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THE COSTING OF PRIMARY HEALTH CARE:
REPORT OF PARTICIPATION
WHO CONSULTATION IN NAZARETH, ETHIOPIA

A Report Prepared By:

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Table of Contents

	Page
Acknowledgements	iii
Abbreviations	v
I. Introduction	1
II. Background	2
III. Observations and Findings	4
IV. Issues Discussed	6
V. Report from Nazareth Workshop	13
VI. Recommendations	25

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ABBREVIATIONS

PHC	Primary Health Care
WHO	World Health Organization
MOH	Ministry of Health

INTRODUCTION

This is a report on the participation of Wayne S. Stinson in the Informal Consultation on the Costing of Primary Health Care, held in Nazareth, Ethiopia, December 12-16, 1983. This meeting was sponsored by the World Health Organization, and Dr. Stinson's participation was at WHO's request. This report is not, except indirectly, a report on the meeting itself since external publication of proceedings prior to WHO's own report would be inappropriate.

The objectives of the Informal Consultation were:

- o To strengthen national capabilities for undertaking the costing of PHC in countries and for the utilization of results for development and management.
- o To exchange experiences on the costing of PHC in different countries.
- o To discuss methodologies used for data collection of PHC center.
- o To make recommendations for future work in this area.

The meeting was organized as a series of plenary sessions interspersed by small discussion groups. Several background papers were presented formally, and in addition country studies were distributed and discussed. The Ethiopian government organized a one day field trip to Arssi Province 100 miles southeast of Addis Ababa.

The consultant's role in this meeting was that of a discussion "facilitator" and commentator, particularly on matters relating to community financing. Throughout the meeting I commented on the need to consider community and individual expenses within the cost of primary health care, and to make specific plans for organizing community financing when this is to be required. A more formal presentation of APHA's issue paper on the latter topic had been tentatively scheduled for the final afternoon but the session as a whole was cancelled because participants preferred to spend the afternoon in Addis.

BACKGROUND

This consultation was the latest in a series of costing and financing meetings held by the World Health Organization since 1970. The most recent meeting prior to 1983 was an inter-regional workshop on the cost and financing of primary health care, held in Geneva in December 1980. Papers distributed at that meeting (which have not yet been published) suggested a need for greater understanding of costing principles and technical refinement of methodologies. Work by Griffith and Mills improved analytical methodologies, while a recent publication by Mach and Abel-Smith persuasively argued the need for cost and financing data in primary health care planning. Judging by the papers presented at the Nazareth workshop, costing efforts have greatly improved since 1980, although it is not clear that there has been a comparable improvement in policy application of results.

To strengthen technical quality, Dr. Andrew Creese of the University College Swansea (U.K.) was invited to develop costing guidelines for primary health care. This invitation resulted partly from Dr. Creese's previous work in the Expanded Programme of Immunizations. Draft guidelines were prepared and distributed to workshop invitees during the summer of 1983, and were to be used in the preparation of country reports. Reports were prepared by most country representatives prior to the meeting and were distributed while we were in Nazareth.

Representatives of the American Public Health Association had participated in several of the earlier cost and financing meetings, and it was partly for this reason that the WHO organizer, Dr. Edward Mach, invited Wayne Stinson to serve as a consultant to the Nazareth workshop. This request was approved by the AID Office of Health for funding under the ADSS contract on November 7, 1983. AID's official scope of work stated that Dr. Stinson was "to provide technical support requested by the World Health Organization (Geneva) at an Informal Consultation on the Costing of Primary Health Care." The plan was that Dr. Stinson should spend a week prior to the meeting with Drs. Mach and Creese in Addis Ababa analyzing the country reports and preparing the workshop agenda, but this was not possible because of the consultant's prior commitment to attend a separate WHO/UNICEF meeting in Lusaka, Zambia the week of December 5 to 9. Dr. Stinson stopped briefly in Geneva on his way to Africa on December 2 and arrived in Addis the evening before the start of the meeting.

Ethiopia was an interesting location for this conference because of its revolutionary primary health care activities and its relatively high quality costing and planning efforts. The country has emerged from a period of turmoil following the end of a feudal monarchy and has charted a course towards economic and social development of rural areas. This course is controversial because of its communist and pro-Soviet orientation, but on the surface at least it has greatly improved the environment for primary health care. Two features stand out: the program's strong emphasis on community participation, most evident in the malaria control program and in the payment of community health agents and traditional birth attendants, and its effort to decentralize decision-making and budget control, even down to the health station level. These efforts were observed during a one-day field trip south of Nazareth and it is not known how representative they are of the country as a whole.

The conference site was the Adamna Ras Hotel in Nazareth, about 50 miles southeast of the capital. Representatives from the following countries participated:

- o Argentina
- o Botswana*
- o Colombia
- o Ethiopia*
- o Gambia*
- o Kenya*
- o Lesotho*
- o Malawi*
- o Sierra Leone
- o Sri Lanka
- o Swaziland*
- o Tanzania
- o Thailand
- o Uganda
- o Zambia*

(Countries marked by asterisks reported costing studies.)

Workshop participants were transferred to Nazareth on Monday morning, December 12, and returned to Addis on Friday afternoon, December 16. Since Dr. Stinson spent the week outside Addis, he was unable to contact any U.S. officials during his stay in Ethiopia.

