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**BASICS SUPPORT TO THE  
ETHIOPIA HEALTH FINANCING STRATEGY**

August 21-27, 1994

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## ACRONYMS

<b>BASICS</b>	<b>Basic Support for Institutionalizing Child Survival Project</b>
<b>CDD</b>	<b>Diarrheal diseases control</b>
<b>EFY</b>	<b>Ethiopian fiscal year</b>
<b>EIC</b>	<b>Ethiopian Insurance Corporation</b>
<b>EPI</b>	<b>Expanded Program on Immunization</b>
<b>ESHE</b>	<b>Essential Services for Health in Ethiopia</b>
<b>FP</b>	<b>Family planning</b>
<b>GOE</b>	<b>Government of Ethiopia</b>
<b>GOK</b>	<b>Government of Kenya</b>
<b>HCF</b>	<b>Health care finance</b>
<b>HIV/AIDS</b>	<b>Acquired Immunodeficiency Syndrome</b>
<b>HQ</b>	<b>Headquarters</b>
<b>IP</b>	<b>In-patient</b>
<b>KNH</b>	<b>Kenyatta National Hospital</b>
<b>MIS</b>	<b>Management information system</b>
<b>MOF</b>	<b>Ministry of Finance</b>
<b>MOH</b>	<b>Ministry of Health</b>
<b>MOH/E</b>	<b>Ministry of Health/Ethiopia</b>
<b>MOH/K</b>	<b>Ministry of Health/Kenya</b>
<b>NPA</b>	<b>Non-project assistance</b>
<b>OP</b>	<b>Out-patient</b>
<b>P/PHC</b>	<b>Preventive/primary health care</b>
<b>PHN</b>	<b>Population, health, nutrition</b>
<b>REDSO/ESA</b>	<b>Regional Economic Development Services Office/East and Southern Africa</b>
<b>SIDA</b>	<b>Swedish International Development Agency</b>
<b>UN</b>	<b>United Nations</b>
<b>USAID</b>	<b>United States Agency for International Development</b>
<b>WHO</b>	<b>World Health Organization</b>

## **Executive Summary**

The Kenya Health Care Financing Project began in October 1990 and will continue through June 1995. The project staff works in collaboration with the Ministry of Health and Kenyatta National Hospital to develop improved strategies for health care financing with a focus on revenue generation through user fees and increased insurance reimbursements. The project promotes increased collaboration between the public and private sectors and seeks, over time, to improve the allocation and use of resources for health.

The project has developed experience and strategies for overcoming initial resistance to user fees. It has sought to remove perceptions of unfairness in the fee schedules and has developed policies with respect to waivers for the poor. The project has linked revenue collection to visible improvements in quality of care.

USAID/Nairobi and REDSO/ESA are interested in sharing the project's experiences with a larger, regional audience. Delegations of health finance experts from several countries have visited Kenya in recent years. A delegation of Ethiopian officials arrived in March 1994 for a series of meetings on various aspects of the Kenya program and its relevance to the health care finance sector in Ethiopia. This report describes the continuing technical collaboration between Kenya and Ethiopia, and represents one aspect of a larger REDSO--BASICS initiative to promote the sharing of experience and development of health networks within the region.

Dr. Dan Kraushaar, chief of party for the health care financing project, and his principal MOH counterpart, Mr. I.M. Hussein, traveled to Ethiopia from August 21-27. They were accompanied by Dr. Richard Sturgis, the health policy advisor for REDSO. The team met with senior MOH officials (including those who had visited Kenya in March), hospital and health center directors, service providers, and USAID staff to discuss ways in which the Kenya health care finance experience could be applied to the development of similar initiatives in Ethiopia.

The team from Kenya provided assistance in organizing the rewriting of the Ethiopian health care finance (HCF) policy, and assisted with a redrafting of the Ethiopian HCF strategy document. It is anticipated that the strategy document will be approved for release by mid-September 1994. Kraushaar and Hussein presented a number of documents to their Ethiopian colleagues (see Appendix B), including reports specific to the Kenya experience as well as more general papers on various aspects of health care financing. A series of short discussion papers related to health care financing was produced by the team for their Ethiopian counterparts. These papers are attached as appendices to this report.

**Next Steps:** The MOH in Ethiopia will be in contact with USAID/Addis, USAID/Nairobi, and REDSO to discuss continued technical collaboration with the Kenya HCF project. This may involve short-term training for the Ethiopia team as well as assistance in setting up "outside" (non-MOH) technical review of the Ethiopian HCF policy document in October or November 1994. There is also the possibility that the Ethiopia team will ask for regional-level review of the document. A request

for this assistance may be forthcoming in September or October, at a time when it could be supported through the proposed REDSO buy-in to BASICS for health networking activities.

## **L Current Financing Situation in Ethiopia**

### **1.1 Decentralization of Health Resources (manpower and budget)**

The Ministry of Health (MOH) has decentralized its budget and manpower to the regions, leaving the central MOH with a vastly reduced budget and fewer human resources. The decentralization process, we learned, was precipitous and accomplished nation-wide very quickly. Consequently, the capability of the regions to handle this responsibility may vary by region and is most certainly under-developed. While we did not visit any regions, we were under the impression that MOH/E headquarters was still uncertain as to their role in implementing national policies. This role uncertainty is also true for the budding national financing strategy. What was clearly evident was that adoption of the strategy needs to be a participatory process with the regions very much involved, not only in agreement on the strategy, but crucial for its implementation. This process, with the exception of a planned national policy meeting on the strategy, is not well defined.

### **1.2 Role of the Religious (Mission) and Private Sector Health Providers**

The previous government nationalized all mission and private facilities. Missions lost their facilities and private sector practitioners had their facilities turned over the government. Facilities which once were the best in the country, such as the Princess Zewditu Hospital, were turned over the MOH. Municipal services and facilities (those in Addis are prime examples) were also appropriated by the MOH. With the resurrection of the mission sector and the return of the private health sector, much work will need to be done to reverse many years of negative growth.

### **1.3 Allocations of Health Resources**

As is the case with many East and Southern African countries, resources have a strong urban and curative care bias. Although we were told that the emphasis of the past government was to P/PHC services, a vast majority of the doctors, a high percentage of the nurses, and a disproportionate share of health resources ended up in the cities (Addis primarily) and for the support of curative care.

Interestingly, we were told by several people, including the medical director for Zewditu hospital, that if a facility had a reasonable good budget when nationalized (i.e., Zewditu hospital), its budget level persisted to date. If the facility had a "poor" budget at the time of nationalization, it remained poor. For this reason there remains a range of "poor" and "better off" facilities with a concomitant variation in amount and quality of care. Future budgets and overall resources for facilities are based on past budgets with little rationalization to relate budgets to need, efficiency, population served, or any other of what we would consider "rational" budget allocation reasons.

#### 1.4 State of Existing Health Resources

The system of referral hospitals, hospitals, health centers, health stations and posts is still evident, but in disrepair or simple destroyed during the war. The level of need for upgrading, repair, and support is extreme.

#### 1.5 The Current Cost Sharing Program

The current cost sharing program is generating substantial revenue. By substantial, we mean substantial when compared to a very low funding base - a funding base which is hard pressed to provide basic health services. If one was to do a curative or P/PHC gap study--a study designed to measure health service need compared to available resources--one would find that "substantial" is not the correct word. No amount of cost sharing revenue can fill the gap between available resources and needed resources. At best, cost sharing revenue could maintain recurrent budget levels once the system is put back into shape.

Cost sharing revenue is accruing not to the MOH or the facility collecting the revenue, but to the Treasury. Consequently, the motivation to collect revenue is low. We did not do a formal study of collection efficiency, but feel that substantially more revenue could be collected. This would require, however, raising fees that have been raised in many years, as well as improving collection performance.

We visited two hospitals and one health center. Zewditu had, by far, the best systems in place to track revenue. Its accounting systems were also the best of the facilities visited. Nevertheless, we observed problems in all the facilities with systems in place. Checks and counterchecks were possible, but were either not part of the described systems or staff were not aware of the information cross checks could provide.

