional and federal health planning, monitoring and evaluating the health sector.

“Public-Private Partnerships in Health: The Case of South Africa – Successful Models and PPPs in Managing Non-clinical Services” was the fourth paper presented. This presentation focused on the rationale for PPP, the systems approach to PPP, and key lessons learned from South Africa in non-clinical service areas. In terms of building experience, it was recommended that PPP in Ethiopia could start by public health institutions outsourcing non-clinical activities. The South Africa experience showed that the success of PPP depends on a wide variety of issues from policy level to that of operational issues, such as contract management and effecting payments when they are due.

Thematic Area: Health Regulations

Four presentations were made in this session. These were The State of Health Regulations in Ethiopia, Collaborative Public Private Quality Improvement: Experiences from Jordan, The Essential of Health Regulations in Resource Limited Countries, and Self-regulation in the Health Sector.

An overview of regulatory functions in the health sector and some of the health reforms undertaken in Ethiopia were highlighted. The achievements as well as the challenges were related to exercising the regulations in Ethiopia to ensure that regulations and standards are being met. It was stressed that the regulatory process is meant to protect the public from unsafe and substandard/ poor quality health and health related products and services. There are four core regulatory core processes: Regulatory Standards Setting; Inspection and Licensing; Product Quality Assessment and Registration; Regulatory Information Delivery System; and Medico-Legal.

The experience from Jordan showed that quality improvement in the health sector is not the legal mandate of the regulatory system but is a collaborative effort among the Government, the public and private health institutions, professional associations and other stakeholders.

It was stressed that health professionals and facilities in Ethiopia should exercise self-regulation in combination with the statutory regulations through delegation by the Government. To this end, it is necessary to define the instruments for self-regulation and developing selection criteria for the professional bodies to be given statutory delegation. It is also essential to develop the framework for operational self-regulatory work and also document a monitoring and evaluation (M&E) framework to oversee the implementation of delegated self-regulation by the Government. This view, although critical, may not be timely. However, given the serious lack of the regulatory capacity in the country, it would be important and advisable for the private sector to prepare the groundwork of a framework for the self-regulation of potential implementation in the near future.

Thematic Area: Health Care Financing

Five presentations were made in the plenary on healthcare financing. The topic of the first presentation was about the “Current Practices and Prospects in Financing Health in Ethiopia.” It focused on the policy and strategy adopted in health financing in Ethiopia, the goals of health care financing, and the sources of health care financing. Three important dimensions that need to be focused on to provide the required financing for universal healthcoverage in the country are maximizing efficiency of resources, increasing the resource envelope for health financing, and developing sustainable revenue streams.

The second topic of the second presentation was on “Models of Health Insurance for Universal Health Coverage.” The key focus areas were the three dimensions of universal health coverage, the challenges of health financing, and the financing policy for universal health coverage. The speaker concluded that no country has fully achieved all the universal health coverage objectives, and this is even more difficult for poorer countries. The overall policy needs to be “moving towards” universal health coverage and not only “achieving” it. The key to improving the financing function and the move towards the goal of universal health coverage is having an effective governance system.

The third paper was on the “Private Health Sector Access to Finance: The African Experience”. This focused on the importance of access to financing for private health providers, the sources of financing for private health care providers, the challenges to access financing, and recommendations to increase access to financing for the private health care providers. The speaker (and paper) emphasized the need for a change in the regulatory environment (from short term loans to long term ones) to provide financing for the private health sector in Ethiopia, to promote Diaspora investment, to develop systems and structures and support guarantees and credit lines for health sector lending, and reducing transaction costs.

The topic of the fourth presentation was “Public-Private Partnerships for Low Cost Commercial Health Insurance: An experience from Nigeria”. This described the Nigeria National Health Insurance Scheme and its health care financing model, the benefits of partnership with microfinance banks, and challenges of Nigerian Health Insurance. The Abt Associates Strengthening Health Outcomes through the Private Sector project pilot in Nigerian was presented as an experience to be shared.

The Nigerian experience has illustrated that in a populous country where the informal sector plays a major role in the economy, the inclusion of microfinance banks in the health insurance system has been advantageous. Though there are challenges in the policy environment as well as in implementation of the policies, the health care financing model has created a win-win situation for all the key actors in the

health insurance system.

“The Role of the Private Sector in Health Care Financing” was the topic of the fifth presentation. This focused on a health care financing system, the elements of total health expenditures of different countries (including Ethiopia), and the attractiveness of the market for private sector financing. This presentation showed that there is a high demand for health care services and the private health service providers play a critical role in the access and quality of these services. Moreover, the current level of out-of-pocket expenditure points to the ability of the user to pay for the services.

Summary Day 2 Group Discussions

On the second day, the participants of the forum were divided into three groups based on their expertise and interest. Each of the groups discussed one of the three thematic areas of the forum. Each of the groups presented on the results of their discussion in a plenary session. Additional questions and comments were forwarded on the appropriate thematic area to enhance the discussion. Below is the summary of the group discussions.

Theme 1: Public Private Partnership

The concept of PPPH was elaborated on, i.e., what it is and what it is not. PPP in the health sector is not about the privatization of health services but rather this is the creation of synergy with a concerted effort from the citizens, the government and the private sector to ensure access to quality health services to the society including vulnerable population groups.

There are a variety of mechanisms that support the development of PPP in the health sector in Ethiopia. These include the Government policy and commitment to develop PPP in many sectors, the establishment of a PPP unit in the FMOH, the inclusion of PPP as one strategic element in the FMOH 20-year visioning document, the engagement of the domestic industry in the health sector, and the market (a large population and increasing personal health service demands).

PPP in the health sector for Ethiopia adds value through tapping of private sector resources, filling the gap not covered by the public health sector, improvement in quality of health services, the development of the indigenous pharmaceutical industry as well as facilitation of technology transfer. Moreover, the stability of the country and the presence of an influential Diaspora also provide a building block to PPPH in Ethiopia.

However, there should be concrete actions that translate the policy guidelines into action, and also a strong legal framework that specifically governs PPP. As the private sector in the country is not very strong, support in the development of multi-sectoral PPP and the provision of financing needs focus.

In order to accelerate the PPP in the health sector, not only the FMOH, but also other public and private institutions need to work together for improving access to quality health services. In particular, the active engagement of stakeholders is critical. These include but are not limited to the Chambers of Commerce, employee and employers' associations, health professional associations, investors, NGOs, donors, banks and insurance companies, microfinance institutes, Ministry of Finance and Economic Development and Ministry of Industry.

Concrete actions that need to be taken to accelerate PPP are needed to further continue inter-sectoral meetings and high level policy dialogue on PPP in the health sector.

Theme 2: Health Regulation

Ethiopia has the legal framework and regulatory bodies to ensure the quality of health and health related products and services for protecting public health. The regulatory functions include registration, licensing, inspection, accreditation, enforcement and development of standards. However, the overall legal framework to govern PPP in the health sector needs more elaboration and detailed directives so as to effectively implement agreements and contracts in PPP projects.

Health regulation is a system that helps to standardize the service, products and other related services according to standards. However, there are a number of factors that need to be considered when developing and implementing health regulatory standards. In the Ethiopian case in the future, all stakeholders need to be engaged during the development of standards and there needs to be the inclusion of the results of stakeholder's forums in the development of standards, policies and guidelines. More importantly, there should be due consideration of the contextual factors in the country when setting and implementing new standards. The challenges and limitation of resources should be taken into consideration while seeking to maintain standards. This implies that customization of the health regulatory standards is an important element in the health regulatory process.

Customization in health regulatory standards is necessary in situations where there is no professional or resource available as required by the standard. In such cases, standards need to be customized to locally available standards. The customization process requires a continuous review, revision and

updating of the standards.

Theme 3: Health Care Financing

Resource limited countries face more difficulty to achieve universal health coverage than developed countries. Thus, universal health coverage and its financing should be discussed in the context of individual countries. In fact, universal health coverage is not only about financing, it is also about ideology, data, and networking.

A wide range of issues that affect access to finance for the Ethiopian private health sector were discussed. These factors included policy, regulations and attitude. As a policy priority, the Ethiopian government has identified agriculture, manufacturing and the export sectors for long term capital investment and short term working capital financing. This will obviously affect the private sector investment in the health sector which is resource constrained.

Based on regulations, banks prefer offering only short-term working capital loans to the private health sector and not long-term loans. This limits the sector's capacity for growth. Many financial institutions in Ethiopia have the attitude that the private health sector is not a viable business and too often do not establish long-term relationships. The sector is considered as too risky and that it lacks sustainability. On the contrary, the history of the private health sector is one of steady growth in terms of number with rare instances of the closure of facilities. These regulations and attitudes need to change and the private health sector should be assisted with financing so that it will improve the range and quality of its services.

Participants discussed the various health insurance models for financing universal health coverage applicable in the Ethiopian context. Accordingly, three models of universal health care financing were brought up as options. These are: compulsory health insurance (payroll based), community-based insurance, and private health insurance. There was no single insurance scheme that could be a solution to such a complex problem of health care financing, and the use of a combination of these different types of health insurance system is preferred. The need for expanding the source of health financing, a stronger health tax system, and achieving a feasible premium payment are all essential to address the financing challenges.

Conclusion and Way Forward

The forum provided an excellent opportunity to bring together the key stakeholders, both public and private, to discuss pertinent issues on PPPH, health regulations, and health care financing. Participants appreciated the organization and management of the forum and called for further discussions and debate so as to internalize the relatively new concept of PPP in the health sector before embarking into changes and the implementation of new regulations and a health insurance system.

The role of the private sector in Ethiopian in general and in the health sector in particular, needs huge support to enable it to play its critical role in the provision of quality health services to the public at-large and also with a focus on the poor.