Report Organization

This report consists of a narrative description of the meeting itself followed by commentary on some of the issues raised. There is then a presentation regarding Arssi Province and Ethiopia as a whole, based on the one-day field trip. (This is in no way a complete or even accurate report on the areas visited because a full assessment was not possible). Finally, recommendations are given regarding AID's further PHC costing efforts.

OBSERVATIONS AND FINDINGS

Opening Session

The meeting opened at 2:00 on December 12, after the morning trip from Addis Ababa. Addressing us as "comrades", the Permanent Secretary of Health, Dr. Getachew Tadesse, welcomed us to Ethiopia and stressed the importance of primary health care in that country's development plans. Dr. Tarimo, Director of the Division of Strengthening of Health Services, WHO/Geneva, accepted Dr. Tadesse's welcome and stated WHO's objectives for the meetings.

Oscar Gish, a WHO-supported professor of community health at the University of Addis Ababa, then reviewed the history of WHO's involvement in primary health care costing. (This history has been briefly summarized in the introduction). He stressed the need for countries to develop a single affordable health care infrastructure and to move away from separately financed projects that waste resources. Program budgeting, rather than input (personnel, equipment, supplies, etc.) budgeting must be more widely applied in primary health care, even though PHC is an orientation to development, not just a program. One of the basic analytical questions for national planners is who gets what out of current organizational patterns, and how can this be changed?

Andrew Creese then discussed the purposes, methods, and limitations of the primary health care costing guidelines which he and others had drafted. The purposes of these guidelines, he said, were to identify the share of health resources being devoted to primary health care both currently and as a trend over time, to assess the distribution of primary health care resources within countries, and to help in the monitoring of primary health care expansion. The guidelines were intended both for analysis of present spending patterns (called stock-taking) and for planning of future costs. Three analytical methods were discussed, namely, disaggregation of budgets, analysis of actual expenditures, and special micro-level studies. The guidelines are not intended as a manual or blueprint, or to be comprehensive. In particular they largely ignore the community role and focus on the Ministry of Health. They also provide for little analysis within the primary health care budget. The guidelines are not intended to be the only approach to costing, but rather a set of suggestions from which countries may develop their own plans.

Dr. Solomon Ayelew, a member of the Supreme Planning Council for Health and a graduate of the Johns Hopkins School of Hygiene and Public Health, next addressed the group concerning Ethiopia's "indicative" ten year health development plan. This plan was prepared by about 20 people and has so far been only partially accepted by the government. It includes all development sectors, not just health, and is broken into three sections of decreasing specificity, the first for two years, the second for three years, and the last for five years. When it is accepted, the government plans to hold a series of regional workshops to acquaint health staff with its contents.

The plan seeks first of all to consolidate current services, particularly in the primary health care area. This requires strengthening of the staff and logistical support for facilities that have already been constructed. Health care coverage is reportedly now 40 percent, and the objective is to extend this to 80 percent by 1994. (In fact, the plan provides for a lower coverage -- 60 percent -- option, but the government has already indicated that it prefers the 80 percent target.) Recurrent spending currently totals 32,000,000 birr per year and is expected to rise to 130,000,000 birr by 1994. (The official exchange rate is 2.07 birr to a dollar, but the black market rate is considerably higher, reportedly as much as 10 to 1 in Geneva). Foreign aid is expected to be a small part of the recurrent budget, but about 25 percent of the development budget. The plan is that hospitals will take 65 percent of the capital budget over the ten years, but only 28.4 percent of the recurrent budget. In theory, these hospitals serve the entire population equitably, although it is recognized that that is not now the case. All health services are to be oriented in support of primary health care, and the Ethiopian representatives constantly questioned the appropriateness of distinguishing primary health care from other health care costs because in Ethiopia no distinction is perceived.

Health expenditures per capita currently range from 1.7 birr per person per annum in the most poorly served region, to 13.1 birr in Addis Ababa. (The best served region outside Addis now gets 7.0 birr per capita.) Ten years from now the most poorly served region will get 6.1 birr while Addis will get 17.7 (12.5 birr for the otherwise best served region). Addis' share will continue to be high because central hospitals and other facilities are located there, but it is hoped that this will not be inequitable.

ISSUES DISCUSSED

Rationale for Costing

While participants accepted Dr. Creese's justification for costing, they also stressed the need to strengthen routine costing efforts in planning, management and evaluation. In planning, the most critical need is to assess the recurrent cost implications of capital investment.

Managers at all levels - even down to health stations, as in Ethiopia - should be aware of the cost implications of alternative program strategies and inputs. In Lesotho, for example, individual rural hospitals are given their own drug budgets and a price list. Clinical staff are encouraged to consider price when making prescriptions. In Ethiopia, communities helped build a 200 bed rural hospital at a total cost of 12,000,000 birr, and the government encouraged them in this. In fact, though, it turned out to be a serious mistake because of high recurrent costs. These uses of costing are not stressed in the current guidelines, but several participants thought they should be.

Several representatives argued that resource allocation patterns were the "litmus" test of a country's commitment to primary health care and that formal studies were required to document current patterns and trends. Costing also helps the Ministry of Health argue for funds within the government. Future primary health care costs should be planned, not just forecast. Elaborate costing studies are not needed, however, to show the current discrepancy between stated primary health care policies and resource allocation patterns. Participants concluded that costing was desirable but that results needed greater recognition by policy makers and program implementers.