As a result of our brief visits to a few facilities, it became evident that systems such as those in place in Kenya are needed in Ethiopia to control collections, bankings, expenditures, and remittances to the Treasury. None of the systems is complex, and a modification of the Kenyan manuals would be possible. Further field visits would be needed to determine the degree of manual modification necessary. It was suggested that the Ethiopian team visit Kenya to view some of the systems in more depth.

#### 1.6 Availability of Health Insurance

Indemnity health insurance is currently available on a very limited basis through the Ethiopian Insurance Corporation. The limited enrollment makes the corporation an insignificant contributor to the current financing situation in Ethiopia. The very existence of the corporation, however, indicates a possible market and that the government condones this type of financing scheme. The present market is limited to the urban (mainly Addis Ababa) area.

During our visits to facilities, we noted that the concept of insurance is alive and well - people just don't know that its insurance. Many employers are self-insured. In addition, some innovative arrangements are being made between employers and local hospitals; for example, the UN contracts with Zewditu hospital for two beds which are always available to UN employees. Government workers are provided subsidized care in government facilities (services are discounted 50 percent). Also, workers in government hospitals are given free care in that hospital.

It is our initial impression that several forms of health insurance would be possible in Ethiopia. Managed care plans could be easily developed in Addis Ababa for the upper-middle-class and for foreigners. Indemnity insurance plans could be developed for groups of small employers. With a flourishing private practice system for government workers, independent group practice association could be developed to serve pre-paid groups. These developments seem likely, but could use additional study. Experiences gained recently in Kenya are, in many instances, applicable to Ethiopia.

## **II. Status of the National Financing Strategy**

### **2.1 MOH/E Team Given Responsibility in Development Strategy**

The MOH gave the responsibility for developing the national health financing strategy to five individuals who were asked to form a temporary health financing task force. The members were Mrs. Beletu Woldensenbet, Team Leader; Mr. Mohammed Abadir, Pharmacist, National Drug Program; Mr. Moges Alemnew, Head, Division of Personnel and Administration; Mr. Gebre-Medhin Abraha, Head, Finance and Budget Division; and Mr. Gebre Madebo Wabeto, Special Assistant to the Vice Minister, MOH.

According to Ms. Woldensenbet, the Ministry asked them not to develop a national health financing strategy, but rather a national strategy for expanding and improving cost sharing (user fees) program. We were unaware of this mandate when they visited us in Kenya and until shortly after our visit began in Ethiopia. The Ethiopian team understood the limitation of this mandate and attempted to broaden the scope of their report to, in fact, become a national financing strategy. Broadening this strategy became one of our main objectives during our visit.

### **2.2 Activities of the Team in Strategy Development**

In order to accomplish their mandate, as well as to expand their scope, the MOH/E team visited Kenya in early 1994. Most of the relevant material from the Kenya program was provided to the visiting team with a major emphasis on the cost sharing materials. Field trips were arranged and conducted. Because their primary emphasis was on cost sharing, the Kenyan health financing strategy documents were not given to them.

After their visit, the MOH/E team worked on the cost sharing portion of the report and attempted to broaden the report to include other financing options. On their own initiative, with no outside

input, the team read materials, gathered references, and thought through various financing strategies which were written up and incorporated into their draft report. This was no small accomplishment and, in fact, indicated an extraordinary effort on their part.

The "financing strategy" went through three drafts before they allowed us to review it. It was based on this review that they agreed to our restructuring their document for their consideration.

### 2.3 Recommendations Made to the MOH/E Team During Discussions

Our review showed a few shortcomings in the draft strategy. First, the strategy emphasis was on cost sharing with a time horizon of approximately one year. We suggested that they take a long-term time frame of 10 years or more and discuss long-term financing options such as cost sharing. A medium-term (five year) portion of the strategy was suggested in which specific options would be discussed. Finally, a one-year time frame was proposed for cost sharing improvements. The one-year time frame gives the MOH/E immediate actions to be taken while still moving in the direction of implementing other concrete options.

Other financing options suggested were 1) addressing Addis Ababa as a special financing problem, 2) returning nationalized mission facilities to the missions and supporting mission sector development, 3) encouraging the rational expansion of the private sector, and 4) developing private sector insurance, particularly for the urban and organized rural areas.

### 2.4 Issue of Retention

The MOH/E team spent considerable time discussing how much revenue generated at the facility level should be retained locally. It was their feeling that retention should take place at the zonal level, and that not all funds should be retained. Experience in Kenya conducting P/PHC and curative gap studies to determine appropriate retention policy was discussed and may be recommended as part of the MOH/E's plan.

### 2.5 Role of MOH/E Headquarters

The MOH/E team, after reviewing the experience in Kenya of a health care finance secretariat, felt that a similar organization should be developed in Ethiopia. They recommended the formation of a "secretariat" to be operated by the MOH/E headquarters for a period of time, with donor-supported financial and technical assistance. The secretariat's role would be time limited, with the group eventually disbanding. The team stressed the need for national conformity in the implementation of policies, and the lack of financial and technical capability to fully implement the program. They expressed the need to have a secretariat to coordinate a number of special studies that would be needed to fully implement the national health financing reform, including cost sharing.

## **2.6 Fundamental Policies**

The fundamental policies of the Kenyan program were discussed and agreement was reached that these policies be recommended to form the basis of the Ethiopian user fee program. The agreed upon policies include: funds are "no year" funds, not to revert to the Treasury at the end of a fiscal year; funds should be retained locally (preferably 100 percent of collected funds) and should be additive to allocations from the MOH and Treasury; funds should not only be retained locally, but use of the funds should be based on local priorities.

## **2.7 Condition of Financing Strategy at the Time of Review**

The financing strategy was restructured during our visit (little could be added in a content perspective due to time constraints). The MOH/E team did not release a copy of the revised draft. They indicated that they needed to review, revise, and present it to the MOH prior to its dissemination. The team indicated that their deadline for the final draft would be September 15, 1994.

### **III. Ability of MOH/E to Implement the Policy as Recommended**

The MOH/Addis Ababa is very lean now. Beyond the development of the strategy, there is no mandate for its implementation by any specific group in the Ministry. Experience in Tanzania and Kenya prove it would be a mistake to undertake a national program with limited policy and implementation guidance from headquarters. The best plan would be to define a core group of technical staff in the Ministry headquarters to be in charge of the national implement. They would, of course, need a budget and some training for this task, as well as donor financial and technical support for the program to be developed and implemented smoothly.

During our visit, the Ministry suggested copying the organizational set-up present in Kenya: a national secretariat for cost sharing and a donor who would provide technical and financial assistance in implementation activities. The Ministry should also consider phased national implementation rather than immediate implementation nation-wide. Phased implementation would allow for the development and refinement of needed controls and systems over a period of time. Starting in Addis and moving outward would be the most likely way to succeed. Lessons learned in Kenya were shared with the Ministry in Addis.

During our visit with the Vice Minister, Dr. Abdi, he agreed with the establishment of a national health financing secretariat.

### **IV. Ability to Implement Cost Sharing**

We provided the MOH with a budget and staffing profile for a national cost sharing secretariat and information on how to proceed with national implementation. The MOH's desire to go national

immediately should be tempered with the likelihood of immediate problems that would take months, if not years, to solve.

The MOH should also consider key policies that are essential if the cost sharing program is to succeed. These policies are outlined in our comments to USAID/Addis' conditions precedent for NPA assistance and include the following:

1. Cost sharing revenues as "no year" funds. Cost sharing revenues should not revert to the Treasury or any central pool of funds accessible to other than the collecting facility if they are not spent by the end of the fiscal year collected.
2. Cost sharing revenue is "additive." Cost sharing revenues should be additive to Treasury allocations and used to improve services and quality of care. Treasury should not review the revenues to reduce allocation accordingly.
3. Local retention and local control. Cost sharing revenues should be retained locally with the use of the revenues determined locally as long as use is pre-determined and acceptable to the local MOH or regions.

At the time of our visit, "additivity" was not being considered as a basic policy of the program.

The role of MOH headquarters and regions was discussed and, as a result, the discussion paper on cost sharing in a federal system was developed (Appendix F).

To implement a national program, as mentioned above, much work is needed to alter feed, develop needed systems, and train central and regional staff. This level of effort is beyond the currently assigned systems and staff to develop the strategy and will require several years of effort. This activity will need to be supported by donor funds and technical assistance.