From the forum point of view, the following objectives were achieved:

- sharing experiences on successful models of the private health sector in other African countries
- generating debate and discussion on how to maximize the potential of the private health sector in Ethiopia
- discussing various financing options for universal health coverage access to emphasize the importance of PPP for high quality universal access to health care
- creating more awareness on the importance of PPP for high quality universal access to health care
- presenting the current state of the private health sector in Ethiopia

Following the discussions in plenary and small groups, the forum participants reached consensus on the following points:

1. To have continuous follow up dialogue between the public and private health sectors on all three thematic areas.
2. To form three core task groups (PPPH, Health Regulation, and Health Care Financing) and provide feedback to these groups to help them to make specific recommendations.
3. Incorporate the final recommendations of the three task groups in the forum proceedings.
4. The Ethiopian Chamber of Commerce to take responsibility to continue the public private deliberations and dialogue from where this forum left off.

I. Introduction and Speech

1. Plenary Session 1: Official Opening -Date and Time: March 26, 09: 00-09:45

a) Topic: Welcome and Purpose of the Forum

Speaker: AbdeljelilReshad, MSc, Director, Partnership and Resource Mobilization Directorate, Federal Ministry of Health, Federal Republic of Ethiopia

Key messages/highlights of the speech

The two-day forum brought together a wide range of organizations from the public and private sectors to create an increased awareness of the contribution and value of the private health sector. The three thematic areas that shaped the agenda for the two days were: Public Private Partnership, Health Regulations, and Health Care Financing.

The key objectives of the forum were:

- To share experiences on successful models of the private health sector from other African countries and develop standard PPPH legislative actions/policies, guidelines and models
- To discuss on how to maximize the potential of the private health sector in Ethiopia and to explore the best regulatory mechanism for the sector
- To reflect on how best to finance universal access to health care
- To emphasize the importance of PPP for high quality universal access to health care
- To create a dialogue between the Government and the private health sector
- To present the current state of the private health sector in Ethiopia

The forum was expected to help identify a series of priorities and recommendations in strengthening PPP, the regulatory systems of the private health sector, and in financing universal access to health services.

b) Topic: Keynote Remarks

Speaker: Tesfai Gabre-Kidan, MD, Chief of Party, USAID|PHSP

Key messages/highlights of the speech

Congratulations all stakeholders: The Government of Ethiopia, despite serious resource constraints and competing needs, has joined the global platform of achievers in health care by improving public health services and meeting global indicators. Congratulations all stakeholders.

Entry of the Ethiopian private health sector into the provision of health care: Although the 1993 Health Policy indicated that the private sector be included in all aspects of health care delivery, the entry of the private health sector into the provision of health care has been a recent phenomenon in the areas of TB, malaria, HIV and family planning. This was due to the fact that these high impact health services were provided by the public sector free of cost.

The Private Sector Program in Ethiopia (PSP-E) (funded by the President’s Emergency Plan for HIV/AIDS Relief (PEPFAR) through USAID),that was initiated in 2006 and implemented by Abt Associates in partnership with donors (e.g., WHO) and the FMOH, piloted the public private mix (PPM) diagnosis and treatment of TB and HIV testing.The PPM pilot was successful and the PPM program was born in 2009, supported by the USAID | Private Health Sector Program (PHSP).

The Private Health Sector Program’s (PHSP’s) primary objective was to support the FMOH and Regional Health Bureaus (RHBs) to partner with the private health sector to provide affordable, high-quality public health services through public-private partnerships; create demand by a well-informed public; and at the same time work towards a policy environment that would enable the private sector to achieve these objectives.

Why is the title of the forum, “Private Health Sector at crossroads?”While supporting regions and woredas, PHSP has learned the potential and limits of the private health sector. Some of the challenges of private health sector include:

- Lack of trust from the government and public due to misrepresentations and exaggeration;
- An unregulated private sector can do more harm than provide a benefit;
- Limited collective potential, i.e., the sector is not organized to regulate and represent itself.

The private health sector commitment: The private health sector has chosen to commit itself to the highest standards of care, professional integrity with sensitivity to social obligations, and to work very closely with the Government of Ethiopia. To affirm the road to constructive engagement, the private health sector has focused its support on facilities as opposed to professional associations for the collective representation in the five regions and woredas that PHSP supports, to work closely with the RHBs and if necessary augment the regions’ capacities in the implementation of health regulatory standards, supportive supervision that includes mentoring, M&E and capacity building. Moreover, private health providers have engaged in conducting an assessment of the new facility health regulatory standards to help identify what would be considered to be rational regulations within the Ethiopian context. The necessary arrangements and preparations to enable the providers to self-regulate are also under way.

Potential of the private health sector: The private health sector is capable of demonstrating accomplishments, as exemplified by the PHSP supported PPM success story. The PPM can serve as a model for rolling out and scaling up other high impact public health services to the private health sector. The intention of this forum, focusing on three thematic areas, is to draw the necessary attention to the state of the private health sector in order to recognize its full potential for the greater good of the Ethiopian people and to lead to better and bigger partnerships between the Government and the private health sector, rational regulation of health care, and health financing to assure universal health coverage.

For a win-win-win future; i.e., win for the patient, win for the Government and win for the private health sector, PHSP believes that the private health sector will emerge from the crossroads onto a road that leads to demonstrated integrity and professionalism and assure improved and quality health care for all Ethiopians.

c) Topic: Keynote Remarks

Speaker: Dennis Weller, Mission Director, USAID Ethiopia

Key messages/highlights of the speech

The achievements in reduction of infant and under-five mortality are propelling Ethiopia to achieve MDG-4. The success is attributable to determined leadership and commitment of the Government, the partnership and support of all stakeholders.

Despite gains, there are gaps within the Ethiopian health system: human resources, resource allocation, infrastructure and equipment, and sustainability and accessibility of finance.

There is a need for public private partnership (PPP) to fill the gaps. To contain costs and to improve health outcomes, to promote good and ethical governance, enhanced partnership between the public and the private sectors are a solution. We need to enhance pro-poor PPP by tapping both for-profit and not-for-profit private organizations not only in health care delivery and hospital infrastructure, but also in the operation of health programs and public health interventions.

Supportive environment for private health sector: The Health Sector Development Program (HSDP) IV and other policy frameworks encourage private sector investments in health sector. There is an increased role of the private sector in the delivery of health services in Ethiopia. As evidenced by the National Health Accounts Report, more than 40 percent of the curative and rehabilitative services are accounted for by the private sector. With Ethiopia's growing economy, the private sector's share is expected to grow quickly.

Resistance: The public health community's opposition, in principle, to the role of private sector in health care in Ethiopia is legitimate. The private health sector is diverse, fragmented and not well organized to produce concrete agendas. Quality of services can be inconsistent. Moreover, the lack of regulatory and accreditation frameworks and systems, combined with a largely uninformed patient population, can sometimes allow for an unscrupulous minority to prevail over responsible providers. However, marginalizing the private sector is not a solution.

Role of the USAID with other partners: With the intention of creating a safe, flourishing and expanding health system, USAID is working in tandem to the Government to create a robust but responsible private sector in Ethiopia. USAID's philosophy is promoting the creation of a vibrant private health sector to help improve access to health services, drive innovation, expand the culture of medical ethics, and improve accountability and value for money in health sector investment.

Results of PHSP: Operating in five regions and two administrative cities, PHSP provides technical support to more than 350 private facilities delivering HIV, TB, family planning and malaria services. PHSP is working closely with the Federal Ministry of Health and Regional Health Bureaus to effectively partner with private health providers to deliver public health services, while improving the quality and affordability of the services to Ethiopians. In addition, the USAID funded program is also engaged in capacity building activities to create strong facilities that engage the private sector, and these include:

- Support to professional associations;
- Assistance in the development of a public-private partnership framework; and
- Provision of technical assistance to develop national service and licensing standards.

USAID noted the Government's commitment to promote a meaningful partnership with the private players in health, and USAID is encouraged with this development and will work to create better health services for the Ethiopian people.

d) Topic: Keynote Address

Speaker: Pierre Mpele-Kilebou, MD, PhD, WHO Ethiopia Representative

Key messages/highlights of the speech

Thank you for bringing together public and private entities working in health in Ethiopia and also in convening international expertise that will help us to better understand the current developments and new initiatives in public private partnerships in the health sector in Ethiopia and in the African region.

Current PPP in health: Currently countries are heavily dependent on an institutional and legal basis related to existing national policies in the health sector. Mostly PPP has taken place in terms of health care delivery and the hospital infrastructure, while little has happened in the operations of health programs and public health interventions.

WHO's hopes: The World Health Organization (WHO) encourages PPP to be oriented to pro-poor efforts. It also hopes to use the opportunity of this forum to see how WHO technical cooperation can be best provided for member states in this area. WHO recognizes the importance of engaging with external stakeholders, including the private entities, and in this respect, a policy about this has been submitted to the WHO Executive board in May 2013 and is still under discussion.

WHO's expectation from the forum: WHO hopes that there will be clarification and a better understanding of the concepts, current landscape and trends in PPPs in the health sector and how this mechanism can be used to mobilize additional resources for health activities and specifically in resource-poor countries. In addition, WHO would like that this forum will cover: what PPP is and is not, the current challenges and opportunities specifically for Ethiopia and the African Region, reflections on the current experiences, examples and lessons learned in PPPs in the health sector, and see how this mechanism can be used in the most appropriate and ethical ways.

New health trends and challenges and the role of PPPs: As ageing populations increase, so too do non-communicable and chronic diseases, in addition to rapidly changing and advancing medical technologies. This is increasing the cost of delivering health care. Governments are looking to PPPs to contain costs and improve health outcomes (access and quality of health care), and thereby achieve some of the critical goals in their health policies. History and experiences of PPPs in social sectors, such as health, are recent. There is not much knowledge or evidence that

include a systematic analysis on 'best practices in PPP for policymakers to draw on' and specifically for low and middle income countries. PPPs can be explored to improve countries' health systems in the context of universal health coverage and social determinants of health through a multi-sectoral approach to address inequalities in health care. PPPs can play a role to complement public priorities with ethical principles and leadership to improve access, efficiency and quality of social and community services.

e) Topic: Opening Speech

Speaker: Dr Addis Tamre, Chief of Staff, Director General Minister's Office, Federal Ministry of Health, Federal Republic of Ethiopia

Key messages/highlights of the speech

All protocols observed, speaking on behalf of the Minister, the Minister sent his apologies and best wishes for the success of the forum.