Definition of Primary Health Care

The critical issue in costing of primary health care is obviously that of definition. This is particularly important if figures are to be compared between countries or over time since definitional changes greatly affect results. Definitions can easily be broadened for political purposes since almost anything can be justified in the name of primary health care. Some cutoff between costs of primary and other care is desirable for analytical purposes, but the cutoff will be somewhat arbitrary and must be country-specific. Virtually everyone supported the principle of costing all of the primary health care elements as defined at Alma Ata but agreed that core Ministry of Health

activities were easier to cost than such things as food supply, water and sanitation, and other activities, especially when run by other ministries or by the private sector. Within the MOH budget there appeared to be three possible ways of distinguishing primary from secondary and tertiary costs:

- o Separation by service level, that is, consideration of everything up to the first hospital level as primary
- o Separation by who benefits rather than by service levels
- o Full inclusion of immunizations and other preventive activities within primary health care and disaggregation of curative costs.

It was generally agreed that only the first of these approaches was practical, however.

One question raised was whether personal and community costs of illness and treatment should be considered within the cost of primary health care. Four types of cost were mentioned but not clearly distinguished, namely:

- o Economic losses due to illness
- o Costs of transportation and time waiting for service
- o Direct personal and community contributions, such as service fees, community financing of health workers, labor contributions, and so forth, and
- o The cost of stimulating community participation.

Since many health plans emphasize community participation, I repeatedly suggested that the costs of mobilizing it must be considered. We were told that these costs had been quite high in Ethiopia, and included many lives lost. There was consensus that most of the costs listed above should be considered; the cost of illness, though, should be distinguished from the cost of treatment.

Practical Difficulties of Aggregating and Disaggregating Costs

Two major analytical difficulties emerged: Activities outside the Ministry of Health are difficult to cost, and so (for different reasons) are those within the Ministry of Health. Outside, the problem is one of obtaining any data at all. Inside, the difficulty is to obtain actual (rather than budgeted) expenditure data and then to apply whatever

operational definition of primary health care the country has adopted. Some countries budget by institution, either including primary health care within hospital budgets or perhaps listing health centers and posts as a separate line. Others have specific, relatively vertical, primary health care programs with their own budgets. Most ministries, however, budget by major department and then by input items such as personnel, drugs, and so forth.

In Botswana, for example, it is relatively easy to distinguish primary health care costs because most first level health services are provided by the Ministry of Local Government and Lands. A small part of the Ministry of Health budget should be considered within the primary health care category also. In Lesotho, health center budgets are included within those for hospitals, making disaggregation difficult. The Ministry of Finance determines budget categories for all ministries, although the Ministry of Health is free to increase the number of internal divisions within fixed budgetary categories. Ethiopia has an extremely detailed health budget, but available summaries are not appropriate for analyzing primary health care. Ethiopia's 1983 analyses were based on disaggregation of the current budget, while 1993 estimates reflected estimates of need derived from micro-level analyses. Argentina has a highly centralized budgetary system, but in fact costs are actually difficult to aggregate (rather than disaggregate).

Reasons given for inappropriate categorization of health expenditures include Ministry of Finance control over budgeting processes, emphasis on accounting and control over expenditures rather than on program planning and evaluation, and, perhaps, reluctance to reveal true primary health care allocations.

A major issue here concerned the degree of disaggregation and cross-classification to be recommended by the WHO costing guidelines. The majority recommended simplicity, while a few urged greater sophistication. The essential minima appear to include disaggregation by geographic region, by level of service (primary versus other), and by major program. Participants mainly questioned the feasibility of multivariate analysis (as opposed to analysis of marginal distribution) on these variables.

Micro-Level Expenditure Studies

It was widely agreed that in addition to disaggregative studies, countries also undertake micro-level analyses in ten to twelve representative localities. Solomon Ayalew from Ethiopia, for example, was about to undertake lengthy participant

observation efforts in Ethiopia to assess the burden of health improvement efforts on community residents. Outsiders, he said, tended to assume that rural people have plenty of free time that can be mobilized, whereas in fact, they may be largely preoccupied with routine activities. Micro-analysis facilitate disaggregation of costs by program and generally give a better picture of how resources are actually applied.

Comparison of Country Studies and Plans

The half day session devoted to analysis of country studies was weakened by late distribution of the papers and the fact that few participants had read them. Possible indicators of commitment to primary health care and of progress toward policy objectives were discussed. Examples included proportion of health budgets going to primary care and rural/urban variation in per capita expenditures. Most participants, however, felt that international comparisons were highly misleading. Country definitions of primary health care and the scope and depth of country studies varied too greatly for useful comparability.

The most interesting comparisons discussed were those between budgeting processes in different countries. A number of countries asserted that costing efforts were improving, but most agreed that estimates for the coming year tend to be based on budgets for the current year. In Swaziland, the Ministry of Finance develops the budget for the health sector, which the Ministry of Health must then use for its own planning purposes. In some other countries, however, planning and budgeting theoretically start at the local level following national guidelines. (An earlier WHO meeting which I attended, in Zambia on district level management also showed that many countries are attempting decentralized planning and budgeting processes.)