## **V. Next Steps in HCF Strategy Development**

The following scenario was discussed with the MOH/E.

- Step 1 MOH/E will modify the draft health financing strategy developed during our visit for presentation to MOH/E headquarters. The final draft will be circulated to USAID, to us in Kenya, and to the MOH/E headquarters on September 15, 1994.
- Step 2 Once approved by the MOH/E headquarters policy committee, the draft will be circulated for technical review. Policy approval is hoped for by the end of September 1994.
- Step 3 MOH/E health financing task force members will attend the health financing course conducted by Management Sciences for Health during October 3-21, 1994, in Nairobi, Kenya.

**Step 4** Members of the task force will travel to Kenya prior to the above-mentioned course to review the lessons learned from the Kenya experience regarding systems developed. In particular, task force members will learn about Kenya's computerized financial information system.

**Step 5** In November 1994, a technical review of the Ethiopian financing strategy will be conducted by the Ethiopian task force with support from Dan Kraushaar and Ibrahim Hussein. The strategy will be revised, with Kraushaar's and Hussein's input, immediately following the review.

**Step 6** After the technical review and modification, there will be a national policy seminar to review Ethiopia's health financing strategy. This should result in a final document to be presented to the Council of Ministers.

**Step 7** The health financing policy will be reviewed by the Council of Ministers and approved.

**Step 8** At minimum, the cost sharing portion of the policy will begin the implementation stage in early 1995, provided technical and financial support is forthcoming from the donor community.

Steps 3-6 would be funded by USAID's REDSO office in Nairobi through its buy-in to the BASICS project as part of its support to regional collaboration in Eastern and Southern Africa.

## **VI. Next Steps in Regional Collaboration**

Kraushaar and Hussein have reserved time in November for a follow-up visit to Ethiopia, if requested, to help plan for the technical review of the HCF strategy. In addition, Kraushaar and Hussein have prepared a 2-3 day itinerary for the Ethiopian task force members to further review the Kenya experience prior to the health financing course.

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## APPENDICES

**APPENDIX A**

## Appendix A

### LIST OF PERSONS CONTACTED

#### **USAID/Addis Ababa**

Dr. Victor Barbiero, PHN Officer  
Dr. Carmela Abate, Health Advisor

#### **REDSO/ESA**

Dr. Richard Sturgis, Health Policy Advisor

#### **Ministry of Health**

Prof. Dr. Abdi Aden Mohammed, Vice Minister of Health  
Mrs. Beletu Woldensenbet, Team Leader, HCF Program Development  
Mr. Mohammed Abadir, Pharmacist, National Drug Program  
Mr. Moges Alemnew, Head, Division of Personnel and Administration  
Mr. Gebre-Medhin Abraha, Head, Finance and Budget Division  
Mr. Gebre Madebo Wabeto, Special Assistant to the Vice Minister  
Dr. Zeru Gebremariam, Medical Director, Black Lion Hospital  
Mr. Omer, Administrator, Black Lion Hospital  
Dr. Asegodich Lawo, Medical Director, Zewditu Hospital  
Matron Murur Haile, Zewditu Hospital  
Dr. Afework Asfaw, Head, Telkehaيمانot Health Center

**APPENDIX B**

## Appendix B

### LIST OF MATERIALS PRESENTED

1. Project Implementation Reports (PIRs) for Kenya HCF Project
2. Project Paper for Kenya HCF Project
3. Mid-term Evaluation Report, Kenya HCF Project
4. Request for Proposals, Kenya HCF Project
5. Kenya HCF Project Survey Instruments
6. Project Paper for the Philippines HCF Project
7. "Human Resources Planning: Issues and Methods," by Dr. Kolehmainen-Aitken, DDM Project, Harvard
8. "Presentation to Technical Teams: Burden of Diseases Workshop, World Bank, Nairobi," by Daniel Kraushaar, Kenya HCF Project.
9. "Clinical Guidelines for Diagnosis and Treatment of Common Hospital Conditions in Kenya," Dr. S.K. Shariff, Dr. N.A. Kimathi, Dr. J.D. Quick, editors.
10. "Health Insurance and the Private Sector," by Sara Bennett and Anne Mills, Health Policy Unit, London School of Hygiene and Tropical Medicine.
11. "Assuring Health Sector Policy Reforms in Africa; The Role of Non-Project Assistance," author unknown.
12. "contracting Out of Health Services in Developing Countries," McPake, Barbara and Elias E. Ngalan Banda Health Policy and Planning; 9 (1): 25-30, 1994.
13. "Pharmaceutical Expenditures and Cost Recovery Schemes in Sub-Saharan Africa, " the World Bank, Technical Working Paper No. 4, June 1992.
14. "Health Financing in Poor Countries: Cost Recovery or Cost Reduction," author unknown.
15. "Five-year Implementation Plan for Financing Health Care in Kenya, : Ministry of Health, Kenya, 13 August 1994.

## APPENDIX C

## Appendix C

### PROPOSED LIST OF CONTACTS AND ITINERARY

August 22-26, 1994

The objectives of the visit:

1. Share experiences on health financing with the MOH, transitional Government of Ethiopia (MOH/E) colleagues. this would be done at the end of the visit and take the form of a small presentation to MOH/E officials. The presentation would be a comparison of our experiences and their program, as we see it. It may also include observations and recommendations concerning
  1. cost sharing design and implementation issues;
  2. potential for social and private sector insurance;
  3. health financing strategy review and comment; and
  4. factors affecting the decentralization of health financing.
2. Review and comment on the MOH/E's national finance strategy.
3. Provide thoughts on specific operational aspects of the MOH/E's cost sharing program.
4. Set the stage, if appropriate and requested, for further assistance in the area of health financing.
5. With USAID/E and REDSO (Dick Sturgis), discuss next steps in regional collaboration between MOH/Kenya and MOH/E, and other countries and USAID missions in East and Southern Africa.

In order to accomplish the above five objectives in a short 5-day visit, it would be useful to visit the following organizations for the purposes cited. The people.organization mentioned below are not arranged in any specific order or priority.

It is assumed that the visits would be approved by USAID/Ethiopia and that the overall agenda be set by Victor Barbiero and that, to the extent possible, we would be accompanied by an MOH/E official who has some responsibility for the cost sharing/financing program of the MOH/E.

#### **Proposed Organizations to be Visited and the Purpose of the Visit**

**Organization:** MOH/E (person(s) responsible for MOH/E financing strategy)

**Reason for Visit:**

1. To discuss and review their financing strategy document and, if possible, travel with one or more staff members to the field to observe financing interventions in action.

2. To discuss the progress in the decentralization of health financing and other aspects of the health system changes including budgeting, planning, expenditure control, etc.
3. To explore their experience and interest in experimenting with other financing options, e.g., social insurance.
4. To review the perceived role of the mission/private sector in health financing.
5. To review current policies and implementation methods as well as the state of decentralization of the cost sharing programs including: a) systems for monitoring and control; b) monitoring and evaluation methods/plans; c) role of the regions versus headquarters; d) legislation; e) degree of community participation; and f) implementation training.
6. To discuss NPA and health financing-related policy change.

**Location:** Addis Ababa; one regional visit.

**Organization:** Treasury

**Reason for Visit:**

1. Review GOE policies on retention and use of cost sharing revenue and additivity policy, as well as GOE policies on administration and management of user fee revenue.
2. To discuss Treasury relations with MOH/E in overall health financing strategy development and implementation.
3. To review methods/systems used in the decentralization of budgeting, allocation of funds, expenditure controls, cost sharing, and audit functions.
4. To visit on regional office (equivalent to central Treasury) to review progress in decentralization and methods/systems used in the cost sharing program.
5. To assess skills, skill deficits, systems gaps, and issues.

**Location:** Addis Ababa; one regional visit.

**Organization:** Regional Office (Bureau?) (Awasa?)

**Reason for Visit:**

1. To review the state of the decentralization of authority and responsibility for the health financing, the level of knowledge of allocative and productive efficiencies, and other financing issues. To understand their financing issues as they see them, and their plans for addressing the issues.
2. To review the level of knowledge, skill, and experience in cost sharing implementation, and to understand the cost sharing implementation issues as they see them.
3. To review systems in-place or planned at regional and facility levels for the collection, banking, management, and planning of revenue use; and for the monitoring and evaluation of the cost sharing program. This activity would include an assessment of the type of fee and facility-perceived operational problems.