We are living in a time where the health sector enjoys many successes: reaching MDG 4; contraceptive prevalence increased to 40%; maternal mortality reduced; HIV prevalence reduced from 9% to 1.2%; and others. And these all successes are not without the contribution of the private health sector.

The private health sector has come a long way, facing challenges and also experiencing good times starting back in the 1990s with more organized involvement as part of the health policy of Ethiopia. For the last two years, the Federal Ministry of Health has been working on a 20 year envisioning exercise. The envisioning exercise is to transform the country's health system and has six pillars; one being the strengthening of the private health sector.

The Federal Ministry of Health considers the potential in the private health sector and wants to tap that for the betterment of health services, and we need to have a way for the private health sector to contribute more, whether we call it partnership or public private partnership, we need to capitalize so that the poor benefit in all planning and engagement, to ensure a sustainable partnership in the health sector.

The theme of this forum, 'Optimize, regulate and cement partnership with the private sector for sustainable universal access' is to draw attention on effective, equitable and high quality, affordable, affordable (repeat) health care. To that end, the Federal Ministry of Health has established a PPP Unit and the development of a framework and policy is underway.

Wishing success for the forum, I officially open the forum.

Recognition of private health service providers: Despite historical restrictions on private practice in health, the transitional Government health policy introduced the need for the involvement of private health service providers, recognizing the growing need and demand for health services. In order to improve the availability and quality of health services in the country, it was acknowledged that the cooperation between various stakeholders active in the health sector has to be strengthened and intensified by exploring and developing new forms of partnership

arrangements. Since then, private health service providers are growing in numbers, particularly in urban areas.

Role of private health providers: The private sector was initially engaged in providing mainly curative services in urban areas but in the recent years, has become more engaged in the provision of public health goods, especially in reproductive health, TB, HIV care and treatment services.

Government commitment: The Government has established a PPP Unit under the Resources Mobilization and Partnership Coordination Directorate and developed a strategic framework for public private partnership in the health sector in collaboration with development partners and with the involvement of private health providers. A policy guideline for PPP to enhance the implementation of PPP projects is under development and will be realized.

II. Main Highlights of the Presentations

2. Plenary Session 2: Public-Private Partnership in Health

2.1 State-of-the-Art Lecture: PPPH March 26, 11: 00-11:50

Presenter: Mrs. Isabelle Wachsmuch, MSc, MPH, Knowledge Ethics, Research and Knowledge Translation Evidence Informed Policy Network, WHO, Geneva

Focus areas

- PPP and PPPH in context
- Current and recommended focus of PPPH
- Potentials of PPP to improve health care
- Main PPP in health care in Africa, 2005-2014
- Types of PPP and PPP contracts in health care
- PPP in health programs and evaluation criteria
- Major risks on the effects of private health care provision and its mitigation

Key messages/highlights

In general, PPP is a commitment to a common goal through joint provision of resources, expertise and risks. PPPH is any partnership in health involving the government and/or inter-governmental institutions and industry but it is not about privatization. According to the WHO definition, PPP for public health means health equity and improving the health of a population through mutually agreed roles and principles.

Historically the focus of PPP has been to mobilize additional resources and support for health activities, notably in resource-poor countries, due to under resourced state capacity. Many issues were raised on equity and access to health care in this regard. However, the current focus of PPPH is health care activities that are oriented to infrastructure (investments), products (investments in research and development into new drugs, vaccines and diagnostic tests), outcome (e.g., addressing

poverty issues related to vaccines and infectious diseases), and activities (specific drugs for a particular disease).

The recommendation now needs to focus on:

- Health capabilities and achievements oriented in health systems, to implement universal health coverage, to improve and strengthen all health systems building blocks and assure national ownership of health programs and good governance.
- Social determinants for health to ensure integrated investments from different sectors to improve well-being and social factors impacting health; this needs to have an equity focus that requires adequate social arrangements that provide individuals the opportunity to achieve good health.

Role of PPPH is to contribute and support the delivery of adequate health coverage and health systems. The trends for PPPH to manage and finance health care delivery and infrastructure show that what is spent on health infrastructure by far is less than what is spent in non-infrastructure health. Therefore, there is a need to use more in the context of low and middle income countries and under pro-poor PPP in resource-poor settings.

The processes to utilize the potential of PPPH include: understanding PPP interventions in varying degrees of success in health for infrastructure needs and health programs and services; focusing on capacity building; provision of not only quantitative, but also qualitative analysis; and the mapping of relevant stakeholders to bring them to enable them to implement together.

Type of PPPH can be categorized by type of contribution (infrastructure construction, ongoing clinical or non-clinical provisions, health programs and services) or by type of the organization (profit, non-profit, or a local community small or medium enterprise).

The type of PPPH contract (models) in health care include: franchising; design, build, finance, and operate; or private financing initiatives; build, own, and operate; build, own, operate, and transfer or concession; and Alzira.

Five key areas identified for PPPH Programs are: Research and Development; Access to Essential Health Products; Public Advocacy and Increasing Awareness; Regulation and Quality Assurance; and Training and Education.

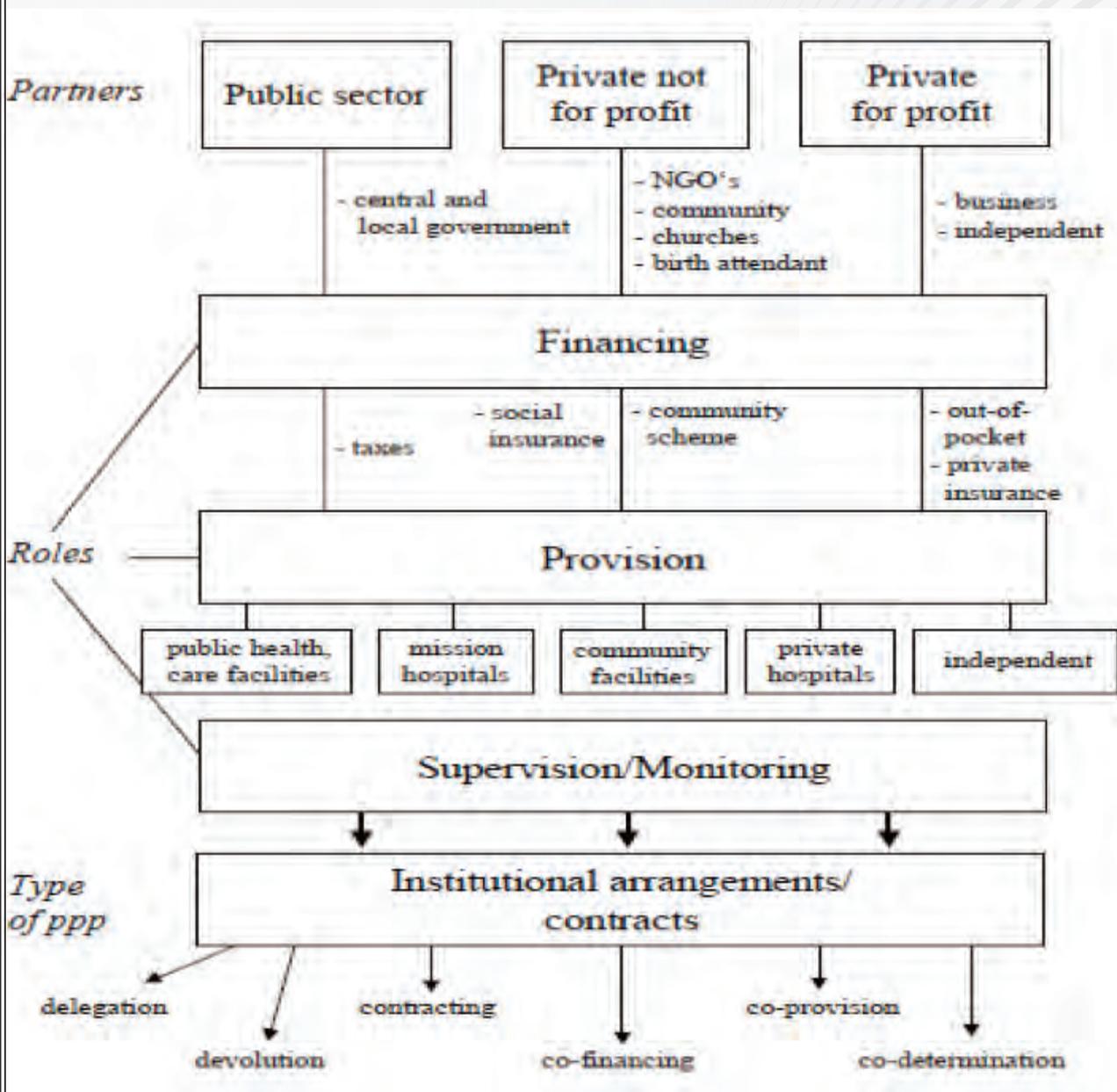
Evaluation of efficiency between public and private facilities uses criteria such as ensuring that there are: a goal, results, and access; equity; efficiency; replicability; context; and type of arrangement.

There are PPP programs that are successful elsewhere, such as Malawi's St. Gabriel Hospital, where integrated health services became exceptionally successful not only in access but also in maintaining this and in the provision of quality of care. If we ask how we can replicate such kinds of PPP into health care, we need to put preconditions of setting standards in prices and quality of the provision of health services. Additionally, we need **to ensure that the service price and quality**

is acceptable(reiterated by the MOH), to check on the role that Government plays in health care provision and the degree of control, to address potential market failures and the desired service and capacity of the Government and the private sector with a guaranteed minimum outcome in service provision.