Is Primary Health Care Affordable?

Participants were asked to consider whether countries would be likely to be able to afford primary health care, but one of the Ethiopians in my sub-group totally rejected the appropriateness of the question. Primary health care, it was argued, is affordable by definition because it is based on whatever resources the particular country has. The impression gained from some of this discussion was that primary health care was an act of faith, something like acceptance of a religion, and once conversion had occurred there would be no problems. Dr. Tarimo made some effort to at least explain the question but gained few converts. For most participants, a better question would have been "how much will primary health care cost, and how will the necessary resources be mobilized?"

Service Fees

There was animated discussion regarding user fees in primary health care, even though the subject was only marginally related to the official agenda. The majority of the group recommended that WHO call a special meeting on the topic. It was clear that countries have very different approaches and that delegates were concerned about the effects of fees on utilization patterns and revenue generation. Dr. Mach later told me that WHO has considerable information on this topic but that he personally saw little value in having a meeting. Issues raised included:

- o whether charges should be flat regardless of services provided or should at least reflect actual costs
- o whether fees should be graduated by a patient's income level or omitted altogether for preventive care
- o whether utilization patterns can or should be influenced by fee structures and
- o whether funds should be retained in local revolving funds or forwarded to the ministry of finance.

In Thailand, the government distributes free health cards to the poorest residents and provides subsidized services for another large group. Other patients pay full charges.

The Gambia has graduated registration charges designed to encourage use of peripheral facilities. The lowest level of health post does not charge at all, while fees rise gradually with the sophistication of the clinic. Fees are collected by the Ministry of Finance rather than retained by the collecting facility, and the Ministry of Finance has resisted suggestions for revolving funds.

Dr. Mariam said that revolving funds lead to abuse and carelessness in use of funds. Ethiopia's experience was that accounting records were not properly kept and that money did not actually go for health purposes.

Sierra Leone started its health program with free services, but some people are beginning to recognize that services are more appreciated if they are charged for. There is also thought that fees might reduce the "bypass syndrome".

In Botswana, most patients must pay a registration fee, which includes necessary drugs. There is some concern that these fees are presently too low. Private patients pay a higher fee. Those unable to pay may bring a letter stating this from local leaders. MCH services are not charged for. Big companies have medical aid schemes for their workers.

In Lesotho, services are charged for. Fees were recently raised; they used to cover all required services for a flat fee, but they are now graduated according to specific services provided. There have been problems with revenue collection. TB, mental health services, and leprosy services are not charged for. Those accepting a general hospital ward are charged \$1.00 per day plus any surgical costs, while private ward patients pay \$10.00 per day. Those that want to see a specific doctor also pay extra. The biggest problem reported in Lesotho is that of fee collection.

In Colombia, 70 percent of health financing comes from the government and the rest from social security. Twenty five percent of costs are covered by hospital fees. There is much regional variation in fee structures. In those areas where drug fees are charged, drugs are generally available, while in those regions without fees they are often unavailable. Fees are considered a big barrier to access to services.

In Malawi, religious missions provide 40 percent of hospital beds, and people must pay. Traditional healers also charge. Government hospitals charge only maternity patients and private patients. Malawi reports that fee collection has been a problem in that country also.

In Sri Lanka, services have been free since 1950. Fees were briefly collected for out-patients in hospitals during 1974, but the scheme was terminated after about three months because of its political unpopularity. Hospital attendance dropped drastically during the experiment, apparently because the wards were being used for social purposes and the fee discouraged such use.

Observations About Ethiopia and Arssi Province

One of the main purposes of this meeting was to critique and further develop the primary health care costing guidelines prepared by Andrew Creese. Participants seemed reluctant to criticize the draft guidelines directly, although there were hints of excessive complexity and suggestions that only costing principles rather than detailed techniques, should be included. A small minority considered the current draft too simple.

As I see it, the draft guidelines make a significant contribution in a difficult area. WHO's effort to promote both the concept and technique of primary health care costing will undoubtedly encourage those in ministries of health who wish to move in this direction. The report of the Nazareth workshop should have similar effects.

My feeling is that the objective of these guidelines should be to strengthen routine costing activities by existing Ministry of Health staff in developing countries. The techniques described should be simple enough for routine use by trained, but often quite busy, planners, with more complex refinements reserved for footnotes or annexes. Involvement of outside specialists is often useful, but I am not sure that even more complicated guidelines will add to their existing skills.

While costing and financing are technically distinct, most non-economists tend to think of them as part of a single problem. As I read the guidelines, there is little discussion of sources of finance or reasonableness of funding expectations. The cost of generating income has to be considered, particularly with regard to fee collection and community participation. Plans calling for community cost sharing are unrealistic if they do not refer to detailed plans of action for stimulating and guiding these activities. WHO documents refer repeatedly to the need for political will to strengthen primary health care, and while we know that this was significant in Ethiopia, we also know that there are also critically important operational steps (which cost money) in making community participation viable. I particularly think it is a mistake to exclude the costs of stimulating community participation from the cost of primary health care.

The guidelines suggest three methods of costing, one based on budgetary disaggregation, another based on costing records, and a third based on micro-level studies. These are likely to produce very different results, and perhaps there should be at least some discussion of what to do in that case.

