

- PN-ACR-144-

# REPORT

## Ethiopia's Health Care Financing Experience

### Report on the Current Status of the Implementation of the Government's Health Care Financing Strategy

By

Jan Valdelin and Netsanet Waleign  
(IR 1 Team of the ESHE/JSI Project)

October, 2000

John Snow, Incorporated



*Submitted to: HPN Office of USAID Ethiopia  
Activity Title: SO #2*

*Intermediate Result 1: Increased Resources Dedicated to the Health Sector,  
Particularly Preventive and Primary Health Care (PPHC)*

*Project No. 015171-0001  
Contract No. 00-663-C-00-99-0323-00*

A

# **ETHIOPIA'S HEALTH CARE FINANCING EXPERIENCE**

## **Report on the Current Status of the Implementation of the Government's Health Care Financing Strategy**



**IRI Team of the ESHE Project  
October 2000, Addis Ababa**

**ACRONYMS**

EC	Ethiopian calendar
EFY	Ethiopian Fiscal Year
ESHE	Essential Services for Health in Ethiopia
ETB	Ethiopian Birr
HC	Health Center
HCF	Health Care Finance
HCFS	Health Care Finance Secretariat
HFR	Health Facility Revenue
HSDP	Health Sector Development Program
HSTD	Health Service and Training Department, MOH
ICU	Istituto per la Cooperazione Univercitari
IR1	Intermediate Result #1 (of ESHE project)
MEDaC	Ministry of Economic Development and Cooperation
MOF	Ministry of Finance
MOH	Ministry of Health
MOLSA	Ministry of Labor and Social Affairs
NGO	Non Government Organization
NHCFITC	National Health Care Finance Implementation Task Force
NPA	Non-Project Assistance
PMP	Prime Minister's Office
PPD	Planning and Programming Department, MOH
RDF	Revolving Drug Fund
RFB	Regional Finance Bureau
RHB	Regional Health Bureau
RHCFC	Regional Health Care Financing Committee
RPEDB	Regional Planning and Economic Development Bureau
SDS	Special Drug Shop
SP	Special Pharmacy
SPP	Special Pharmacy Project
USAID	United States Agency for International Development
USD	US Dollar
WHO	World Health Organization
WorEO	Woreda Education Office
WorHO	Woreda Health Office
ZHD	Zonal Health Department

## TABLE OF CONTENTS

<b>EXECUTIVE SUMMARY .....</b>	<b>1</b>
<i>Strategy Components .....</i>	<i>1</i>
1. Organizational structure .....	1
2. User fee revision .....	1
3. Exemption and waiver.....	2
4. Retention .....	3
5. Special Pharmacies.....	4
6. Health insurance.....	6
7. Private sector investment .....	6
8. Facility budgets: the component of increased resources to the sector .....	7
9. The market for pharmaceuticals .....	7
<i>Policy Issues and Tentative Recommendations.....</i>	<i>8</i>
<b>1. BACKGROUND .....</b>	<b>10</b>
<b>2. ADDIS ABABA ADMINISTRATIVE COUNCIL .....</b>	<b>11</b>
<b>3. OROMIYA REGION.....</b>	<b>12</b>
3.1 East Shoa Zone .....	12
3.2 Asella Zone .....	13
<b>4. DIRE DAWA ADMINISTRATIVE COUNCIL .....</b>	<b>15</b>
<b>5. HARARE REGION.....</b>	<b>16</b>
<b>6. AMHARA REGION.....</b>	<b>17</b>
6.1 Bahir Dar Special Zone .....	17
6.2 South Gondar Zone .....	18
<b>7. SOUTHERN NATIONS, NATIONALITIES AND PEOPLES' REGION (SNNPR) .....</b>	<b>19</b>
7.1 Sidama Zone .....	19
7.2 North Omo Zone .....	20
7.3 Hadiya Zone.....	22
7.4 Gurage Zone .....	23
<b>8. TIGRAI REGION .....</b>	<b>24</b>
8.1 Eastern Tigray Zone .....	26
<b>9. MARKET FOR PHARMACEUTICALS AND MEDICAL SUPPLIES .....</b>	<b>28</b>