Some risks associated with PPP include distortions in resource allocation, excessive administration and sales. The way to mitigate the risk is applying the principle of equity, i.e., the initial distribution of ownership and policy, such as having exemptions from payment for some services. A combined system for risk management, risk analysis and flexibility has to be considered to mitigate risks in PPPH programs.

Conceptual Framework of PPPH: See figure below.



Creation of new management models for public hospitals and setting up of alternative insurance schemes based on risk sharing and solidarity

Why PPP is necessary:

- The private sector alone cannot solve the problem of an equitable provision of health care services.
- A balance between curative and preventive services is critical.
- Unequal coverage, i.e., the oversupply of high quality and cost intensive services, while at the same time an undersupply of prevention services and high administrative costs are the major factors explaining the inefficiencies.

Success/challenge/implications to health care

Current challenges in health care include: overestimation of the needs for health care; overprescription of drugs; overprescription of lab tests by practitioners; privatization of care services; privatization of health insurance; poor management and sick behavior of the drugs departments, specifically in African countries; the issue of individual and collective responsibilities by health authorities, donors, scientists and all those that sincerely fought for better health among the poor.

Potentials of a PPP to improve health care include: private providers, both non-profit or for profit, can play an important role in health care provision; identify the different strengths and weaknesses of the state, for-profit and non-profit institutions; determine what extent complementarity between these partners can be organized in the provision of health care services; how PPP can improve equitable access and quality of basic public health care services.

Potential positive effects of PPPH that have been observed include empowerment at the local level, the active participation of the concerned population and synergistic effects leading to positive impacts on the efficiency, and equity and quality of health care provision. Consideration should be given to new ways of service provision and a legal framework which guarantees a transparent and credible relationship between the different actors.

Conclusion: way forward, relevance, significance to PPPH

Lessons Learned:

- Political commitment for a shift of financial and political power from the national government level to the local level and to other actors is a pre-condition for any PPP.
- Without political will to challenge vested interests, particularly among suppliers of medical inputs and equipment, it is nearly impossible to get other actors involved.
- The contribution of communities to make services available is a necessity for an effective PPP.
- The debate on the merits of different approaches has been characterized by ideology rather than evidence, with a reluctance to undertake evaluations.

2.2 Questions and Answers: March 26, 11:50-12:00

Questions and main issues raised, discussed and consensus/ conclusion reached

Questions

Chair: The need to focus on the right diagnosis for PPP has been shared in the presentation covering with the global and African context. Let us Ethiopianize it.

Questions

Q. The models presented are great. What emphasis is there on the lesson learned from political commitment? Malawi is cited as pro-poor. How does the political will help Malawi?

Q/Comment. PPP is cited as a best tool to promote global health. And also in a Washington debate, the colonial and pre-colonial PPP thinking was raised. The problem is on modalities: common goal; trust; win-win approach. There is a need for terms of reference or a memorandum of understanding for a similar platform with a regulatory framework to implement the memorandum of understanding. Our focus is on “the poor and again the poor.”

Q/Comment: In the pro-poor approach, PPP is not the primary way to reach the poor in the Malawi case. PPPH is mainly for efficiency. PPP for equity purposes allows the Government to free up resources that can then be used to help the poor, which is a group that is difficult for the private sector to cover since this sector is profit oriented.

Q. Regulation and quality assurance in PPP was raised by the Ethiopia’s FMHACA. Regarding PPP, it seems to be sector oriented. Regarding PPPH for example, construction seems to be acknowledged. But how can PPP that is sector based be sustained without having a general framework at the national level?

Q. How do you see hospital performance when comparing for profit and public?

Answers:

Malawi: Political commitment and the success: The key factor for this was good management of the project, in addition to a common goal among the partners (faith-based organization and the Government), clear understanding by the government; doctors were not permanently in the hospital; good nursing and midwifery commitment were part of the faith-based organization. There was the adaptation of technology, e.g., mobile health; PPP with one provider; and consideration of the local language. Keeping the equilibrium and managing the technical expertise are necessary to succeed

Issue of trust: This is key; the mind set and the spirit of continual learning; learn together; transparent and effective communication to anticipate risks and solutions; flexibility in not only

PPP but also in projects; seeing the different benefits of the parties must be established well in the beginning. It is also the responsibility of each party if changes appear to redo the terms of reference. Collaboration and being inquisitive are necessary to learn from each other but not to judge another.

Models: There is no one model fits all for PPP, not only in terms of efficiency but also with regard to social responsibilities, especially the small and medium enterprises that exist in the middle income countries that are interested in arriving at local solution. Sometimes the local solutions are not captured and used. Also the profit sector has additional social responsibility. Sometimes projects do not include community people as part of PPP There has to be a systematic mapping; as the arena changes rapidly, quick and fast adjustments to technology and ideology are necessary.

PPPH and sector-wide framework: We need to have a framework for a multi-sectorial approach, and then sector specific ones. The nation has to have strategies for a multi-sectorial approach, not just one.

Contributions against the sub-sectors (profit, nonprofit, small and medium enterprises): Africa for example, has many faith-based NGOs; some are aligned with clinical services, but the majority of contracts are made by a very few large organizations. These also relate to the question of profit orientation for the private sector.

3. Panel Session 1: Public-Private Partnership in Health

3.1 Presentations March 26, 13:00 – 14:45

a) Topic: State of PPPH in Ethiopia: Trends and Prospects

Presenter: Mr. Awel Ababulgu (MPH): Partnership Coordination Team Leader, Federal Ministry of Health

Focus areas

- Health policy in Ethiopia
- Current collaborations and partnerships
- Creation of an enabling environment for PPPH

Key messages/highlights

The Ethiopian health policy includes the involvement and collaboration of the private sector and includes significant incentives for both local and foreign investors in the health sector. Various programs and directives helped engage the private sector in improving access to and quality of health services. Private investors in the sector have increased tremendously in numbers and diversity but are skewed to urban areas. Due to policy and strategies implemented for almost the last 20 years with four rounds of Health Sector Development Programs, the Ethiopian public demand for quality health services has increased more than what is currently available.

Government started the implementation of the different modalities of public private partnership

specifically for increasing access to service provision in the area of TB, HIV, malaria and family planning and the like. In these partnerships the Government provides supplies and the necessary training, whereas the private facilities provide the services with nominal payments.

Success/challenge/implications to health care financing

The creation of an enabling environment for the active engagement of the private sector as well as steps being taken to strengthen PPP is considered as a success. This covers:

- The establishment of a PPP Unit in Federal Ministry of Health
- The development of a strategic framework for PPP in the health sector by FMOH
- The development by the FMOH of a policy guideline for PPPH
- The development of a legal and policy framework at national level by Ministry of Finance and Economic Development (MOFED)

Despite the various public private collaborations, the challenge is that these partnerships are based on non-legally binding memoranda of understanding. There is a lack of a legal framework to further strengthen these collaborations.

Conclusion: way forward, relevance, significance to PPPH

The health policy and the various programs and directives of the Government have created an enabling environment for the active participation of the private sector in the provision of health care services.

The development of a strategic framework for PPPH and the establishment of a PPP Unit by the FMOH illustrate that the right steps are being taken to foster PPPH. Furthermore, policy guidelines and national frameworks for PPP are under development and will enhance PPP when implemented.

There are already a number of collaborations and partnerships between the public and private sectors in the health sector and these would be further strengthened by the development of an appropriate legal framework, which is currently lacking.

Questions and main issues raised, discussed and consensus/ conclusion reached

Refer to the questions and discussion under 3.2.

b) Topic: Legal Framework for PPP

Presenter: Benyam Tefesse, LLB, Associate Dean and Lecturer, College of Law and Governance Studies, School of Law, Addis Ababa University, Addis Ababa, Ethiopia

Focus areas

- The need for a PPP legal framework
- PPP and a legal framework in Ethiopia
- Major issues that impact PPPH in Ethiopia

Key messages/highlights

The presentation focused on what ought to be done, as we do not already have an existing framework for PPP. It is a nice gesture that the FMOH started developing a PPP policy and strategies.

What is required for a legal framework:

- A successful PPP experience that is supported by a policy, procedures, institutions, and rules defining PPP implementation
- The selection, preparation and procurement of projects require a PPP guideline
- A regulatory framework to sustain the effectiveness of a long-term contractual PPP agreement (to be done according to law not just for interest purposes)

Sample general PPP laws:

- Kenya PPP Act of 2013, Turkey's healthcare PPP law

Ethiopia has policy provisions in the various sectors for PPPs and a national health policy that includes ensuring quality through an inter-sectoral approach; the only law, i.e., Proclamation 649/2009-Public Procurement Proclamation, Art. 27 talks about three modalities for PPP, e.g., Art. 34 states that the Ministry of Finance and Economic Development may issue a prescriptive directive. What is recommended is to have a flexible procurement procedure, but Art. 34 includes the provision for drafting a law. The proclamation also mostly talks about concessions. The 1960 Civil Code also deals with contract of concession, taken from the French system.

Success/challenge/implications to PPPH

Major issues that impact PPPH in Ethiopia:

Contract awarding and procurement rules: Require flexibility. They are not designed for PPP or the private sector (only for public procurements).

Ethiopia bankruptcy regime: The law has to be amended, because during bankruptcy, the focus is on liquidation, but the law should give a chance to come up again (flourish). ***The incentive mechanism:*** Investment laws do not allow for tax holidays for health and diagnostic services; there are provisions for importation of construction materials, not for service.

Other forms of Government support: This includes guaranteed loans, training support and facilitation of access to land and markets put in place by the Government for private sector engagement in sector-wide activities can be a good foundation for PPPs, but these must be specially tailored for PPP project needs.