My overall feeling is that the guidelines have been adequately developed technically -- especially considering what I assume to be the target audience -- but that improvement in presentation is necessary. Those already familiar with the topic can probably use the guidelines as they stand, but unfamiliar or only partially motivated readers may ignore parts they don't understand. APHA's papers have benefited from non-technical editing by people who specialize in presentation, and the same process might help here.

In general, the guidelines appear to be a significant development in a highly complex area and thus worthy of pursuit. I think they should be circulated widely for discussion, but perhaps only after clarity of presentation has been approved. As written, they are probably too simple for specialists and too complicated for generalists, and I suggest that one or the other audience be given greater attention. My own preference would be to write the guidelines for generalists.

REPORT FROM NAZARETH WORKSHOP

Political Environment

The Ethiopian Revolution began in 1974 and has adopted much of the symbolism and rhetoric of international Communism. Ideological fever appears moderated by pragmatism, however, and signs hailing the proletarian revolution are intermixed with Coca-Cola ads and other signs. Production is only partially collectivized, and emphasis, at least officially, is on voluntarism. The government gained full control of central areas only five to seven years ago, however, and major areas are still in rebellion, famine or warfare; so there has been little time for radical change.

We were told that the entire health care system, from the central Black Lion Hospital, to the lowest level, has been reoriented to primary health care, and, in fact, the Ethiopian group at the Nazareth meeting was reluctant to discuss primary health care costs as a separate category. The 10 year "Indicative Health Plan" projects a 10 percent annual increase in government health expenditures, with most of that going first to the least developed areas. Community self-help and decentralized management are key ingredients to the plan, and have already been implemented in at least some areas.

Ethiopia has undertaken massive literacy campaigns, and illiteracy has reportedly fallen from 95 to 63 percent in the last 4 years. Families achieving 100 percent literacy have special plaques mounted on their homes. Their communities are similarly rewarded. Sensitization to primary health care is included in functional literacy classes, but there is reportedly little nutritional content.

Communal Organizations

Virtually the entire population belongs to some kind of association ("Kebele") ranging from relatively unorganized community groups to full collectives. Descriptions were sometimes confusing and were, of course, unverifiable, so the following is likely to be only partly correct:

- o Peasants Associations are administrative bodies and may include up to 2,000 households. Members retain private property and the direct proceeds of their labor. They settle conflicts among members and handle political and defense affairs. (They may, if necessary, defend the country against foreign aggression.) Everyone in the country belongs to one.

- o Urban Dweller Associations fill the same role in cities.
- o Service cooperatives include two to ten Peasants Associations. Their main function is to "serve" members by buying their produce and selling them goods bought in bulk from the government. They borrow government money at normal interest rates but loan it without interest to Peasants Associations. They also rent farm machinery to the associations. Sometimes they raise money from the associations to pay for construction projects, roads, schools, and so forth.
- o Producers Cooperatives are fully collectivised and based on the principle "from each according to his ability, to each according to his production." In health, as in other areas, these are organized much like Chinese communes. They exist in both agriculture and industry.
- o There are also labor unions, women's groups and other special interest associations which appear to overlap with the ones described above.

Arssi, the smallest of Ethiopia's 14 regions with a population of 1.3 million, has 1,086 kebele, including 17 Urban Dwellers Associations, 1,053 Women's Groups, 90 labor unions, and 143 Service Cooperatives. (These numbers obviously don't add properly and exclude Peasants Associations and Producers Cooperatives, but I can't explain why.) Approximately 40,000 people have been grouped into new settlements.

There is a new national policy to create intersectoral social development committees. One sub-committee is supposed to be for health. In most cases the committees are just being formed, so their strength and role in local management varies. The committee structure goes all the way to the national level.

Levels of Health Activity

Health activities occur at six levels:

- o At the Kebele level, through community health agents (CHAs).
- o At the sub-district level, through health stations serving 20,000 - 25,000 population each.
- o At the district level, through health centers serving 200,000 - 300,000 population each.

- o At the regional level, through simple hospitals.
- o At higher regional levels, through specialized hospitals.
- o At national levels, through central referral hospitals.

Arssi Region, for example, has one referral hospital, one rural hospital, six health centers, and 72 health stations for its 1.3 million people.

Emphasis is reportedly on peripheral areas. Several Ethiopians mentioned to me that the central Ministry of Health has problems but that peripheral areas are very active.

Planning and management are reportedly decentralized, and even health stations have their own budgets and discretionary authority. Shifts in local spending are acceptable as long as the total for any given type of institution is not exceeded. Money allocated to hospitals, for example, cannot be transferred to health stations, or vice versa. Health centers reportedly have an accountant and cashier who also help at the health station level. Budgets are kept by traditional categories (personnel, drugs, etc.).

Staff and Training

There used to be a school of public health at Gondar which provided five years of training and produced numerous high-quality graduates. Most health centers are now directed by graduates of this school, called health officers. The school was reportedly closed because most graduates wanted to become doctors. There are now two medical schools, one at Addis, and the other at Gondar, graduating a total of 140 physicians per year. Each doctor must give two years of rural service upon graduation. Oscar Gish and others are trying to re-establish a school of public health.

Health centers usually include nurses (3 years' training) and at least one sanitarian, in addition to health officers. The latter inspects food and drinking places and protects water supply but he must work mainly through community health agents because of the size of the area to be covered.