## EXECUTIVE SUMMARY

### Strategy Components

The health care financing secretariat (HCFS) and the IRI team of the Essential Service for Health in Ethiopia (ESHE) project conducted visits to five regions (Amhara, Oromiya, SNNPR, Harare and Tigray) and the two administrative councils (Addis Ababa and Dire Dawa) during the months of June and October 2000. The visits were generally aimed at learning from experience of regions in implementing the Health Care Financing Strategy (the Strategy). The team discussed issues related to Health Care Finance (HCF) with regional officials at different levels (7 RHBs and 9 ZHDs) and health professionals at facilities (12 hospitals and 7 health centers)

#### 1. Organizational structure

It is well known that the Strategy was adopted by the Council of Ministers two years ago (June 1998). To facilitate its implementation an implementation guideline was submitted to the Prime Minister Office (PMO) a year ago (August 1999). Both the Strategy and the guideline stated organizational requirements for the implementation. The national responsibility is vested with the National Health Care Financing Implementation Task Force chaired by the Vice Minister of MOH, where head of RHBs, representatives from MOF, MOLSA, MEDaC, NGO, organized health service consumer groups, and different departments of MOH are members. This is the highest body responsible for policy decision related to the Strategy. A Health Care Financing Secretariat based in Health Service and Training Department (HSTD) of MOH serves as Secretariat for the national task force. Likewise, the Regional Health Care Financing Committee in each region chaired by regional state council social sector head, where regional council women's affairs head, RHB head (secretary), RFB head, RPEDB head, representatives from NGOs, and consumer groups are members, is responsible in each region. This structure goes down to zones, woredas and health facilities. However, these bodies were not established as of the end of September 2000, except for the national task force, which, however, met only a couple of times and didn't meet in the last one and a half years. In the MOH, the Strategy suggests that the HSTD should be restructured and accommodate the HCF Secretariat. At the end of October 2000, the Secretariat has not been staffed and the HSTD not restructured. Many of these organizational structures are therefore not in place or not effective, and this has resulted in the present retarded pace of implementation.

Nevertheless, looking at the implementation of specific components separately we observed impressive performance in most of the regions. At the top of well-practiced components is the establishment of Special Pharmacies through revolving drug funds obtained from different sources (donors, government, hospital, suppliers etc). It is being exercised in almost all regions, with varying degree of arrangements and performance. In the work plan of the ESHE project and in the implementation ideas for the Health Care Financing Secretariat the concept of pilot testing is often applied. Our observation is that most of the piloting is done by the regions, sometimes in their own special way. It is therefore more fruitful for the national level implementation to pick up ideas and learn from the regions, than to arrange special pilot projects (there are exceptions to this, i.e. user fee changes). The progress achieved by the regions and the challenges faced under each component are summarized below.

#### 2. User fee revision

The Strategy summarized the issue of user fee revision and waiver as follows:

*There has been [in Ethiopia] a long history of fee-for-service in its health sector but lacked periodic revision. Surprisingly, it has not been revised for the last 47 years. There were also increasing proportion of fee waivers. Subjective estimates of the number of free patient*

*ranged from 30-80% ... Thus the share of recurring health expenditures covered by government user fees has decreased from about 19% in 1981 to an estimated 7.9% in 1994.<sup>1</sup>*

These statements hold true at present. There is no systematic revision as such of the user fee structure. Of course, one can find a fragmented change of user fee charges in some regions, but this is often not uniform across all facilities in the region. Based on the government's principle of cost sharing in health services between the provider and the receiver, revision of user fee charges according to ability to pay is mandatory, however.

Some regions have done detailed study of the user fee structure at various levels. For instance:

- ❖ RHB of Addis Ababa has presented a study on user fee structure to the regional council, which has approved its proposal. It is now in MOH for comment and approval before implementation.
- ❖ RHB of Amhara region formed a task force to propose a revision of user fees two years ago. The task force has submitted its proposal and it is being discussed at higher level.
- ❖ In Dire Dawa administrative council a committee formed to assess the experience of other regions and come up with proposal for the administrative council. The committee submitted its proposal a year ago.
- ❖ RHB of Tigray conducted a study three years ago and later presented the results in a workshop. It is now in the regional council. RHB is waiting for a decision.