4. To see systems in operation for fee collection, expenditure planning and approval, monitoring, audit, and protecting the poor. This would include a general review of personnel skills; motivation; training; and understanding of concepts, methods, and issues.

**Location:** One regional office; one hospital; one health center.

**Organization:** SIDA

**Reason for Visit:**

To discuss development of the MIS within MOH/E to see whether it currently supports the user fee program and whether there is any link between service statistics and revenue.

**Location:** Addis Ababa

**Organization:** WHO

**Reason for Visit:**

To discuss the state of the decentralization of management of the health systems and training plans for management areas related to the cost sharing program and health financing, specifically.

**Location:** Addis Ababa

**Organization:** Ethiopian Insurance Corporation

**Reason for Visit:**

To discuss the current state of private provision of health insurance in Ethiopia. Included would be discussions on plans for future expansion, level of knowledge, and implementation of systems and methods which may support insurance implementation.

**Location:** Addis Ababa; one large employer purchasing EIC insurance.

**Organization:** Large employer

**Reason for visit:**

To discuss how employers are currently covering their employees for health care; their knowledge of insurance options; and their interest in exploring alternatives.

**Location:** Addis Ababa.

**Organization:** USAID/Ethiopia

**Reason for Visit:**

1. To discuss USAID's planned support to GOE and MOH/E in health financing.
2. To discuss sustainability issues of USAID-funded core programs (CDD, EPI, FP, AIDS control).
3. To discuss NPA and planned policy changes.

**Location:** Addis Ababa.

**Members of the Ethiopian team who visited Kenya in early 1994:**

1. Mrs. Beletu Woldensenbet, Team Leader
2. Mr. Mohammed Abadir, Pharmacist, National Drug Program
3. Mr. Mogel Alemnew, Head, Division of Personnel and Administration
4. Mr. Gebre-Medhin Abraha, Head, Finance and Budget Division
5. Dr. Abdulhamid Badri Kello, Lecturer in Economics, Addis Ababa University

### Proposed Schedule of Activities

<b>Monday</b>	<b>morning</b>	<b>USAID/E visit and discussion of agenda MOH/E visit and discussion of agenda</b>
	<b>afternoon</b>	<b>MOH/E specific discussion of topics</b>
<b>Tuesday</b>	<b>all day</b>	<b>visit regional headquarters, hospital, and health center<sup>1</sup></b>
<b>Wednesday</b>	<b>morning</b>	<b>meet with SIDA meet with WHO</b>
	<b>afternoon</b>	<b>meet with Treasury meet with Ethiopia Insurance Corporation</b>
<b>Thursday</b>	<b>morning</b>	<b>meet with one or more large employer(s) presentation preparation</b>
<b>Friday</b>	<b>morning</b>	<b>presentation to USAID/E and MOH/E</b>
	<b>afternoon</b>	<b>planning the future discussion of REDSO regional activities<sup>2</sup></b>

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<sup>1</sup> The time may be too short to review facilities. If this is the case, such facility-specific visits may have to be done in the vicinity of Addis Ababa.

<sup>2</sup> This discussion would be with Victor Barbiero and Dick Sturgis and would be a general discussion of regional collaboration efforts funded by BASICS and supported by REDSO.

**APPENDIX D**

## Appendix D

### COMMENTS ON THE ILLUSTRATIVE POLICY CONDITIONALITY TRANCHES FOR THE ESHE PROGRAM/PROJECT

#### **I. Kenyan Experience with Conditionalities**

These comments are based on our experience with implementing policy conditionalities in Kenya. Please disregard if unacceptable, inappropriate, or untimely. Our comments are based on very little exposure to the extensive studies, planning, and discussions which have occurred in Ethiopia, resulting from external technical assistance and internal USAID/Addis technical expertise. As such, these comments should be taken only as possible input.

In general, the conditions seem to be well-defined, carefully thought out, appropriately limited in number, as well as realistic. It's clear that a great deal of planning has gone into these conditions and they are a logical outgrowth of the numerous studies and papers which have been developed by internal and external consultants over time. Although our recent experience in Ethiopia is limited, the conditions also seem to reflect what is strategically possible in the health sector in the given time frame.

Although neither of us was working on the Kenya Health Care Financing Project at the time the conditionalities were developed, the approach used remained valid and may be appropriate for Ethiopia as well. The approach used was to specify a few global and over-riding conditions to be met over the entire period of the program and, at the beginning of the program, an illustrative list of conditions was provided to the GOK for discussion. It was agreed that these illustrative conditions could be altered upon agreement with the GOK, depending on implementation priorities and experience of the HCF program. This tactic provided the GOK with enough information so that they could see what was coming, and USAID/K needed implementation flexibility to adapt to a changing environment.

#### **II. Critical Global Conditionalities for the Kenyan Program**

Some of the Kenyan global conditions may be appropriate for the USAID/E program. Outlined below are the global conditions which have proven to be critical to the success of the Kenya HCF program.

Global Condition in Kenya	Proposed Condition for Ethiopia
User fee revenue is to be additive to MOF budget allocations for MOH/E	No
User fee revenues are "no-year" funds	No
User fee revenue is to be split, with a proportion to be used for curative care and another proportion to be used to support P/PHC services, including AIDS/FP services and health education. In the Kenya case, the ratio was 75% versus 25%	No
User fee revenue is to be used to improve the quality of health care services, not for the purpose of purchasing basic supplies, equipment, renovation, or construction, a;; are GOK responsibilities	No
User fee revenue is locally controlled (at the district level)	No

USAID/Addis does have one illustrative conditionality that is specifically mentioned and that is to be maintained from year to year. That conditionality is: "At least 45 percent of total central and regional expenditures continue to be spent on operating expenses (drugs, PH commodities, etc.)" This conditionality is obviously sound.

### III. Suggested Supplemental Conditions for Future Consideration

In a discussion with Victor Barbiero, USAID PHN Officer, we were told why the number of conditions is small and the strategy of influencing the GOE through a few selected and critical conditionalities was understood. There are other conditions which may be useful, but are not specifically address int he current illustrative list. If at some point in the future, additional conditions are considered, these could be reviewed. These potential conditions are:

- \* Set a specific curative care versus P/PHC allocation or specified shifts which are to be made and maintained or increased in actual expenditures. This would be more specific than the general condition of requiring increased budgetary allocation of a 10 to 15 percent increase in PHC sector government expenditures.
- \* Specify the percent of budget which is to generated by user fee revenue and how those funds are to be spent.  
  
Address staffing patterns and allocation (allocative inefficiencies) which affect over 60 percent of GOE health spending.
- \* Specify the magnitude (in absolute terms or percentages) of shifts in expenditures from wage to non-wage, or from curative to P/PHC.

- \* Specify that an adequate system for the supply and distribution of drugs and medical supplies be designed and in place.
- \* Specify that restriction to private/mission sector entrance into the health care sector be reduced or eliminated (needs qualification).

#### **IV. General Comments and Observations**

We understand that HIV/AIDS program development and the provision of HIV/AIDS services are priorities for USAID/Addis. While family planning promotion and development is a policy objective and specifically mentioned in eight illustrative conditionalities, AIDS program development and service delivery are not mentioned specifically, either in a policy objective or in any illustrative conditionality. It may be useful for USAID/Addis to specify AIDS program development and AIDS service delivery either as an example in policy objective #2 (concerning family planning) or as a specific conditionality.

We understand that the illustrative conditionalities are aimed at helping the MOH/E to adopt policies which are national and that national implementation is the overall objective. Some conditionalities, however, require action only in the ESHE project focus regions: adequate supplies of essential drugs (second tranche); cost recovery; national implementation plans for fee retention; and continued adequate supply of essential drugs (tranches 3-4). It may be useful to specify national conditionalities in monitoring and evaluation of achievement of these condition (as well as targeted USAID/Addis technical assistance) just in the focus regions.

Dr. Barbiero noted that USAID/Addis has focused on achieving expenditure targets rather than budget targets. Experience in Kenya suggests that the focus on expenditures is far more rigorous and important and that expenditures should be the focus of the conditionalities. The fact that the MOH/E has not expended its budget allocations for the past several years bears witness to the fact that budgets are plans, but not reality. We are striving for reality.