Health stations are generally directed by health assistants, who have two years' training. The government, with community assistance, also trains community health agents and traditional birth attendants.

Arssi Regional health activities were supported by 550 salaried staff, about half of whom had administrative rather than health functions. This total included 187 health assistants. CHAs and TBAs are not included in this total. Sixty percent of the regional health budget goes for salaries.

Community Participation and Financing

The government relies heavily on community participation and raises both tangible and intangible resources from it. Communities assist with facility construction, training, purchase of drugs, and malaria control activities. In the last two years, communities in Arssi Region have built two health centers worth 702,000 birr. (The official exchange rate is 2.07 birr per dollar, but outside the country the rate may be as low as 10 birr to the dollar.) Communities also built seven health stations worth 156,000 birr and maintained three others at a value of 9,500 birr. The total community contribution in the last year is thus valued at 867,000 birr. (We were often given precise numbers such as these, although it was never clear how they were derived.) Communities must get approval before constructing new health centers and health stations because of the recurrent cost implications. In what has apparently become a "cause celebre", one community built a hospital valued at 12 million birr. The government, at first, glorified the self-help contribution but then regretted its long term staffing implications. New facilities must be in accordance with the national plan; otherwise well-off areas would build clinics first and thus claim new staff. Annual running costs for a health center are a minimum of 20,000 birr.

Fees are collected only for curative activities and revert to the national treasury. They are least in health stations and greatest in hospitals. At the health station level, patients pay only for drugs, and if UNICEF provided the drugs, they are given free. (I believe the health station we visited reported that it did charge fees for service, however, I am not sure if this report is correct.) Health centers charge a 50¢ (Ethiopian) registration fee good for two months and also charge for drugs.

Hospital patients must deposit 70 birr upon admission but are refunded any surplus upon discharge. Fees are levied at the rate of 3-12 birr per day plus drug charges. All fees are waived if the patient's Kebele provides a certificate of poverty. Reportedly 70 percent of patients at the national referral hospital (Black Lion) in Addis Ababa receive free service. In the Arssi region, fees reportedly total 15 percent to 20 percent of expenditures (but are sent to the treasury and thus do not enter the budget directly.)

Communities help defray training costs for CHAs and TBAs. They must pay for the trainee's food and lodging and look after his or her family during training. The Producers Cooperative that some workshop participants visited, for example, paid 840 birr for the room and lodging expenses of its CHA during training, in addition to in kind support for the trainee's family.

Routine CHA and TBA payment varies by locality. Producers Cooperatives pay them in the form of work points, as in China, while Peasants Associations either pay them in cash or in kind. A TBA whom we met said that in previous times she charged five birr for each delivery, but now she is a member of the Producers Cooperative and contributes her skills in exchange for "work points". (She currently serves two Producer Cooperatives, but it was unclear how the one of which she is not a member pays her.)

Communities help with immunizations by organizing activities beforehand and by helping to trace defaulters. They are also heavily involved in at least one malaria control effort, as discussed below.

Visit to Arssi Region

Workshop participants spent one day visiting health and cooperative facilities in Arssi Region, about 150 kilometers southeast of Addis Ababa. Part of the visit was made en masse, while other parts were made in sub-groups. We have no way of judging the representativeness of what we saw, although it clear that our local hosts were well-accustomed to foreign visitors.

The Arssi region has a grain surplus, and 40 percent of its produce is marketed. Wheat and barley comprise 60 percent of the total production. We were told that the per capita grain consumption has clearly doubled since the revolution. Malnutrition was, nevertheless, widespread, apparently because farmers sell off too much of their produce.

Regional Health Office and Hospital

The regional health office is located at the referral hospital in the town of Assela. (It should eventually have its own building.) The hospital is partly staffed and financed by the Italian Government, and it is not clear whether current standards can be maintained after this support ends. The hospital is already considered small and understaffed.

The regional health office includes sections for communicable disease control, environmental health, MCH, community health services, pharmacy, administration, and statistics. Training is done at the regional office. Immunization is done at 20 sites in the region. The regional office handles planning, and drug procurement and distribution. UNICEF provides cash for supervision and training. It also provides vehicles and supports vehicle maintenance and operation, drug supplies, and control of communicable diseases.

Assela Health Center

The health center that we visited is one of three in this district and serves a population of 350,000. It was established in 1961. Sixteen health stations operate under its supervision.

The center has 19 health personnel, and an additional 12 non-health staff. Twenty-nine community health agents (CHAs) were trained in 1981 for work in the area's health stations and kebele, and thirty were trained in 1983. During this period 31 traditional birth attendants were also trained. We were told that the "majority" of trained CHAs and TBAs are still at work.

The budget during 1983 was as follows:

<u>Item</u>	<u>Health Center</u>	<u>16 Health Stations</u>
Salaries	102,180 birr	110,764 birr
Operational Costs	36,946	96,579
Per diem	(3,887)	(10,205)
Drugs and medical equipment	(13,885)	(51,575)
Vehicle repair and maintenance	(3,598)	---
Fuel and oil	(2,750)	---
Other	(12,826)	(34,799)
Total	<u>139,126 birr</u>	<u>207,343 birr</u>

The center had a total of 18,000 visits in 1983 for 6,969 patients. It had 400 family planning clients, and did 483 normal deliveries (also seven abnormal deliveries). Separate sessions are held for antenatal patients. Tuberculosis defaulters are a major problem.