Conclusion: way forward, relevance, significance to PPPH

Government needs to have a comprehensive PPP policy which would serve as a spring board for the formulation of general and specific of PPP laws.

In order to ensure the application of the PPP mechanisms, relevant new legislation should be adopted as well as existing laws should be amended whenever necessary.

Questions and main issues raised, discussed and consensus/conclusion reached

Refer to the questions and discussions under 3.2.

c) Topic: The State of the Private Health Sector in Ethiopia

Presenter: AsfawessenGebreyohannes (MD), Director of Clinical Services, USAID|PHSP, Abt Associates Inc.

Focus areas

- The policy environment for the private health sector
- The private health sector in Ethiopia: size, scope and contribution
- The legal framework and financing the private health sector
- Way forward for the private health sector and the Government

Key messages/highlights

The policy environment in the country has enabled the private health sector to develop and increase its influence in the provision of health services in both urban and rural areas. The private health sector in Ethiopia is considered a diverse and complex industry contributing to health and economic development. Weak organization and networks within itself and lack of transparency in the business aspect characterizes the private health sector.

The private health sector is making a significant contribution in the delivery of health services, providing key public health services and advanced health care. The private health sector in Ethiopia comprises of over 4,000 health facilities; about 4,170 pharmacies, drug vendors and stores; 124 importers; and 13 manufacturers of medical equipment. Furthermore, the private health sector has about 40 diagnostic facilities and more than 80 training institutes.

The private health sector was operating unregulated for two decades. FMHACA has been the regulatory body since 2009, and responsible for the implementation of new standards for all types and levels of health facilities. However, there are concerns, particularly in the implementation of the new standards which are not simple for either the public or private health sectors to follow.

The issue of financing has become critical for the development of the private health sector. The majority of the private health facilities is self-financed and faces many barriers to gain access to finance.

Success/challenge/implications to PPPH

The following examples of achievements by the private health sector indicate its relevance and contribution in the delivery of health services in the country. Some of the results achieved so far include:

- The private health sector is the source of advanced health care in the country.
- More than one third of pregnant women in Addis Ababa deliver and receive HIV testing in private health facilities.
- In terms of TB, 5-26% TB case detection notifications are done by private health facilities.

Conclusion: way forward, relevance, significance to PPPH

The way forward for the further development of the private health sector includes the concerted effort from both the private health sector and the Government.

The private health sector in Ethiopia requires the following:

- Establish a representative organization and ensure that there is meaningful interaction and dialogue with the Government, banks, etc.
- Consider group investment to overcome financial barriers to expand business
- Build capacity towards self-regulation
- Strengthen skills in and increase knowledge about business management

On the other hand, the Government of Ethiopia needs to:

- Translate policy statements into concrete and workable actions
- Formalize interaction and dialogue with the private health sector towards PPP
- Establish a structure within the Federal Ministry of Health and Regional Health Bureaus to be responsible for working with the private health sector
- Engage the private health sector in planning, monitoring and reviewing the health sector

Questions and main issues raised, discussed and consensus/conclusion reached

Refer to the questions and discussions under 3.2.

d) Topic: PPPH: The Case of South Africa-Successful Models and PPP in Non-Clinical Services

Presenter: Barry Kistnasamy, Executive Director, National Institute of Occupational Health , Department of Health, South Africa

Focus areas

- Rationale for PPP
- The systems approach to PPP
- Lessons learned from South Africa's PPP in non-clinical services

Key messages/highlights

The rationale for the PPP in non-clinical services in South Africa is a policy option that seeks to re-introduce a greater reliance upon private inputs into the health sector, share risk and achieve better health outcomes. The PPP in the non-clinical services is preceded by different stages of PPP in state enterprises, infrastructure and utilities, and finally in social services.

The health market is a complex system that involves various actors and stakeholders with varying interests. The private health sector, within this market system, comprises of private health services (both formal and informal), private financing of the health services, and private provision of products (manufacturers and distributors).

A systems approach towards the management of PPP allows for the consideration of a range of issues and actors that will influence the success of the partnership. The PPP experience of South Africa focused on the non-clinical services which included clinical support (in the areas of diagnostic services, elective patient transport, and clinical engineering) and in the non-clinical support (mainly the hospitality services, i.e., porters, catering, security, maintenance, cleaning, and gardens) and administrative services (filing, archive, revenue collection).

Successes/challenges/implications for PPPH

Lessons learned from the South Africa case showed that PPP would be successful when there are:

- Proper procurement processes
- Effective contract management
- Transparency and information sharing
- The availability local suppliers of services
- Safety, health and environment issues are considered
- Continuous capacity building
- Capacity enhancement
- Payments made on time

Conclusion: way forward, relevance, significance to PPPH

PPP in Ethiopia could begin with outsourcing non-clinical activities, and the success of the partnerships depends on a wide variety of issues, from policy level to that of operational issues such as contract management and effecting payments when they are due.

Questions and main issues raised, discussed and consensus/conclusion reached

Refer to the questions and discussions under 3.2.

3.2 Discussion and Conclusion: March 26, 13:45-14:25

Questions and main issues raised, discussed and consensus/conclusions reached:

Q1. To what extent should our regulations be flexible?

In terms of the degree of flexibility of the rules and regulations to be applied for a PPP arrangement, it is essential to look into the details and identify if there are barriers in the regulation that do not support the partnership. For instance, it would be difficult to apply the public procurement law as it is in PPP, where the private and public actors work together. Though accountability is always there, the speed of the response and efficiency may be in question if the lengthy process is followed.

Therefore, if there are areas of concern in the regulations, they should be amended or new regulations should be developed. In general, a balance should be struck in these regulations to allow the benefits of the partnership without creating loop holes for unwanted practices.

Q2. Why is the contribution of the private for-non-profit organizations not considered in the PPP discussions?

PPP is a partnership that also involves civil societies, not –for-profit organizations and NGOs. The actors in health care services are diverse and partnership is all about creating synergy among these stakeholders. It is not only the private and public institutions per se, but also all other forms and types of organizations in the health sector. In the current civil society and NGO law, PPP in the health sector may not be explicitly addressed. However, the Ministry of Finance and Economic Development will soon develop a framework for PPP in all sectors and not just in the health sector, and a great part of this issue would be addressed in the framework.

Q3. With regard to an enabling environment, why is the private sector not engaged in the development process of policies and strategies with the Federal Ministry of Health?

There has been the participation of the private sector in policy and strategy development but the representation was evidently not strong. For instance, different medical and health professional associations have been invited and participated in various consultation forums but these associations are not necessarily the representatives of the private health sector. Strong private sector representation in policy dialogue is desirable for the benefit of all.

4. Panel Session 2: Health Regulations

4.1 Presentations: March 26, 14:35 – 16:00

a) Topic: State of Health Regulations in Ethiopia

Presenter: Mengiste-AbW/Aregay, Deputy Director General, Standard and Licensing, Food, Medicine and Health Care Administration and Control Authority, Ethiopia

Focus areas

Health Reform

- Overview of regulatory functions
- Achievements
- Challenges
- Recommendations

Key messages/highlights

“Life is partnership,” so regulation is important for coexistence.”

To drive the country to meet the MDGs and attain middle income by 2025, the 20 year Health Sector Development Program has resulted in positive outcomes. The Health Reform/Business Process Re-engineering has identified two gaps: access and quality in health. The reform has three pillars (provider, purchaser and regulator), six outcomes and eight core processes.

The regulatory process is meant to protect the public from unsafe and substandard/ poor quality health and health related products and services. The regulatory core processes include: Regulatory Standards Setting (no double standards); Inspection and Licensing; Product Quality Assessment and Registration; Regulatory Information Delivery System; and Medico Legal.

The regulatory process and bodies are established with a legal framework, Proclamation 661/2009 and Regulation 299/2014 for the Ethiopian Food, Medicine and Health Care Administration and Control Authority. Regulation 189/2010 establishes FMHACA.

Objectives of the regulatory sector are:

- To establish and maintain an effective and efficient quality assurance, market authorization, inspection and licensing system.
 - To ensure safety, efficacy, quality and proper use of medicines (conventional and traditional)
 - To ensure food safety and quality
 - To standardize health services and protect the public from unqualified and unethical professionals and substandard health institutions
 - To ensure an uninterrupted regulatory information provision and promote rational drug use
- It is difficult for FMHACA to set clear difference between private and public (!!).

Regulatory bodies are three tiered: Federal, regional states regulatory body and an additional 850 district regulatory bodies (each with around 10 staff). FMHACA believes in sharing responsibilities among the health regulatory sectors, like the saying, 50 lemons are a heavy load for one but 50

lemons for 50 individuals are like a medicinal ornament. So sharing responsibilities is necessary. This is also manifested in the thematic areas of the Strategic Plan 2011-15.

Success/challenge/implications to health regulation

Major regulatory functions and achievements include: community ownership for regulation (partnership); Regulatory Standards Setting, promoting and enforcement; product quality assessment and registration; product post-marketing surveillance; pre-import approval; port inspection and clearance permit; Inspection and Licensing; control of narcotics, psychotropic substances and tobacco; ensure proper disposal of wastes; Regulatory Information Delivery System; Medico Legal (suspend license but we do not do it, etc.)

Major challenges of the regulatory activities include:

- Inadequate regulatory body capacity with regard to human resources and finance at Federal (FMHACA), regional and district levels
- Inadequate enforcement of the major regulatory functions of health facilities' standards in existing health facilities
- Regulatory functions not backed by information communication technology and networking
- Inadequate availability of appropriate disposal facilities
- Licensing and registration of health professionals not based on an objective ethical and competence-based review system
- Inadequate support by development partners for regulation
- Inadequate partnership and self-regulation

Conclusion: way forward, relevance, significance to PPPH

There is the need to:

- Strengthen capacity: efficiency, effectiveness, and coverage
- Invest in compliance of the health facility standards
- Enable the private sector associations at different levels to also have influence

Sample PPP for Ethiopians is the renaissance dam. This is being built with contributions from the public and private stakeholders. Here also, let us work hand-in-hand, and we can mitigate our challenges.