Based on our reading, the drugs and medical supply problem is, to some extent, wrapped up in EPHARMCORE as a virtual national monopoly. In order to address the problems rather than the symptoms, should there be somewhere in the illustrative conditions the need to address this organization? It could be as simple as making it a required chapter in the national HCF strategy document, given that drugs account for one of the largest expenditure items in the MOH/E budget.

Regions will be the principal implementing agencies in the future, with control over their own budgets. The same inefficiencies and financing problems witnessed in the past at the national level may eventually find their way to the numerous regions. Should there be mention in the conditionalities that certain national policies and methods of financing be binding on the regions? If we read the illustrative conditionalities correctly, this already may be implied. For example, the conditionality "increased share of total budget is allocated to P/PHC (and family planning)" can only be implemented at the regional level.

After reading the conditionalities, we see what may be an inherent conflict between two conditionalities. "A 10-15 percent increase in PHN sector share of total government expenditures in EFY 1986" may eventually be in conflict with "increased share of total budget is allocated to P/PHC (and family planning)." Are "PHN sector" and primary/preventive care, synonymous?

It appears that the conditionalities are directed at MOH/E. Yet, the conditionalities consistently specify the "government" and PHN sector." It may be more specific and desirable to specify "MOH/E and regions" in place of "government." Also, when discussing "budgetary allocation" (initial tranche), it may be better to specify "MOH/E and provincial budgetary allocation."

Finally, for pure clout, it may be appropriate to have some or all of these conditionalities adopted by other donors as conditions for their assistance. In Kenya, the conditionalities were supported, for example, by the World Bank and a Health Financing Committee and a Health Financing Donor Coordinating Committee were established to monitor progress and coordinate donor assistance. Progress on conditionality implementation is reported to these committees.

#### **V. Proposed Modifications to Illustrative Conditionalities**

Given our experience in Kenya, we suggest pushing up the implementation aspects of the user fee program to the start of the ESHE program. The user fee program is ongoing at present and implementation interventions can be made immediately; they do not have to wait for years three and four. We also recommend being more specific, e.g., by replacing "government" with "MOH/E," and putting measurable objectives in place of less measurable one, e.g., a specific target in place of "demonstrable increase" for tranche 3 and/or 4. We also suggest requiring policies and plans, and having tranches 2, 3, and 4 based on implementation of the plans.

#### **VI. Policy Objectives**

The policy objectives are excellent, with one exception. Key words should be specifically defined or operationalized. For example, we'd recommend that in objectives one and two, the word "increased" should be quantified. In objective three, the words "enabling environment" should be specified, and the word "resources" should have an operational definition. For example, it is not clear what services are included in the "PHN sector." Do these services include FP, AIDS, and essential primary and preventive services? Should objectives two or three have specific mention of AIDS services, if even as an example placed in parentheses?

APPENDIX E

## Appendix E

### REVIEW OF USER FEE PROGRAM IMPLEMENTATION IN GOVERNMENT OF ETHIOPIA HEALTH FACILITIES

The following rough questionnaire was developed for the purpose of seeing, in hospitals and health centers visited, whether systems are in place and functioning. The questionnaire is based loosely on the FIF supervision manual developed for the Kenya HCF program by the HCF project and HCF secretariat.

KEY COST SHARING SYSTEMS

a check mark means "YES"

system component

GUIDING PRINCIPLES AND POLICIES OF THE USER FEE PROGRAM

- \* Are objectives of user fee program understood?
\* Do all staff have same perception of objectives?
\* Are guiding principles documented?

SETTING REVENUE TARGETS

- \* Are revenue targets set?
\* Are targets set periodically?
\* Are revenue targets known by management?
\* Is target setting process documented? what is it?
\* Can process be located in facility visited?

COLLECTING USER FEE REVENUE

- \* Collecting and accounting procedures known?
\* Accounting procedures documented?
\* Accounting documents available in facility?
\* Is there accounting for revenue lost?
. through waivers (people who can't pay)
. through exemptions
. through abuse
. other reasons - specify:
\* Is there reporting of revenue lost from all causes?
\* Is there reporting of collections?
. are reporting procedures documented and followed?
. are they written and available in facility?
. date of last collections report
\* Monitoring collections performance
. role of MOH/HQ known?
. role of treasury known?
\* Procedures and policies documented?
\* Procedures and policies available in facility?
\* Is 80/20 rule followed?
\* Are individual officers held accountable?
\* Are individual departments held accountable?
\* Can user fee revenue be traced through the institution from departments to accounts?
\* What are the procedures for after-hour or weekend/holiday revenue collecting?
\* Is revenue compared against utilization?
\* How many collection points?
\* Are fees posted?

BANKING COLLECTED USER FEE REVENUE

- \* Who banks user fee revenue?
\* How often is banking done?
\* Is banked revenue compared to collected revenue?
\* How often are reconciliations done?
\* Does Treasury ever report back to facilities on amounts of funds received and banked from that facility?

**SPENDING USER FEE REVENUE**

- \* If the facility could retain and spend user fee revenue at the facility, what would they spend it on?  
\_\_\_\_\_
- \* Would collected revenue be enough to make a difference? \_\_\_\_\_
- \* If not all revenue would be retained at the facility level, how much should they be allowed to retain? \_\_\_\_\_ %
- \* Who should decide how much is retained? \_\_\_\_\_
- \* What procedures should be adopted to determine how collected and retained revenues are spent? \_\_\_\_\_

**FEE EXEMPTIONS AND WAIVERS**

- \* Waiver system documented? \_\_\_\_\_
- \* Waiver system followed? \_\_\_\_\_
- \* Waiver system understood by collection staff? \_\_\_\_\_
- \* Waiver system understood by professional staff? \_\_\_\_\_
- \* Documentation available in facility? \_\_\_\_\_
- \* Accounting for waivers granted? \_\_\_\_\_
- \* Waiver targets set? \_\_\_\_\_
- \* Waiver targets known to management? \_\_\_\_\_
- \* Is there a different procedure for IP vs OP waivers? \_\_\_\_\_
- \* What is the waiver procedures? \_\_\_\_\_
- \_\_\_\_\_
- \* Exemption system documented? \_\_\_\_\_
- \* Exemption system followed? \_\_\_\_\_
- \* Exemption system understood by collection staff? \_\_\_\_\_
- \* Documentation available in facility? \_\_\_\_\_
- \* Waiver system understood by professional staff? \_\_\_\_\_
- \* Accounting for exemptions granted? \_\_\_\_\_
- \* Exemption targets set? \_\_\_\_\_
- \* Exemption targets known to management? \_\_\_\_\_
- \* Are waiver/exemption policies posted? \_\_\_\_\_

**SUPERVISION OF USER FEE PROGRAM**

- \* Is there supervision of collections?
  - . within facility? \_\_\_\_\_
  - . from zone? \_\_\_\_\_
  - . from region? \_\_\_\_\_
  - . from MOH/HQ or treasury? \_\_\_\_\_
- \* Should there be supervision of spending?
  - . within facility? \_\_\_\_\_
  - . from zone? \_\_\_\_\_
  - . from region? \_\_\_\_\_
  - . from MOH/HQ or Treasury? \_\_\_\_\_
- \* Do supervisory guidelines exist? \_\_\_\_\_
- \* Is the documentation available? \_\_\_\_\_
- \* Have you ever been visited by Treasury officials who were supervising the user fee program? \_\_\_\_\_
- \* Have you ever been visited by MOH/HQ officials who were supervising the user fee program? \_\_\_\_\_
- \* What was the date of the last supervisory visit? \_\_\_\_\_