MOH through the HCFS has produced information for a user fee revision proposal by taking sample of existing fee structure from different regions and levels (regional hospital, zonal hospital, health center). But considering the sensitivity of the issue and the living standard of the population, more caution needs to be taken before moving to action. To give more inputs for decision makers the HCFS in collaboration with the ESHE project is currently conducting a package of studies '*Willingness and ability to pay for health care service*', '*Delineation Study*' and '*Private health expenditure review*'. Results of these studies will give more inputs to decision makers towards informed revision of the existing fee structure. In order to increase user fees without decreased utilization, it must be preceded by an increase in quality of services. The sequencing of the components of the implementation of the Strategy is, therefore, crucial for its success. As the lessons from the public providers demonstrate below, the first step to take is to improve quality of service by increasing the availability of pharmaceuticals (cf. below, section 4)

### **3. Exemption and waiver**

Closely related to user fee is the exemption and waiver system to benefit the poor. Poverty certificates are presently issued by councils or kebeles and it is common knowledge that it is not difficult to obtain one. A large part of the explanation is the loose arrangements of issuance. All agree that with the present exemption and waiver procedure it is difficult to distinguish the poor from those who can afford to pay and still come with the poverty certificate. As a result, in some facilities the rate of free patients reaches up to 95%. But as correctly put in the Strategy '*... no service is "free", there is always a third party paying for it*'. It is taxpayer's money that finances the public facilities and why should one pay tax and pay for health care services as well, while others are getting free services while being able to pay. There should be some way to solve this problem including credit services by facilities and budget allocation for free patients every year under, for example, the municipality so that proper screening will be in place of who is poor and who is not.

MOH has submitted a research proposal on '*Exemptions and waiver mechanisms that*

---

<sup>1</sup> The implication of this percentage decline is not yet sufficiently clarified as the increase of recurrent health expenditure has been considerable since the beginning of the 1990's.

ensure equitable access to health care by the poor and vulnerable in Ethiopia' to WHO for financing. The results of this study may contribute to provide options for a proper exemption and waiver system in the health care service.

#### 4. Retention

The health sector in Ethiopia is under-funded and this is one of the major causes of the existing weak health care system in the country. To increase resources to the sector the Strategy has introduced a core concept called 'Health Facility Revenue (HFR)'. With the introduction of this concept the Strategy allows retention of all revenue at facilities that is meant to be additive to annual government budget allocation. These issues are stated in the Strategy in the following way:<sup>2</sup>

- ❖ *All the income generated by health facilities from various income-generating activities (user fees, RDFs, private and community/employer based risk sharing schemes, donations, gifts, etc.) will be considered as 'health facility revenue' after the necessary arrangements are made.*

Further, the Strategy states that HFR will be:

- ❖ *additional to government budget*
- ❖ *retained and used by the health facility that generates it*
- ❖ *deposited in a special account opened by the respective by the respective health facilities,*
- ❖ *used to improve the quality and quantity of health service,*
- ❖ *subjected for appropriate control and audit by authorized government body as per the new financial regulation.*

On the other hand, the new financial proclamation of the Federal government, Proclamation No. 57/1996, is based on the concept of consolidated fund. That is:<sup>3</sup>

- ❖ *There shall be one consolidated fund into which all public money shall be paid except that otherwise allowed by law.*
- ❖ *The consolidated fund shall be maintained and administered by the Ministry (MOF).*
- ❖ *The Ministry may open in the name of any public body bank accounts for the deposit of public money and such accounts shall form part of the consolidated fund.*
- ❖ *No public money shall be collected without the use of the official receipts of the Ministry.*
- ❖ *All public money shall be deposited in the consolidated fund to the credit of the Ministry except aid in kind which it shall be recorded in the consolidated fund and therefore deemed to be deposited.*

Currently, these two government documents are not harmonized. As the Strategy states, the HFR will exist *after the necessary arrangements are made*. To practice HFR as stated in the Strategy requires some arrangements. A major requirement would be its synchronization with the financial proclamation. The financial proclamation has a provision for such arrangements by allowing the establishment of special funds (like the road fund and the pension fund). What is required is, therefore, closer discussion between MOH and MOF at federal level and between RHBs and RFBs at regional level for proper legal backing of the Strategy to implement HFR. For instance, establishment of a special health fund, like the road fund and the pension fund.