Questions and main issues raised, discussed and consensus/conclusion reached

Refer to the questions and discussion under 4.2.

b) Topic: Collaborative Public-Private Quality Improvement: Experiences from Jordan

Presenter: Salah Gammouh, PharmaD., Deputy Chief of Party, Health Systems Strengthening II Project, Jordan

Focus areas

- Health Systems Strengthening II (HSS II) Project
- Primary health care quality improvement component
- The collaborative approach

The presentation focused on how Jordan's experience fits with previous points. For example, The building blocks on how to start a PPP: capacity, results; how to do PPP: set standards; service provision; an enabling environment; implementation; common challenges: human resources; finance; equity in care, etc.

Key messages/highlights

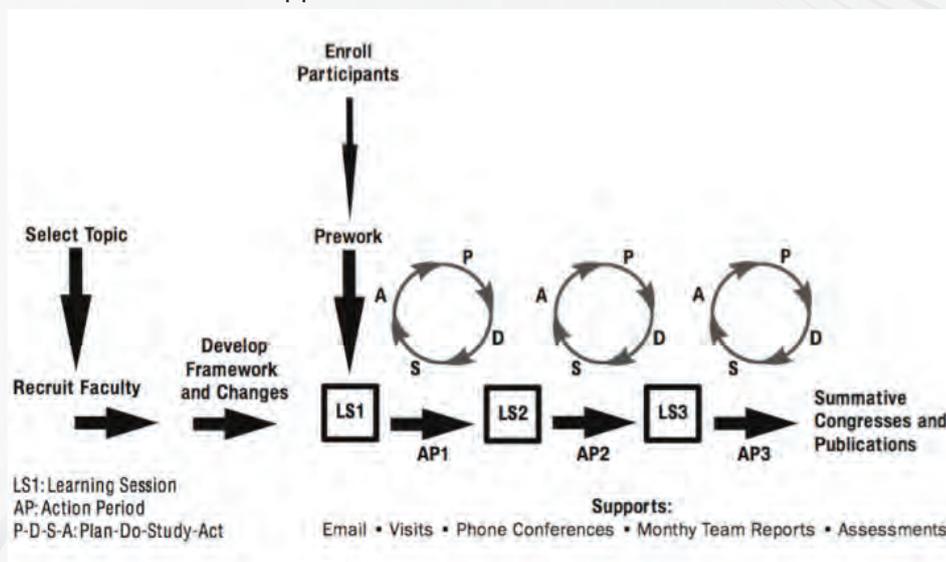
Jordan has a health system (Ministry of Health) that has 252 Village Health Centers, 367 Primary Centers, 81 Comprehensive Health Centers, and 29 hospitals.

HSS II background: Common focus is quality; introduce quality inspection teams for quality improvement (QI)

HSSII Results Framework has six areas: Knowledge Management, QI /Primary Health Care, Safe Motherhood, Family Planning, Community Health with improved human resource capacities across all areas due to their effect.

Quality improvement at the primary health care level covers: QI and accreditation; a referral system; updated clinical guidelines updated; updated and tested medical records; and operational planning.

The primary health care/family planning QI collaborative approach to increase accreditation: traditional one (set structure) + collaborative (learning sessions) applied to check your gaps and improve. Quality Structure: policy is at the top and responsibility at bottom, but all included. The key elements of the collaborative approach is below:



Meeting the standards: Standards are classified as critical, core, and stretch. Accreditation requires meeting 100 % of all critical standards, 70 % of core standards, and 40 % of the stretch standards.

Success/challenge/implications to health regulation

QI is referral system. The catalyst from the private sector is Jordan's National Health Agenda 2006-15 that sets accreditation as a health care priority. The Health Care Accreditation Council that was created in 2007 has achieved International Society for Quality in Healthcare certification for its primary health care/family planning. Setting standard... and achieving them! how to achieve the standards is important.

Institutionalization and sustainability initiatives/successes include: a number of Ministry of Health staff are now accredited surveyors; synchronized internal management processes; learning sessions led by the Ministry of Health counterparts; a toolkit and guidelines for primary health care/family planning.

Conclusion: way forward, relevance, significance to PPPH

Private-Public: Profit, increase profit while decreasing costs; public service coverage at reduced costs. Therefore, PPPH can work in areas where costs can be reduced.

Standards must be the same for all; decreased cost equals obtaining service quality and this implies increased demand.

Questions and main issues raised, discussed and consensus/conclusion reached

Refer to the questions and discussions under 4.2.

c) Topic: The Essentials of Health Regulations in Resource Limited Countries

Presenter: Barry Kistnasamy, MD, Executive Director, National Institute for Occupational Health, National Health Lab Services, South Africa

Focus areas

- Policy frameworks and regulatory instruments that governments can use
- External factors affecting the health sector

Key messages/highlights

Policy frameworks: Normally policy comes from the political party level and then this is incorporated into government system.

Frameworks are cross sectoral and should include Ministry of Finance and functional line ministries with regulations, and PPP support units.

Financing options: health insurance; demand driven community financing schemes; vouchers in reproductive care, i.e., no cash transfer; and tax exemptions, e.g., if you want to bring in somebody into the country, you need to talk to immigration.

Regulating the private (and public) sectors, e.g., nursing and medical schools of low quality standards are flourishing in Africa, and we should manage these. How? With licensing,

accreditation, certificate of need (is the ordered examination needed or through inspection), standards compliance Office (patient satisfaction).

Different types of PPP: contracting, leasing concessions, franchising and divestitures (selling the land, may be renting in Ethiopia)

PPP pitfalls to avoid: Sole source and no competition; must specify services that the private sector must provide; include penalties; define costs and who bears what risk; establish who will monitor the contract; and establish the duration of contract.

Governance: Need to ensure no corruption; transparency/upfront declarations by Government officials and service providers (check bank accounts); tax compliance and good citizenry (carbon trading, waste disposal, do not exploit workers; certificate of tax compliance).

External factors affecting the health sector: Trade-Related Aspects of Intellectual Property Rights Agreement (World Trade Organization patents, copyrights, etc.); traditional medicines; the General Agreement on Tariffs and Trade: movement of services; and globalization (brain drain); remittances; WHO framework for mobility.

Enabling Mechanisms for PPP: Covers: strong leadership and political commitment; good governance; an appropriate regulatory framework; efficient tax systems; genuine risk transfers; level playing field; access to finance.

Success/challenge/implications to health regulation

South Africa's Regulatory Framework for PPP:

The Constitution (Act 108 of 1996), Section 217 (1): "When an organ of state... contracts for goods and services, it must do so in accordance with a system which is fair, equitable, transparent, competitive and cost-effective."

Public Finance Act (Act 1 of 1999): Accounting Officer or Accounting Authority is responsible for effective and efficient use of fiscal resources in the public interest. Procurement is the responsibility of the Accounting Officer/Authority.

Treasury Regulation 16 (2004): Issued in terms of the Public Finance Management Act (1999) with the power resting with national treasury. Delegation to provincial treasuries is possible.

National Treasury PPP Manual and Standardized PPP Provisions: This is based on the Public Finance Management Act and Treasury Regulation 16 and issued by national treasury as a practice note.

- Consider the whole health system and not just the public sector (quality of care, financing, provision)
- Ensure that the organization encourages public sector to have a PPP policy, structures, focal persons and procedures and the private sector becomes organized;

Expand and scale Up: Given the results so far, PPPs may make a real difference in achieving MDGs.

Evaluate: Evidence is good but not great; evidence should be used to make decisions about PPPs and apply lessons learnt.

Conclusion: way forward, relevance, significance to PPPH

The establishment of a PPP Unit in the Government is a good sign to work together. The private sector does not work without professionals and lawyers, however the public sector lacks that approach and support and Government should think about and check that.

Shift should be from doing and growing to coordinating and steering.

Move towards regulatory, monitoring and enabling activities; and ensure CAPACITY.

Questions and main issues raised, discussed and consensus/conclusion reached

Refer to the questions and discussions under 4.2.

d) Topic: Self-Regulation in Health Care

Presenter: Birhanu Tekle, MD, MPH, Board Chairman, Medical Association of Physicians in Private Practice in Ethiopia (MAPPP-E)

Focus areas

Hippocratic oath origin of self-regulation

- What and why is self-regulation?
- Conceptual framework on self-regulation
- Situating self-regulation and its categories
- Benefits of self-regulation to (facility, regulatory sector)
- Ethiopia - the way forward

Key messages/highlights

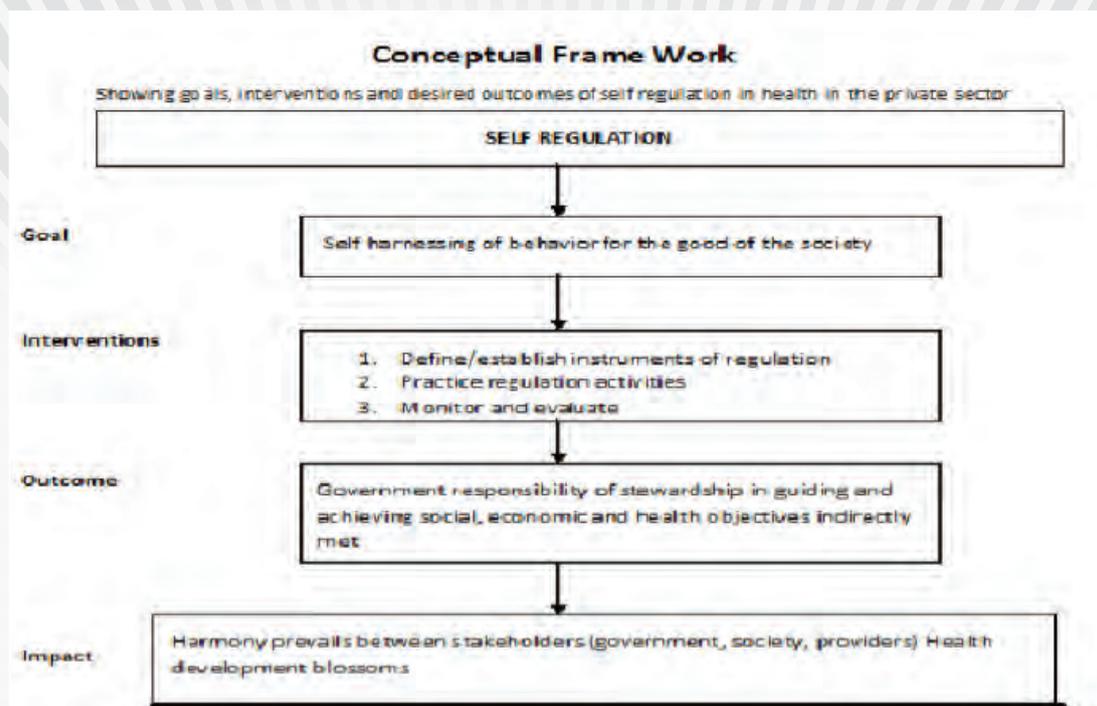
Self-regulation: not known in Ethiopia.