**COST SHARING PROGRAM MANAGEMENT**

- \* Has there ever been any training in user fee program implementation issues? \_\_\_\_\_
- \* When was the last training session? \_\_\_\_\_
- \* What is the user fee program management structure within facility?
  - . specific person in charge? \_\_\_\_\_
  - . is specific person senior? \_\_\_\_\_
  - . Health Management Team exists? \_\_\_\_\_
  - . Executive Expenditure Committee exists? \_\_\_\_\_
  - . systems documented and available? \_\_\_\_\_
  - . systems known? \_\_\_\_\_
  - . systems followed? \_\_\_\_\_
  - . role of staff documented and understood?
    - . nurses \_\_\_\_\_
    - . physicians \_\_\_\_\_
    - . clerical officers \_\_\_\_\_
    - . accountants \_\_\_\_\_
    - . departmental staff \_\_\_\_\_
  - . regular meetings of persons responsible? \_\_\_\_\_
- \* Is there a management structure within region/zone responsible for overseeing the user fee program?
  - . District Health Management Team? \_\_\_\_\_
  - . District Health Management Board? \_\_\_\_\_
  - . provincial office of health? \_\_\_\_\_
- \* Is there a management structure within MOH/HQ responsible for overseeing the user fee program?
  - . any management teams? \_\_\_\_\_
  - . Board composition including nurses? \_\_\_\_\_
  - . structure documented? \_\_\_\_\_
- \* Are resources available for user fee program management and supervision?
  - . facility level \_\_\_\_\_
  - . zonal level \_\_\_\_\_
  - . regional level \_\_\_\_\_
  - . MOH/HQ level \_\_\_\_\_

**DISCIPLINARY PROCEDURES**

- \* Written? \_\_\_\_\_
- \* Known? \_\_\_\_\_
- \* Followed? \_\_\_\_\_
- \* Date of last disciplinary action \_\_\_\_\_
- \* What constitutes need for disciplinary action?
  - . fraud \_\_\_\_\_
  - . general abuse
    - . of waivers \_\_\_\_\_
    - . of exemptions \_\_\_\_\_
  - . poor/under reporting \_\_\_\_\_
  - . poor/under collecting \_\_\_\_\_
  - . poor record keeping \_\_\_\_\_
  - . spending revenue before banking \_\_\_\_\_
  - . inappropriate spending \_\_\_\_\_
- \* Who is responsible for disciplinary action? \_\_\_\_\_
- \* When was the last disciplinary action taken at your facility? \_\_\_\_\_

AVAILABILITY OF ESSENTIAL DRUGS, SUPPLIES AND EQUIPMENT  
ITEMS ASSOCIATED WITH QUALITY OF CARE)

- \* What do you consider as essential patient care supplies?
  - . drugs
  - . linen
  - . gloves
  - . x-ray film

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- \* What things would you think patients would like to see in your facility to encourage them to pay user charges?

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- \* Is there an amenity/private ward in your facility?

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GENERAL OBSERVATIONS ABOUT THE FACILITY?

- \* Is the facility clean?
- \* Does it smell?
- \* Are staff courteous and friendly?
- \* Are there long queues?
  - . where are the queues? \_\_\_\_\_

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- \* Is there linen on the beds?
- \* By observation, how many people per bed?
- \* Are their patient uniforms?
- \* Other general observations \_\_\_\_\_

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PATIENT FLOW CHARACTERISTICS

- \* What is the general patient flow like? \_\_\_\_\_

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- \* Are charge sheets being used on the wards?
- \* Do patients flow through Accounts upon discharge?
- \* What is the discharge process? \_\_\_\_\_

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- \* What is the role of the accounts clerk at time of discharge?

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**APPENDIX F**

## Appendix F

### IMPLEMENTING A NATIONAL PROGRAM IN A FEDERAL SYSTEM: A POSSIBLE APPROACH FOR USER FEE IMPLEMENTATION

#### I. COMMON MISTAKE - A TOP DOWN APPROACH

National programs are most often conceived at a national level by Ministries of Health. Because most countries have a strong central Ministry of Health, design and implementation is carried out centrally with the regions implementing directions, guidelines, and methods dictated centrally. Problems which arise are fairly obvious. Ownership at the local level is lacking, health workers and managers fear that it is yet one more burden placed on them by central government. The central Ministry of Health becomes a policeman trying to supervise, control, and catch those people/facilities/institutions which don't follow directions. The role of the central program becomes one of supervisor, auditor, controller, and disciplinarian. Implementation is not considered top priority for the regions.

In a federal system, a much different approach must be taken. The participation of the regions is necessary in developing the national policies, in conceptualizing the "core program," and in systems development. The result of such a participatory approach is that the program becomes their program, standards which are nationwide can be defined with everyone at the bargaining table, and the degree of freedom to alter the program at the regional level can be defined together.

In this participatory approach to policy and program development, the national level sets the very minimum core package, policies, and procedures with suggestions for refinements made in concert with the regions.

While it may take longer and require additional resources initially, the result will be a more efficient design and implementation phase, and should save money in the long-term.

#### II. USER FEE PROGRAM DEVELOPMENT - A PROPOSED PARTICIPATORY APPROACH

The Ministry of Health in Ethiopia (MOH/E) may want to consider a participatory approach to policy refinement (as opposed to basic policy development which is the realm of the MOH/E HQ) and systems development for the user fee program. The steps in this process may look like this:

1. MOH/E HQ defines the basic policy framework.
2. MOH/E HQ calls a one-day meeting of heads of regional health bureaus to discuss and refine the basic policy with Treasury and other relevant national policy makers.

3. MOH/E HQ further refines the policy after step #2, above.
4. A national workshop of relevant people from the regional bureaus is called to discuss the policy, reasons for it's development and, most important at this stage, development of a joint time schedule for implementation of the policy.
5. Task groups are defined to work on various parts of the systems which need to be developed. What would be developed would be the proposed core systems which could later be supplemented with regional specific add-ons.

Systems which lend themselves to this approach are

- a. accounting and control systems within facilities,
  - b. audit and control systems within regions,
  - c. waiver and exemption systems and procedures for facility implementation,
  - d. basic core regional reports which would be sent to HQ,
  - e. basic reports and procedures for feedback from HQ to regions,
  - f. supervisory guidelines from HQ to the field and from regional bureaus to facilities, and
  - g. monitoring and evaluation methods.
6. Regions are asked to be pilot test sites (including Addis Ababa), and testing begins along with refinements in the same groups identified in #5, above.
  7. Core systems are finalized and a phased implementation plan from top-down in the system is planned. Training of regional staff would occur at appropriate levels as implementation takes place.
  8. Monitoring and evaluation would commence before implementation to collect adequate baseline.
  9. Initial supervision to the regions from the HCF secretariat until systems are well in place and core standards adhered to in regions.
  10. Disbandment of the HCF secretariat.

### III. THE ROLE OF A HEALTH CARE FINANCING SECRETARIAT

A central MOH/E HQ health care financing secretariat is important for technical inputs, for standardization design and implementation of core policies, for training, for national level monitoring and evaluation, and finally, for initial control. However, once the program is ingrained, the role of MOH/HQ becomes less important.

The other role for the health care financing secretariat goes beyond the user fee program. There are many financing strategies which need to be developed and implemented which only a central Ministry can tackle. Development of privatization policies and procedures for GOE facilities, and

development and piloting of social and health insurance schemes are alternative strategies, as is the development of methods for determining staffing needs and staffing norms. Application of these policies, procedures, and methods can be left up to the regions and may, in fact, take a similar participatory approach. However, these are not cross-cutting issues since these types of policies would apply to only some of the regions and more urbanized areas of the country.

#### IV. IS TECHNICAL ASSISTANCE NEEDED?

There is no doubt that Ethiopians know Ethiopia better than non-Ethiopians. Nothing can take the place of an intimate understanding of the politics, social values, and way of thinking of the people in each of the diverse regions of Ethiopia. This knowledge and understanding, however, is not enough. Policy and implementation experience gained from other countries, in other settings, and with other systems is very useful if Ethiopia is to avoid making the mistakes made elsewhere. If the proper skills and experience are to be found in professionals in Ethiopia then no outside technical assistance is required.

#### V. WHAT KINDS OF TECHNICAL SKILLS ARE NECESSARY?

At a minimum, for a user fee program, the following professional skills are essential in the design and implementation of a successful program, and are necessary full-time, long-term during the design and implementation phase of the program. These skills and experts need not be from outside but, as a whole, are necessary either from within or outside.

- Chartered Accounting (or Certified Public Accountant)
- Senior Hospital Administrator
- Health Planner/Survey Research Specialist
- Physician (not necessary a specialist)
- Senior Nurse
- Management Information Systems/Computer Specialist

In addition, short-term assistance from the following types of experts is needed:

- Economists
- Survey Specialists/data collection and analysis
- Statisticians
- Auditors
- Manpower Specialists
- Insurance Specialists
- Actuaries
- etc.