The progress along the retention issue is limited. Most regions raised the inconsistency

---

<sup>2</sup>Ministry of Health, Health Care and Financing Strategy, 1998, item 3.11

<sup>3</sup> Proclamation No. 57/1996

between the Strategy and the financial proclamation as a major obstacle to cost recovery.

Nevertheless, the SNNPR has introduced retention at hospital level this fiscal year (1992 EC). All hospitals in the region are allowed to retain 50% of the revenue collected at facility level and the remaining 50% is transferred to the RFB. Since this is the base year, the 50% calculation is based on last year's revenue of the facility. This is a step ahead in terms of translating the Strategy into action and it is still too early to judge the pros and cons.<sup>4</sup>

Two other regions (Amhara and Addis Ababa) have prepared retention regulation proposals and are waiting for approval from the MOH.

In one area, a majority of regions have already introduced 100% retention at facility level. This is in the area of pharmaceuticals and it is done by the establishment of Special Pharmacies (SPs).

### **5. Special Pharmacies**

To establish and expand Special Pharmacies through the impact of working capital and retention is one of the means envisaged to bring in money to the health facilities. There is ample experience in almost all regions in this regard, with diversified arrangements. What they do have in common is the retention level of 100%.

The sources of fund for the initial working capital to establish these pharmacies are from government, donors, both donors and government, and in some cases credit from suppliers. The seed money was provided sometimes in cash and sometimes in kind (medical drugs). The amount of initial capital ranges from 10,000 Birr to 150,000 Birr. To establish these pharmacies, the license of the pharmacist in the facility, the RHB or ZHD is used. If no pharmacist is available in the facility or the ZHD, pharmacy technician's license is used. For the license of the pharmacist or pharmacy technician some amount is usually paid on a monthly bases. This fee for license is between the range of 250 and 1,000 Birr (1,000 Birr is in Addis Ababa hospitals).

Different kinds of incentives for staff are applied by the Special Pharmacies. Other than the staff involvement as such in the day-to-day activities, the SPs also give incentives based on hours worked, supplementary hours worked, an agreed lump sum or sometimes as a proportion of monthly sale revenues.

Special Pharmacies are governed by the guidelines approved by the zone or the region. In most cases, different zones in a region follow different guidelines. However, regions are now trying to develop region-wide guidelines (Amhara region conducted a two day workshop with two HD heads, M/directors and pharmacists from the seven zones to discuss the draft guideline; SNNPR has drafted a guideline which is now submitted to the RFB for comment; Tigray has adopted a regional guideline). Likewise the HCFS and ESHE project are working on a model national SP guideline that could be adopted and modified to the situation of any particular region.

Generally, a special committee manages the Special Pharmacies. The arrangement is actually not uniform, different regions have different arrangements and in some cases a two level management committee is adopted to run the pharmacy (management and technical committee). The management committee is the higher body, while the technical committee is responsible for the day-to-day follow up. Similarly, composition of committee members is diversified from region to region. In most cases the committee members include:

- ❖ M/director (if it is in hospital); HC head (if health center)

---

<sup>4</sup> The Strategy defines HFR to be retained at 100%. The 50% experience in SNNPR is carried out with the aim of raising the level to 100% as well as to apply it also at health centers.

- ❖ Pharmacist/pharmacy technician
- ❖ RHB/ZHD/WorHD representative
- ❖ Accountant of the facility

In all facilities the SP functions in parallel to the budget pharmacy<sup>5</sup>. The SP is peculiar from the other in the following sense:

- ❖ Sales revenue is collected by its own receipt (not MOF), retained by the facility, and deposited in a separate bank account,
- ❖ Sales price is determined by the facility with a mark-up of 20 - 25% on the purchase price,
- ❖ Generated surplus is used to increase working capital (to sustain drug availability), to give incentive to staff, to improve the facility (equipment, building, ambulance...).