Hippocratic oath on the origin of self-regulation, its legacy that a physician positions her/himself in different states and all is behavioral self-regulation.

What is self-regulation?: It is the conduct that organizations, groups take/act by themselves. Regulatory rules are self-specified; conduct is self-monitored; and the rules are self-enforced. Usually it is a mixed scheme and the focus for Ethiopia is on self-regulation.

Rationale/arguments for self-regulation: Dispute resolution; efficiencies in cost.

Conceptual framework:



Situating self-regulation: There is either no regulation, self-regulation, co-regulation or statutory regulation.

Categories of self-regulation: 1) cooperation– this is between the regulator and regulated on the operation of statutory regulation; 2) delegated -- the delegation of implementation of statutory duties by a public authority to self-regulatory bodies; 3) devolved -- the devolution of statutory powers to self-regulatory bodies, often thought of as ‘statutory self-regulation’, i.e., the specification of self-regulatory schemes in statute; 4) facilitated --- self-regulation explicitly supported by the state in some way but where the scheme itself is not backed by a statute; 5) tacit -- close to ‘pure’ self-regulation or self-regulation with little explicit state support, but its implicit role can be influential.

Success/challenge/implications to health regulation

Benefit to regulator: The regulator can overcome political constraints and minimize regulatory capture; administrative costs can be lowered by the regulator and information about the role and activities performed by private providers can easily be obtained by the regulator for evidence based decision making.

Benefit to the sector: Stakeholder satisfaction; market failure can be prevented; social and economic objectives can be achieved; and health development can be expedited.

Benefit to facilities: Improvement in quality of services; customer satisfaction; increase in revenue; and growth and expansion

Conclusion: way forward, relevance, significance to PPPH

- In Ethiopia, self-regulation is permitted as part of the political economy
- Statutory regulation is in place
- Professional associations are many
- Need to define instruments for self-regulation
- Develop selection criteria for choosing the professional bodies to be given statutory delegation
- Operationalizing self-regulatory work
- Develop M&E framework to oversee the implementation of delegated self-regulation by the Government

The saying goes, “gan be’tteter yidegafal.”

Questions and main issues raised, discussed and consensus/conclusion reached

Refer to the questions and discussions under 4.2.

4.2 Discussion and Conclusions: March 26, 15:20-15:55

Questions and main issues raised, discussed and consensus/conclusions reached

Summary

On the topic of what should be regulated and how, the areas covered included: community engagement; working to reduce costs; financing PPP; conducting a needs assessment for areas; declaring a conflict of interest, Trade-Related Aspects of Intellectual Property Rights; the ethical foundation of self-regulation and a step by step self-regulatory process being a better option to a punitive process in terms of cost and efficiency.

Questions

Q. On the idea of self-regulation, for example, we regulators want to address self-regulation. One way we do it is by involving professional association as part of regulatory advisory committees. What is the difference?

Q. The private sector says that the Government does not have a strong stick to bring everyone in line. How do we use self-regulation in this aspect? Advise us.

Q. Many sayings are heard today such as: the private health sector is at a broken crossroad; no double standard in regulatory system. There are challenges in implementing the standards issue with regard to the Government’s commitment to use its own standards. How can self-regulation work where one hospital serves so many districts in Ethiopia?

Correction: FMHACA in Gambella is not under the RHB.

Q. Can we elaborate on Jordan’s three types of health system?

Comment: The regulatory body should not use regulation for punitive purposes; it should capacitate (emphasis on Jordan's collaborative approach), especially when the private health sector is not aware of the rules and regulation. We do not receive all the frameworks and regulations plus training. The saying goes that a 'grandchild asking granny why we cut the Fish's tail and head?' The business as usual approach does not change things. Let us work sincerely.

Answers

A.Regulation is also self-regulation. We create capacity by involving the community and we do it in a systematic way like holding different meetings and discussions. The Government considers community as its strength. Let us work wholeheartedly. Let us create a forum to work with the public too. We are not alone.

A.Different groups say the regulatory body is lenient. No double standards for any hospital. Studies are being conducted, and we are refining the existing standards.

A. The three sectors in Jordan are: Village Health Sector, Primary Health Sector, and Comprehensive (like radiology, surgeries).

A. An example of a self-regulation exercise in South Africa: a lottery system for regulation is used. We select 10 percent and ask them to fill out a questionnaire. The advantage of a lottery is that they do not know that they will be inspected.

A. In self-regulation, there is the stick and carrot capacity approach for the regulator. There is a need to adopt both a self and statutory-based approach together. The advice is the same for preventing market failure through a working PPP, which is also should be self-regulated.

5. Panel Session 3: Financing Universal Health Coverage

5.1 Presentations March 26, 16:20: 17:15

a) Topic: Current Practices and Prospects in Financing Health in Ethiopia

Presenter: Mr. Abduljelil Reshad, Partnership and Resource Mobilization Directorate, Federal Ministry of Health

Focus areas

- Policy and strategy adopted in health financing in Ethiopia
- Goals of health care financing
- Sources of health care financing
- Requirement for achieving universal health coverage

Key messages/highlights

The Federal Government of Ethiopia has adopted various policies and strategies that help improve the access and quality of health services for the public.

The development of National Health Policy as well as the development of a 20 year Health Sector Development Program launched (1998-2018) with the basic objective of improving the coverage and quality of health services are cited as prime examples.

The public health service is currently financed from diverse sources: Federal, regional and local governments cover 21% of the total health expenditure whereas donors and international NGOs

finance 39% of the total expenditure. Private households cover 37% by means of out of pocket purchases and private employers and national NGOs share the remaining 3%.

Success/challenge/implications to health care financing

The major achievements to date to improve health financing include:

- Development of the Code of Conduct(Oct 2005)
- A Health Sector Development Program Implementation Manual (HHM) developed (April 2007)
- An Ethiopian International Health Partnership roadmap launched (February 2008)
- Country International Health Partnership Compact developed and signed (Aug 2008)

Conclusion: way forward, relevance, significance to health care financing

Three important dimensions that need to be focused on to provide the required financing for universal health care:

- Maximizing efficiency of resources
- Increasing the resource envelope
- Developing sustainable revenue streams
- MDG Performance Fund Joint Financing Agreement developed and signed (April 2009)
- Health care financing reform implemented in health facilities

Questions and main issues raised, discussed and consensus/conclusion reached

Refer to the questions and discussion under 5.2.

b) Topic: Models of Health Insurance for Universal Health Coverage

Presenter: Mr. LeulsegedAgeze, Chief of Party, USAID Health Sector Financing Reform/Health Financing and Governance Project, Ethiopia

Focus areas

- Dimensions of universal health coverage
- Challenges of health financing
- Financing policy for universal health coverage

Key messages/highlights

World Health Assembly Resolution 58.33, 2005, urged countries to develop health financing systems to ensure that all people have access to needed services without the risk of financial ruin linked to paying for care.

Universal health coverage is measured along three dimensions:

- Population dimension – who is covered?
- Services dimension – which services are provided?

- Financial protection dimension – what do people have to pay out of pocket?

The interplay of raising more money, pooling it and using it well is the direction countries should follow. Introducing health insurance or reducing user fees does not necessarily reduce out of pocket payments without focusing on how providers are paid. The various types of health insurance and their major sources of financing are also presented as summarized in the table below.

Types of Insurance Model	Financing Source
National health insurance	General taxes
Social health insurance	Payroll taxes from employers and employees
Private voluntary insurance – commercial	Premium payments from individuals or employers/employees
Community- based health insurance	Premium payments from individuals and/or community

Success/challenge/implications to health financing

The major health financing challenges are summarized in three areas. The first one is the challenge of raising sufficient funds for health services. The second one is ensuring financial risk protection, i.e., ensure that financial barriers do not prevent people using needed health services nor lead to financial ruin when using them. The third major challenge is related to minimizing inefficiency and inequity in using resources and assures transparency and accountability in the health system.

Conclusion: way forward, relevance, significance to health financing

No country fully achieves all the universal health coverage objectives, and this is even more difficult for poorer countries. The overall policy needs to be “moving towards” universal health coverage, not “achieving” it. Effective governance is key to improving financing and to move towards the goal of universal health coverage.

Questions and main issues raised, discussed and consensus/conclusion reached

Refer to the questions and discussion under 5.2.

c) Topic: Private Health Sector Access to Finance: The African Experience

Presenter: Meaghan Smith, Banyan Global, Washington, DC, USA

Focus areas

- Importance of access to finance for private health providers
- Sources of finances for private health care providers
- Challenges to access for finance
- Recommendation to increase access to finance for the private health care providers

Key messages/highlights

In most countries in Africa, financing is limited and lack of access to finance has been identified as a major barrier to the development of the private health sector. Lack of access to finance has a negative impact on scale and quality of health care services.