## VI. HOW LONG WILL IT TAKE AND WHAT WILL IT COST?

The Kenyan program has taken three years from the design phase to the accountability phase. About \$2 million US has been needed for implementation the bulk of which has been taken up by implementation training for facility, district, and provincial staff. The Kenyan program has two vehicles which have proved to be inadequate for the need, and a full secretarial and administrative staff.

**APPENDIX G**

## Appendix G

### HEALTH FINANCING STRATEGY: THE KENYAN EXPERIENCE AND ITS APPLICATION TO ETHIOPIA

#### KEY FINANCING PROBLEMS AND CAUSES

Health financing problems are the result of a few issues:

1. Direct over/under funding
2. Productive inefficiencies
  - over/under treatment
    - e.g., higher/lower drug use than necessary
  - over/under consumption
    - e.g., higher/lower service use than necessary
  - over production (more services in general than necessary)
  - mal-distribution of resources
  - under collection, fraud, or abuse of user fee programs
  - mismanagement of existing resources
3. Allocative inefficiencies
  - over/under staffing
  - geographical over/under supply of facilities
  - over/under budgeted
4. Mal-distribution of services/facilities
  - lack of private/mission sector
  - facilities in inappropriate locations through lack of planning

The first issue normally is a situation in which funds are simply inadequate and additional funds are necessary. If this is the case, several options for additional revenue are appropriate<sup>1</sup>. Increased taxation and user fee programs are two ends of the spectrum of possible solutions.

The health financing program in Kenya primarily addressed the problem of under budgeting, resulting in a concentration of efforts on revenue generation through user charges. The remaining financing problems, however, were addressed only minimally and, at times, belatedly. The types of things which we did, or are doing, are listed below:

- \* establishment of a method for setting staffing standards which was picked up by the World Bank for national implementation,

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<sup>1</sup> These issues are all outlined in papers written for and about the Ethiopian health care system.

- \* development of treatment protocols which are being printed by WHO (a copy of the protocols is attached),
- \* development of a Better Management of Drugs manual for use in GOK hospitals, and
- \* development of a computer program which is capable of tracking required and anticipated shifts from curative to P/PHC and staff to non-staff amounts in the GOK MOH budget.

We've acknowledged that other problems, however, are some of the most important. Staffing costs are approximately 60 percent of the total budget of the MOH/K. Costs of drugs is approximately 10 percent of the MOH/K budget. All the revenue generated from the national user fee program in Kenya would not last one month if it were used to pay for only drugs. The user fee program itself, depending on the system put in place, may in fact exacerbate the drug problem and cause further inefficiencies<sup>1</sup>.

The specific role of the private/mission sector and social financing were addressed as separate sections of this strategy because of their importance in revenue generation, unburdening the government health system, and providing quality services at a reasonable cost. We feel that development of risk-pooling mechanisms and health insurance is a fundamental financing strategy for urban and, on occasion, specific rural areas where organized groups can be formed into a large purchasing pool. In light of this, our program next year will concentrate on the development of various insurance models. Some of these models are perfectly suited for the situation found in Addis Ababa. These models include:

- \* pre-paid insurance for cooperative members funded through voluntary membership with services provided by a mission hospital;
- \* development of an managed care program (staff model Health Maintenance Organization) for a rural part of Kenya where organized private sector farms have numerous unskilled, but salaried employees;
- \* development of a credit card-based Independent Practice Association form of managed care for urban areas of Kenya; and
- \* using local insurance companies to form "pools" of employees of small employers in Nairobi for in-patient and out-patient service coverage.

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<sup>1</sup> If a "door" or "entrance" fee is charged, then there is no incentive for the consumer or provider to reduce treatment inputs (drugs and supplies per patient). However, with a treatment fee and a per item charge, the more drugs and supplies provided, the higher the cost to the patient and the lower the demand.

**APPENDIX H**

## Appendix H

### ETHIOPIA'S HEALTH FINANCING STRATEGY

Ethiopia's health financing strategy should allude to all finance problems and options, even if it does not address them directly. Initiating new fees may, if all goes well, contribute about 25 percent to the total health budget for a facility. Revenue generation from improved systems may double that amount. Savings from improvements in efficiency, drug management, staffing, and productivity could free up that amount of revenue yet again. Finally, developing private sector provision of health care, and financing that through insurance could alleviate some of the health care burden now faced by the Ministry of Health. Those funds could then be used for care of the more needy. In other words, all aspects of health financing should be addressed in the financing strategy as a global policy document for MOH/E. Exactly what is done initially, however, can be left for the HCF implementation plan.

### PROCESS OF HEALTH FINANCING STRATEGY DEVELOPMENT IN KENYA

In Kenya, the process of developing the health care financing strategy was an iterative and participatory process. From the onset, the strategy attempted to address all aspects of health financing. The MOH/Kenya hired technical specialists in the issue areas to study the background, magnitude, and nature of the problem. A group was then formed to debate and recommend solutions. Numerous technical specialists, politicians, and health professionals were involved in workshop discussions and in drafting materials which were later circulated widely for review. Donors were included in this review process. The outcome was a document which, while not perfect, had the involvement and endorsement of many of the key players in the health field.

### DEVELOPING AN HCF MID-TERM IMPLEMENTATION PLAN

The second step in the HCF strategy was the development of a 5-year implementation plan. This plan was to quantify desired changes with a short time scale, determine the sequence of steps to accomplish short- to medium-term changes, and assign responsibility. This, also, was developed with a great deal of participation of the MOH technical staff, donors and others. The result was an implementation plan which is, in hindsight, too optimistic, but potentially implementable in the not too distant future.

Ethiopia may want to consider implementation planning as a next step after the strategy is developed and approved.

**APPENDIX I**

## Appendix I

### LESSONS LEARNED KENYAN USER FEE PROGRAM

- \* Out-patient fees need to be affordable and acceptable. Patients are less sensitive to in-patient fee changes
- \* Management and accounting systems are critical and should be developed in collaboration with the facilities that will implement the systems.
- \* Implementation by circular doesn't work. Constant supervision and extensive training of facility staff is necessary.
- \* Good policies alone are inadequate for successful implementation. A fully staffed and operational secretariat at high level within the Ministry of Health with specific technical support is necessary. An adequate operational budget is required.
- \* It's easy to underestimate the amount of time, skills, and resources required to implement a refined user fee program.
- \* Phased implementation from top-down in the referral system assures allows one to begin collecting revenue where the most revenue is likely to be, and time to modify and refine systems.
- \* Management for performance (management as if health is a business) is necessary to generate adequate funds. Setting collection targets, holding staff accountable, and measuring performance is necessary.
- \* Local supervision (as close to the point of collection and retention) is desirable and more sustainable in the long term.
- \* People who abuse the system must be disciplined.
- \* The poor must be protected.
- \* Health financing isn't only about getting money. It's about getting that money to the service providers as fast as possible to support the highest priority services.

**APPENDIX J**

## Appendix J

### STEPS IN DESIGN and IMPLEMENTATION OF THE KENYAN USER FEE PROGRAM

#### PRE-USER FEE PHASE (1963-1989)

- \* Nominal fees with minimal revenue generation
- \* All fees revert to treasury
- \* Little incentive to collect fees

#### USAID-FUNDED PRE-PROGRAM PHASE (1988-1990)

- \* Various studies
  - primary and preventive health care gap study
  - ability and willingness to pay assessments
  - feasibility studies
  - quality assessment studies at KNH
  - Nairobi area study<sup>1</sup>
  - provincial and district study
- \* Pre-program design
  - non-project assistance for policy and program changes
  - project design for technical assistance

#### EARLY IMPLEMENTATION PHASE (1989-1991)

- \* Nation-wide implementation of all fee changes at all levels (except dispensaries)
- \* Minimal controls and systems in place
- \* Limited staff preparation and training
- \* Management and implementation by circular
- \* Out-patient fee suspended after nine (9) months

#### SYSTEMS DEVELOPMENT PHASE (1991-1992)

- \* Focus on strengthening management systems level-by-level
- \* Standardized collection, exemption/waiver and spending policies and procedures
- \* Participatory systems development
- \* Focused workshops, training, and regular supervision starting from top of system downward in concert with level-by-level implementation
- \* Systems tried first at top of system (Kenya National Hospital and provincial referral hospitals)<sup>2</sup>
- \* Exemptions broad for acceptability
- \* First operations manual developed

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<sup>1</sup> The health system of Nairobi Area was considered a special case for health financing and the delivery of health services.