Challenges facing Special Pharmacies include:

1. The inconsistency between the financial proclamation and the Strategy needs to be overcome. In at least some case, the regional guidelines provide for full retention at the pharmacy. In most cases, this is not fully formalized, but rests on a *modus vivendi* between the finance bureau and the health bureau. Some two years back, one finance bureau claimed a transfer to the treasury and this has been noted by other regions, creating a tension at pharmacies in other regions as well.
2. The procurement guidelines need to be unified to enable cost-effective procurement. For example, some regions have restricted purchasing to one supplier only, which reduces the options and may lead to temporary shortages. A broader range of supply sources would improve the safety of availability. Bulk procurement on regional or even national level could be suitable for some specific products to reduce purchase costs.
3. Financial management of the HFR needs to be adequate. The few cases where financial management may have been inadequate should not discourage the retention reforms. All SP's visited by the team had acceptable systems, be it computerized or wholly manual, often supplemented by proper auditing. This notwithstanding, the need for capacity in financial management, will be met at least in part by including accounting standards and procedures in the national guidelines and the model regional guidelines.
4. Storage requirements increase when the volume of sales rises. Some facilities will face difficulties in finding adequate storage space as they move to establish the SP. The working capital estimates may, therefore, need to include the erection of new infrastructure.

The potential policy advantages behind the expansion of Special Pharmacies are:

1. It could be a good opportunity to test and practice the concept of health facility revenue.
2. It will lead to the required financial autonomy (financial reform) of health facilities.
3. It will strengthen cost sharing principles in the health sector.
4. Improved quality is a precondition for fee revision and expansion. The surplus

---

<sup>5</sup> The budget pharmacy is financed through annual budget allocation from the treasury. It usually serves the free patients, inpatients and staff. When the allocated budget is finished before the end of the fiscal year (which it usually does) the pharmacy will be out of stock. No drug in the facility means poor quality health service, since availability of drugs is a major component of service. In the long run, the successful establishment of Special Pharmacies should lead to subsidies to the budget pharmacy, thus reduced needs from the treasury, and finally to a merger between the two pharmacies.

from SPs could be used to improve quality<sup>6</sup>. In effect it will contribute towards the revision and expansion of user fee charges that has not been revised for the last five decades. User fee charges revision is government's priority.

To explore these potential advantages at present the HCFS and the ESHE Project have submitted a project proposal for financing<sup>7</sup>. The Special Pharmacy Project (SPP) aims to take SPs to national scale by establishing SPs in 150 facilities (50 hospitals and 100 health centers).

#### **6. Health insurance**

To date, this component of the Strategy is not practiced in regions. Considering the existing level of income in the country there is less hope for the general development of health insurance in the short run. However, it could possibly be introduced at community level through community health insurance schemes and gradually develop to full fledged health insurance, particularly in the urban areas. To introduce and develop health insurance at a reasonable speed, there is presently an urgency of intensive advocacy and promotion work. The ESHE project has started by surveying existing health insurance schemes in the nascent insurance market in Ethiopia. In a forthcoming report (October, 2000) a preliminary plan of action will be proposed for advocacy, promotion and further study of the options for the country. This plan of action is based on the main observation from the insurance market in the country: no company considers individual health insurance as a produce and even collective health insurance is not breaking even unless it is linked to other insurances.

#### **7. Private sector investment**

The Strategy component of increasing resources to the health sector by increased private health care service provision has not been much dealt with during the study visits. The regions have not been active in this field. On the federal level, however, some matters have been dealt with or started.