The director of the health center reported a growing interest in family planning but a shortage of contraceptives. The center is assisted by the Ethiopian Family Guidance Association. The law requires that husbands sign a permission slip for a wife seeking contraception. The center enforces this provision since it might otherwise be sued. I believe the director then said that most of the family planning clients are widows, and so do not require permission. Pills are widely sold in the market. The center keeps immunizations records, a growth chart and a nutritional record on all of its registered clients. The parent keeps only an identification card. Workers register all new-born infants. The center is trying to get TBAs to report births. I picked up a copy of the combined growth monitoring/immunization card.

Boru-Jawa Health Station

Health stations are the lowest level of fixed facility in the Ethiopian system and, judging by the single one that we visited, are quite well developed. The Boru-Jawa Health Station was built at a cost of 40,000 birr, half of it paid by the community. It serves a population of 3,000 and is staffed by two health assistants and a traditional birth attendant. Among other things, it was equipped with a baby scale donated by UNICEF, an adult scale, and a stethoscope. The clinic had just been sprayed with DDT before we visited (the smell was quite strong). Statistical charts and health education posters lined the walls.

The clinic register was in English, even though the health assistant spoke to us in Amharic through a translator. The register recorded patient symptoms more than diagnoses, using the WHO lay reporting system. The monthly report includes 44 diagnostic categories.

The clinic reportedly had 6,500 patient visits in the last year, including 2,500 new visits and 4,000 repeat visits. One hundred-twenty-six women made a total of 248 antenatal visits. Twenty-one babies were delivered at the health station, the rest being delivered at home. Five hundred six children under five made a total of 725 well-child visits. The health station saw 107 measles cases in the last year, of whom 18 were referred to the district hospital and 18 died. Children are immunized at the health stations, but vaccines are brought from the health center rather than stored on site. The health station had UNICEF oral rehydration packets, but we were told that there was no widely available one litre bottle in the district.

The monthly report also includes data on supervision, MCH, health education, sanitation activities, and so forth. The health education roster includes analysis by topic covered. These include sanitation, skin diseases, flies, circumcision, care of pregnant women, prevention of accidents, child feeding, treatment of diarrhea, and so forth. A separate register is kept for visits by children. (Andrew Creese later told me that other health stations and centers he has visited have not had such well-collected statistics.)

The health assistant brought out the budget for the health station and individual receipts for the fees that had been collected during the past year. We were informed that each health station had its own budget and some control over how it was used. This one, for example, had an allocation of 3,000 birr for drugs during 1983. (Drugs are actually purchased from the health center, however.) Drugs provided by UNICEF (which include oral rehydration packets) are not charged for and are not included in the budget. Community contributions are locally collected and used. Fees, on the other hand, are given to the local office of the Ministry of Finance (which also disburses funds for clinic activities.) The maximum fee for drugs is two birr.

Community contributions include the digging of garbage pits. One participation problem reported to us was that women had to spend so much time fetching water that they were able to spend little time in community development work.

The traditional birth attendant was the only staff person not paid by the government, and her health responsibilities were limited to those relating to pregnancy and delivery. The government trained her two years ago, but prior to that she had had 27 years of practical experience. She delivered 74 babies in 1983, out of which five were referred for more complicated deliveries.

The TBA kept a register of deliveries, although, since she was illiterate, someone else had to make the actual recording. The register showed the date of delivery, the mother's name, the TBA name, sex of the newborn, age and address of the mother.

The TBA was dressed in a long red robe and greeted both male and female visitors by taking their hand in hers and bowing. She was an impressive public performer.

Heruta Health Station

This health station was visited by another group. It had three health assistants and a rather low patient load of 15 to 20 new patients and 10 to 15 repeat patients per day. (Apparently many of the cases go directly to the health center rather than follow the preferred referral chain.) Most of the reported health problems appeared to be water-related, and much emphasis is therefore put on health education, with sessions twice weekly at local schools. The health station serves a population of 9,600 persons, although some of these live as much as two hours' walking distance.

Drugs are unavailable three months out of twelve, a situation that is reportedly common in Ethiopia (as in other countries). A great deal of powdered milk was being distributed, apparently because it was given free by the Catholic Relief Service.

The station had 177 antenatal patients last year, of whom only 14 were delivered by station staff. There is no trained TBA.

The station reportedly receives supervisory visits from health center staff just two times per year.

The station's budget totals 15,000 birr, of which 3,700 go for drugs, 9,500 for salaries, and the rest for operating expenses. Fee collection during 1983 has totaled 5,200 birr, or approximately 1/3 of total costs, although this money reverts to the treasury and is not retained locally. Although exemptions are available for the poorest people, the visiting group was told that virtually everyone paid.

Malaria Control

The sub-group visiting the malaria control office was told that 74 percent of Ethiopian land, and 64 percent of its population, are below 2,000 meters and therefore subject to malaria. There are 15 malaria control zones in Ethiopia, and in the Arssi region, 84,000 households are considered at risk. Frequency of spraying (a residual household spray is used) varies by the prevalence of parasites in blood samples, with the maximum frequency being twice per year. In this region, reportedly 97 percent of households are reached.