<sup>2</sup> Kenya National Hospital is the equivalent to the Tikur Anbessa (Black Lion) Hospital in Addis Ababa

**ACCEPTABILITY PHASE (1991-1993)**

- \* Exemptions expanded
- \* Treatment fee introduced in place of registration fee
- \* Focus on high revenue areas, visible use of funds, clinician, and nurse involvement

**ACCOUNTABILITY PHASE (1993-1995)**

- \* Supervisory manual developed
- \* Training and support to District Health Management Boards for monitoring and accountability
- \* Involvement of provincial officer of health for improved and decentralized supervision
- \* Setting and monitoring collection targets
- \* Measuring expenditures against plans
- \* Improving the audit function

**APPENDIX K**

## Appendix K

### GUIDING PRINCIPLES OF THE KENYAN USER FEE PROGRAM

100 percent of revenue retained locally

- 75 percent for hospital/ health center collecting the funds
- 25 percent for district preventive/promotive activities (P/PHC)

Facility-level planning and control for use of the facility (75 percent) funds.

District level planning and control for the use of the P/PHC (25 percent) funds.

All user fee revenue is additive to treasury allocations (Treasury does not reduce MOH budget allocations as a result of additional user fee revenues).

All user fee revenue is no-year revenue. If not spent by the end of the fiscal year, it is carried forward and does not revert to MOH or treasury.

The higher one goes up the referral ladder, the higher the fees. The fees are lowest at health centers, and highest at Kenyatta National Hospital. This fee schedule is done to encourage proper referral and efficient use of resources.

Vigorous pursuit of insurance reimbursements.

Discretionary waivers for the poor.

Exemptions for selected categories of diseases which have public health significance<sup>1</sup>.

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<sup>1</sup> Not all exemptions were put in place for public health reasons. Most were done for acceptability purposes.

**APPENDIX L**

## Appendix L

### MONITORING AND EVALUATION OF THE KENYA COST SHARING (USER FEE) PROGRAM

The monitoring and evaluation of the user fee program in Kenya was made up of several components. They are described in the following table.

M & E SYSTEM COMPONENT	METHOD OF IMPLEMENTATION	LOCATION OF RESPONSIBILITY
Monitoring collections, bankings, waivers, exemptions	Monthly performance reports - Departmental - Facility	Facility level - Department - Facility, Mgmt
	Quarterly reports	MOH HQ level
	Annual reports	MOH HQ level
Monitoring user fee impact on utilization	Patient surveys - Patient profile surveys - Outpatient surveys - Inpatient surveys	MOH HQ
	Quality of care surveys (avail. of critical patient care items) - Patient perception of quality - Household surveys	MOH HQ
	Willingness to pay surveys - Client survey - Provider survey	MOH HQ
	Household survey (pre-post changes)	MOH HQ
Monitoring expenditures P/PHC Curative care	Facility reports	Facility level
	Plans from District Health Management Boards (DHMBs)	DHMB, from facilities
	Expenditures against plans	facility level and MOH HQ

#### **Problems Encountered**

The following problems were faced in the monitoring and evaluation of the user fee program in Kenya.

1. We initially concentrated primarily on generating revenue and measuring that revenue, not on measuring the impact on patients of fee changes.

2. We did not spend enough time finding out what service(s) people would be willing to pay for before we asked them to pay for services.
3. When we did begin measuring the impact of fee changes on utilization patterns, we did not measure the impact both inside and outside the government health system. Therefore, we did not know if we were locking people out of the system who really needed care and didn't get it simply because they couldn't afford the fee.
4. The timing of the eventual surveys was not perfect.

### **What Would We Do If We Could Set Up a Monitoring and Evaluation System Again?**

The sequence of events would be as follows:

**STEP 1: Initial studies**

- willingness to pay
- global curative and P/PHC gap study - global to influence policy makers of the need for local retention
- facility gap study - to determine the amount of funds retained
- baseline household survey in indicator districts to measure baseline health care seeking behavior of community members
- baseline exit interviews (OP and IP) at GOK facilities to discover patient perceptions of quality of care
- baseline collection of service statistics from selected indicator districts (all facilities including government, mission and private)

**STEP 2: Implementation at the top of the system (KNH)**

**STEP 3: First round of evaluation surveys**

- exit interviews to discover patient perceptions of quality of care
- household survey near initial facility(ies) to determine any shift in patterns of utilization of all types of facilities
- collection of service statistics from indicator districts to assess changes in utilization patterns

**STEP 4: Expansion of fee changes to next level**

- exit interviews to discern patient perceptions of quality of care
- household survey near initial facility(ies) to determine any shift in patterns of utilization of all types of facilities
- collection of service statistics from indicator districts to assess changes in utilization patterns

This process would be carried out until all changes are implemented in all levels of the GOK system.

Ongoing during this process would be the monitoring and evaluation of fees collected, fees collected against targets, user fee revenue spent as compared to approved plans, and levels of exemptions and waivers.

### **M & E Instruments Provided to the Ministry of Health, Ethiopia**

The HCF program has developed, tested, and used the following survey instruments for the planning and monitoring of the program.

**PATIENT SURVEYS** -- Conducted before and after major fee changes in six diverse indicator Districts, using standard sampling and field procedures.

- (1) Patient Profile (outpatient) -- to assess changes in diagnoses, drug prescribing practices, investigations requested by providers.
- (2) Out-patient Survey -- to assess changes in socioeconomic characteristics, perceptions of quality, knowledge of workers.
- (3) In-patient Survey -- similar to outpatient survey.

**QUALITY OF CARE** -- Periodic survey of the availability of critical/essential patient care items.

- (4) Survey instrument for availability of supplies.

**WILLINGNESS TO PAY** -- Pre-1990 cost sharing survey instruments were not readily available. Two 1994 survey instruments are attached which were used to determine willingness to pay for family planning services. The same types of questions can be used or adapted for community surveys.

- (5) Client survey.
- (6) Provider survey.

**HOUSEHOLD SURVEY** -- Conducted before and after major fee changes in the six indicator districts.

- (7) Household survey used with standard sampling procedures.

APPENDIX M

## Appendix M

### ANALYTIC AND PLANNING METHODS HUMAN RESOURCES PLANNING<sup>1</sup>

Staff costs make up 60 percent of the Ethiopian health budget and will continue to consume approximately this amount of the budget for some time to come. Without addressing staffing needs and manpower supply any health care financing strategy impact is limited.

Found below is a very brief outline of available methods for determining current and future supply of health manpower, methods for determining staffing needs and setting staffing standards. Rationalization of staffing patterns is one of the most critical services and financing activities a Ministry of Health can undertake.

#### Supply of Health Personnel

Four different concepts have to be distinguished in estimating the work force supply:

1. Active supply consists of health workers who are currently economically active in the health sector;
2. Inactive supply refers to qualified staff who are not active in the health sector at the present moment;
3. Potential supply includes that proportion of personnel in the inactive supply who could potentially be recruited back into the health system; and
4. Projected supply refers to a projection of the probable active supply of health workers in future years.

#### Estimating Health Personnel Needs

There are four main generic methods for estimating the required needs for health staff:

1. The personnel-to-population method (or personnel-to-bed method for in-patient facilities);
2. The health-needs method;
3. The service-demands methods or service-targets method; and
4. The managed health-care method.

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<sup>1</sup> Taken from "Human Resources Planning: Issues and Methods" Kolehmainen-Aitken, R. Data for Decision Making Project, Harvard University.

## **Determination of Staffing Standards**

Staffing standards should reflect both the services to be delivered and the level of technology available, and will most likely vary over time. Various methods have been used, and there is no one best method. Available methods include:

- \* standards obtained from external sources;
- \* standards based on expert opinion;
- \* standards based on experience;
- \* standards based on functional and/or task analysis; and
- \* indicators of staffing needs.