The private sector team of the MOH has finalized a proposal for revised guidelines for private clinics. These guidelines are awaiting comments from regions followed by a national workshop, leading to approval and release by the MOH. The HCFS and the ESHE project have commissioned one study on *Private Facility Expenditures* and one on *Health Sector Delineation*. The study on facility expenditure has been presented at the National Health Accounts workshop in June, 2000, conducted by the Ministry of Health. The final report will be available for distribution by the end of October, 2000. Based on this report and secondary data from the Central Statistical Authority, the advisors of the ESHE project have finalized a paper on *Private Health Expenditure Trends and Implications for Health Systems Financing*. This paper will be presented at a global conference on "Finance of health systems in low income countries" in November 2000. The Delineation study will be reported in November, 2000, and will also be presented as part of the national workshop on public-private mix in January, 2001.

All these studies will serve to better inform what role the private sector could play in the future development at the health sector. Meanwhile, private investments are continuing to increase in pharmaceutical production as well as in health facilities at different levels. In the private sector, for example, the private health service providers are not yet organized into associations, which would simplify a dialogue. The ESHE project is preparing a national workshop on the public-private cooperation for the first quarter of 2000.

---

<sup>6</sup> There are cases where SPs have contributed towards this end through purchase of medical equipment such as ultrasound, ambulance, IV fluid plant, and buildings on top of their primary objective of making available pharmaceuticals on a sustainable basis and affordable price, which by themselves are critical parameters for quality.

<sup>7</sup> Copies of the Special Pharmacy Project proposal can be obtained from the HCFS or the IR1 team of the ESHE project.

#### **8. Facility budgets: the component of increased resources to the sector**

In connection with discussions on the Strategy with the representatives of health facilities, the facility budgets were often discussed. Some highlights of the facility budget discussions are summarized here. All comparisons between budget years are between 1991 EFY and 1992 EFY. The recurrent budgets of the facilities had the following in common:

- The total budget for 1992 was smaller, sometimes considerably smaller, than the year before (cf. however, the budget line for drugs below).
- The salary budget was most of the time almost the same in 1992 as it had been the year before (with one exception it was a bit higher in 1992)
- The other recurrent items were reduced from 1991 to 1992.
- With the exception of one region visited, all facilities had been dependent on a donor funded pharmaceutical input, which had not materialized. Some facilities knew about a figure for the amount of pharmaceuticals, others were not even aware of the amount.

The picture of operations of these health facilities confirms observations made by review missions etc.: the budget squeeze on operational expenses is such that the health staff finds itself in a very difficult situation. The particular year of 1992 also brought the availability of drugs to a record low due to the donor dependent delivery that failed. Given the extreme importance of pharmaceuticals for the quality of service, the failure of the system to secure adequate budget and supply of drugs is a serious matter.

#### **9. The market for pharmaceuticals**

The Ethiopian market for pharmaceuticals totals an estimated 900 million ETB per year. The per capita consumption annually would then be in the magnitude of 15 ETB. After having been practically a monopoly market for public production, imports and distribution, the market has since 1991 been in a process of restructuring. Private companies have been entering the market in imports and distribution, as well as in retailing. Private investment in production is also under way. Competition has been gradually increasing in all steps of the distribution chain.

Foreign grants and credits with international bidding procedures need to be better integrated into the system of government finance and supplies as well as into the present market structure of the country.

## **Policy Issues and Tentative Recommendations**

The following list presents policy issues, which were identified during the study visits. It also contains non-policy items that need to be addressed during implementation. Many regions have been asking for national or model regional guidelines to apply within their respective contexts.

Please note that the list is presented also as an effort of sequencing of the components on steps in the implementation. A careful sequencing is required to minimize the risks of failure of the implementation.