In many countries, financial institutions do not lend to the health sector in a significant way. In some countries, the regulatory environment restricts lending. On the other hand, many private providers lack business and financial management skills and have difficulty preparing a bankable business plan.

Sources of financing for the private health sector in Africa include equity (international investment funds, social impact funds, local funds, and individuals), leasing and supplier credit, loans (from local financial institutions and international loan funds), remittances, and individual savings.

The Strengthening Health Outcomes through the Private Sector (SHOPS) project is operating in Ethiopia with the objective of increasing the use and range of HIV services and sustainability of private health providers through enhanced business capacity and access to finance. The project works closely with stakeholders and provides support to hospitals, pharmacies, and two private banks. The SHOPS approach is to work on both the demand and supply side of financing to increase access to finance in the private health sector in Ethiopia.

Success/challenge/implications to health care financing

SHOPS results to date include:

- 11 loans totaling 23 million Ethiopian Birr (US\$1.2 million) approved
- loans used for: purchasing equipment, renovating facilities, for working capital
- 22 loans currently under review by banks
- 229 health providers trained in business management skills
- 35 providers received one-on-one business counseling

The main challenges to access finance for the private health sector include:

- Policy environment (Central Bank has requirements and the Government prioritizes sector lending programs which do not include the health sector)
- Financial sector development (this includes the lack of liquidity, low competition)
- Limited products, and few alternative financing options)
- Marketing the health sector to banks (the challenge of prompting the health sector as a niche market, and balancing health goals and commercial viability)
- Credit guarantee as an incentive

Conclusion: way forward, relevance, significance to health care financing

Recommendations for the way forward include:

- Changes in the regulatory environment (making health a priority sector) would incentivize lending to the health sector
- Support investment
- Structure and support guarantees and credit lines for health sector lending
- Promote leasing

- Promote Diaspora investment and reduce the transaction costs for remittances

Questions and main issues raised, discussed and consensus/conclusion reached

Refer to the questions and discussion under 5.21

d) Topic: PPP for Low Cost Commercial Health Insurance: An Experience from Nigeria

Presenter: Jeff Barnes, Principal Associate, Abt Associates Inc., Bethesda, MD, USA

Focus areas

- The Nigeria National Health Insurance Scheme and the Health Care Financing I Model
- Benefits of partnership with microfinance banks
- Abt Associates supported pilot
- Challenges of the Nigerian health insurance

Key messages/highlights

The National Health Insurance Scheme (NHIS) of Nigeria is limited to the formal sector government workers and has not expanded beyond this. The NHIS has helped establish and expand the number of private health insurers in Nigeria and has also popularized use of capitation funding (through the Health Care Financing I Model) which provides incentives for preventive care. Challenge for the health insurers in reaching low-income groups has been reaching scale while maintaining low costs in administration.

The development of a partnership with microfinance banks in Nigeria, using the Health Care Financing I Model, has created a win-win situation for the households, the health care service provider, the microfinance banks, and the private insurers. Such an approach reduces the risk of default for microfinance banks while reducing costs of marketing and the premium collection for the private insurer while providing low cost insurance for the borrower.

Health Care International and Seap Microfinance Bank partnered to sell health insurance to borrowers. From 2010-2013, 13,600 persons out of 20,000 Microfinance Bank members enrolled with a premium cost between \$22 and \$40 per person per year. Coverage included consultations, inpatient care, annual exam, maternity care, minor surgery— with a \$1,875 maximum payout per person per year. So far, it is so fully sustainable, but slow to scale up.

Abt Associates, through the Partnerships for Transforming Health Systems (PATHS) 2 project, is attempting to facilitate scale up and document the model to convince the State Ministry of Health to introduce a targeted price subsidy to increase demand. This encourages microfinance banks to market health insurance and collected premiums through a loan repayment process. Health insurance should be required for loans above a certain amount and promotes the policy using a cost effectiveness of capitation— to encourage providers to offer preventive care.

Challenges/implications to health care financing

The challenges in the Nigerian Health Insurance system include:

- Difficult environment, price sensitivity and lack of trust in financial institutions

- Lack of incentives for microfinance bank loan officers to market insurance
- Lack of availability of quality health facilities in rural areas
- Low levels of literacy and high documentation needs to process insurance claims
- Need to show cost savings to ensure government provision of the subsidy

Conclusion: way forward, relevance, significance to health care financing

The Nigerian experience has showed that in a populous country where the informal sector plays the major role in the economy, the inclusion of microfinance banks in the health insurance system can be advantageous. Though there are challenges in the policy environment, the Health Care Financing IModel has created a win-win situation for all the key actors in the health insurance system.

Questions and main issues raised, discussed and consensus/conclusion reached

Refer to the questions and discussion under 5.2.

e) Topic: The Role of the Private Sector in Health Care Financing

Presenter: Dr. Ambrose Nyangao , Insight Health Advisors, Kenya

Focus areas

- Health care financing system
- Financing proportion of the total health expenditure
- Market for private sector financing

Key messages/highlights

Health care financing involves the mobilization of funds for health care, the efficient allocation of these funds to targeted groups, and the mechanisms for paying health care. In general, health care services are paid by different mechanisms including the government (taxes ,a national health insurance scheme or both), a private insurance scheme, an employer, employee contribution, out-of-pocket, charity and private voluntary organization, medical savings accounts, and/or foreign aid.

The financing of health care is categorized into two types, public and private financing. The method of public financing involves internal financing through a unified or fragmented social insurance system as well as securing external funding for health service. The methods of private financing include user payment (out-of-pocket payment), for-profit or non-profit private insurance, medical savings voluntary or compulsory, and contributions of employers and employees.

The total health expenditure (THE) of some countries was discussed to get insight into the proportion of financing as a percentage of the gross domestic product as a share of the private health sector and out-of-pocket expenditures. According to WHO (2012), Ethiopian's THE as a percentage of the gross domestic product is 4% and the share of the private health expenditure as a percentage of the THE is 52%. Also the out-of-pocket as a percent of the private health expenditure and THE is 80% and 41% respectively. Moreover, private insurance as a percent of the private health expenditure is only 1%. These parameters clearly indicate the need to improve the financing of the sector through the private health sector in general and reducing the out-of-pocket expenditure to a much lower level.

Challenges/implications for health care financing

- Most people are self-employed and therefore not an organized market
- Inability to pay, lack of knowledge, or other factors, related to geography or discrimination
- Too much of cream skinning, i.e., selection of less risky groups by financiers

Conclusion: way forward, relevance, significance to health care financing

There is a high demand for health care services, and the private health service providers play a critical role in the access and quality of these services. Moreover, the current level of out-of-pocket expenditure points to ability of the user to pay for the services.

5.2 Discussions and Conclusions: March 27, 8:30-8:45

Questions and main issues raised, discussed and consensus/conclusion reached:

Q1. What are the challenges that the private health sector faced to be an integral part of the health insurance system?

The critical issue with regard to the private health sector becoming part of the health insurance system is the premium payment. Particularly in the compulsory pay-roll based insurance system, the premium payment is low and the private sector may not find it an attractive business to engage with. This is partly because many of the costs in public health facilities are low or subsidized.

The private sector needs to be engaged in the provision of health care services under the insurance system, but the issues of premium and efficiency should be addressed. Both public and private health sectors need to work together to cater the services to the public.

Q2. What are the implications of increasing out-of-pocket expenses in the health sector?

It is evident that the current level of out-of-pocket expenditure is very high and increasing in Ethiopia and that needs to be reduced, and reversing the increasing pattern is a must. In general, if the out-of-pocket expenditure is greater than 20%, access to the health system will be questionable. Some data suggest that currently the out-of-pocket expenditure is about 34% in Ethiopia, which indicates that it needs to be reduced. The new health insurance system helps to discourage payment at the point of service (out-of-pocket) and brings down the out-of-pocket expenditure to less than 20% in the long run. Otherwise, the move towards universal health coverage will be hampered without the active involvement of both public and private health service providers.

Q3. What are the main reasons to increase the share of THE to the gross domestic product from 4% to 16%, and does this include the capital investment of private sector?

Generally, the Government allotment and expenditure are calculated. We recognize the investment by the private sector in the health sector, and even want to encourage more private investment. In addition the Government is working to increase the source of funding, from both internal and external sources, to increase access to quality health care for the citizens, particularly for the poor.

Inclusion of private sector investment in health can further increase the percentage of the THE to the gross domestic product from the existing 16%.

Q4. What is the Government's plan to finance universal health coverage for the poor?

The Government will finance health care services through different mechanisms. For example, subsidizing is one mechanism. The Government will have two types of subsidies: a general subsidy and a targeted subsidy. Particularly, the targeted subsidy will focus on the poor to ensure access to quality health care. Moreover, the federal and regional Government will partly share the health expenditures, and the woreda level administrations will also cover their share.

Q5. How could the public health facilities meet the quality standards when the health insurance system rolls out as many of them are under resourced?

It is necessary to underscore the fact that from time to time, the public health facilities are improving the quality of services they provide. This is observed in terms of the availability of human resources, construction of buildings, the purchase of equipment, the provision of medicines, and the like. In most aspects, public health facilities are better than the private ones. The public health facilities are better positioned to implement the insurance system soon as compared to the private. However, the Government will address challenges that we may face in implementation and work with the private health sector for the success of the health insurance system. In fact, in our case it will be with the public health facilities that the health insurance system will begin.

III. Next Steps: Recommendations for Follow Up

- Consensus reached on the following:
- Follow up extended discussions to be held on all three themes
- Formation and feedback to be given to the three core task groups to finalize the recommendations
- Supplement the final recommendations of the forum proceedings
- Ethiopian Chamber of Commerce to continue deliberations based on the ground work done so far



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