The malaria control program used to hire labor and transportation, but now works strictly through community efforts. Community-selected volunteers -- who are usually not the same people as health agents -- train for eight days at regional headquarters, but only the best of these are selected for spraying responsibilities. One problem reported is that spraying times are the same as peak agricultural seasons, thus creating extra burdens on the community. Logistics continue to be a problem. In spite of difficulties, we were told that only 0.6 percent of blood slides now show malaria parasites, a very sharp decrease from just three years ago.

Visit to Producers Cooperative

One of the sub-groups visited a Producers Cooperative. It was told that membership in the cooperative is voluntary and has risen from 45 to 500 families in three years. The leadership initially preferred relatively wealthy members in order to establish financial viability, but now gives priority to poor families. An effort is still made to keep out "divisive elements". There are 168 similar cooperatives in the Arssi region, although their rate of progress differs.

Cooperative members averaged an annual income of 120 birr prior to the revolution, and now average 300 birr per month. Thirty percent of profits are retained by the cooperative, of which 18 percent goes for capital accumulation, 7 1/2 percent for savings, 4 percent for social purposes; and 1/2 percent as incentive rewards for good producers. The 40 percent for social purposes goes for medical care for those who cannot afford it, for a nursery, and for other activities. The cooperative can buy drugs and have its own pharmacy in addition to those operated by the health service.

The Cooperative began three years ago with capital accumulation of 2,000 birr and has now accumulated 300,000 birr. The plan is to use this capital for constructing a consolidated village, since members currently live in separate communities.

Arssi Rural Development Unit

This agricultural development station is a semi-autonomous unit under the Ministry of Agriculture. Half of its finances come from SIDA (or CIDA) and the other half from the government of Ethiopia. It was started in 1967 and employes 1,900 persons. It works with 143 service cooperatives.

Before the 1974 revolution the station favored the model farmer approach under which outstanding individual farmers were promoted and publicized. Now there is a mass approach which attempts to promote whole communities.

The total budget for the Agricultural Development project is six million birr per year, including the SIDA contribution. We were told that the project does not charge for its services.

Other Ethiopia Notes

The University of Addis Ababa is starting an English language journal on health and development. The journal will concentrate initially on Ethiopian activities but may later broaden its audience.

The government is starting an experimental primary health care project in Sidamo province that will include considerable nutrition content. UNICEF is assisting the project, which is headed by Estaphanos Tekle of the Ethiopian Nutrition Institute. UNICEF is also supporting an urban primary health care project in Addis which is attempting to reduce infant mortality by 50 percent within ten years. There is also a UNICEF supported Integrated Basic Services Project in Bale resettlement villages.

Observations

Meetings such as this one are extremely useful for exchange of ideas and experiences, but they seem not to refine issues or provide clear guidelines for future actions. Participants undoubtedly benefit from attendance, but those who only read the report may benefit less. Exchange of information on country experiences must be an on-going process rather than one limited to small expensive meetings such as this one. Perhaps it is not inappropriate that such meetings be held every 3 years or so, which seems to be the current pattern. They need to be constantly reinforced by activities in between, however.

The individual country studies are of interest and will hopefully be summarized by WHO in their forthcoming report (Summarization here would be inappropriate without prior permission from WHO and from the countries concerned.) It appears that only Dr. Janofsky of Kenya followed the guidelines in her country study, and even she did so only partially. It is not clear whether or not this represents an adequate test of the guidelines. To a certain extent countries may not have received the guidelines early enough to launch effective studies.

Alternatively, the guidelines may be too complicated or require more staff time than overworked MOH planners can afford. Personnel attending the meeting appeared to be of uniformly high quality, but they are all heavily involved in other planning and administrative tasks, and may find little supervisory support for special studies.

A major and quite useful result of this meeting may be greater pressure on governments to adopt program budgeting and disaggregation of budgets by institutional levels. Much will depend on WHO's workshop report and follow-up action by national governments.

RECOMMENDATIONS

1. AID should encourage governments to undertake comprehensive cost analyses and projections following WHO leadership. There is little doubt that WHO's efforts to develop costing guidelines, to train analysts in their use, and to improve policy applications, are worthy of support. AID should encourage governments to make comprehensive analyses of their needs and resources and to look beyond the context of individual projects. AID should not confuse its internal bureaucratic requirements with those of recipient governments.
2. All costing efforts including AID's should respond to needs identified by planners and policymakers. Analysts must work closely with senior Ministry of Health staff and avoid research which shows little sign of influencing decision processes. This often means patient counseling and consultation with research users and avoidance of analyses which decisionmakers will not use. It is not enough to reflect policy needs in research; rather, policymakers must feel themselves to be in charge. Greater effort must be put into communication of research results.
3. AID should, nevertheless, pursue its own costing efforts, particularly related to recurrent cost analysis and strengthening of cost consciousness at all levels of management and evaluation. As a project-oriented donor, however, AID does have special needs and resources which can be complementary to those of the recipient governments. One of its most essential needs is to ensure the survival of project activities after external funding ceases. Project design must also consider the feasibility of replication, for which costs and host country ability to meet them are critical. AID can often afford more sophisticated research than host countries can with existing staff, and it should apply these resources - but only in harmony with recommendation two above.