- 1. Appointment of Regional Health Care Finance Committees (RHCFC):** As stated in the Strategy, the regional implementation is vested with the RHCFC, which in September 2000, still remained to be established. In the same month, the Prime Minister's Office requested the regions to appoint the RHCFC and it is now expected that they will be ready to assume their responsibilities by October 2000. The National Task Force should then be convened for January 2001. Meanwhile, the restructuring of HSTD and the full establishment of the HCF Secretariat are moves that would be needed to support the National and Regional Task Forces. In many components of the Strategy the regions are waiting for national guidelines, recommendations, etc.
- 2. The HFR as defined in the Strategy:** needs to be established to allow for retention at facility level to achieve rapid impact on quality of services. The effort to make the necessary arrangements is ongoing in cooperation between the MOH and the MOF. This is an area, where all regions have requested national initiatives and where many health and business professionals have identified main constraints for the effectiveness of facilities.
- 3. Special Pharmacies:** the arrangement of HFR will facilitate the nation-wide implementation of SPs. The demonstrated positive impact on availability of drugs will then be achieved in all regions. The MOH and the ESHE project are preparing a project proposal to support facilities. National guidelines should be issued to guide the regions (including financial management). The importance of the pharmaceuticals in a health sector in a state of transition due to reforms is such that the SPs merit special monitoring. Further, the gradual increase of out-of-pocket spending on pharmaceuticals bought in the private sector raises doubts about possible misuse of drugs, as seen in other countries. It is, therefore, recommended that a special operations research project be linked to the SPs. This piece of operations research should study two parameters: drug use among different socio-economic strata and the impact of the SPP on quality of service. The ESHE project will work out operations research proposal and search ways of funding such a project.
- 4. User Fee Revision:** only after the establishment of HFR and improvement of quality of service through the SP's is it recommended to selectively raise user fees, without negative impact on utilization rates. The revision should be based on the forthcoming study results of ability to pay and be preceded by pilot testing. It should not be introduced without parallel revision of the mechanisms for waivers and exemptions.
- 5. Exemptions and waivers:** the new mechanism for screening and issue of certificates for service without fees should be set up in parallel with the raise of user fees. Given the HFR, ways must be sought to allocate resources to finance these services by the certificate issuing authority rather than by the health care facility.

6. **Health insurance:** what is currently required is intensive advocacy and promotion of the concept of health insurance as well as lessons learnt from other countries. This work is ongoing.
7. **Private sector investment:** As this component of the Strategy is the subject of the special study effort, it will be reported separately. The main studies are expected to be fully reported in November.
8. **Facility budgets** The poor budget situation, the low share of non-salary recurrent expenditures and the complete lack of budget for pharmaceuticals in EFY 1992, only point to the need for reforms along the line of the Strategy. The need for better donor mapping and improved coordination of government and donor funds in the HSDP is illuminated by the drug problem, as drugs have been available in the country during the same period.

## **2. ADDIS ABABA ADMINISTRATIVE COUNCIL**

Addis Ababa, with a population of over 2.5 million people, has 5 regional hospitals, 21 health centers, 7 clinics, 3 private hospitals, 395 private clinics and 200 NGO clinics. Missionaries established all hospitals, except Zewditu. The health system in the region is a two-tier system: regional hospitals and health centers (HC), as clinics are upgraded to HC.

A detailed study to revise user fees has been presented and approved by the regional council. It is now in MOH for comments and approval before implementation. During the study, special attention was paid to the third class (the poor). Revisions are proposed on card, service, and in-patient fees, but not on drugs.

There are Special Pharmacies in five hospitals and one health center. They were first introduced independently by the pharmacy department of the RHB, without formal approval of the RHB. The surplus was mostly used as incentive to staff of the pharmacy, while moves to upgrade facility quality were limited. The availability of drugs was however improved.

### *Zewditu Hospital*

The major objectives of the SP are:

- ❖ To stabilize the price of pharmaceuticals,
- ❖ To procure some medical equipment, and
- ❖ To provide incentive for staff.

According to people in the facility, previously they had full autonomy in running the SP. Autonomy in terms of procurement, incentive to workers, and amount of drugs procured. But as of last year there was an intervention from the RHB and loss of the autonomy they previously had.

### *Yekatit 12 Hospital*

The SP was established around 1997 with an initial capital of 20,000 Birr from the RHB, as a follow-up of the Bamako initiative. The basic reason for its establishment was the hospital's difficulty of providing essential drugs from its budget pharmacy.

Despite a study made to introduce SPs, the implementation encountered difficulties at the initial stage. First, the arrangement was not uniform across hospitals; second, it was not in accordance with the financial law.

In early 1999, the RFB forced the Special Pharmacies to strictly follow the financial law. Technical people in facilities, however, have little knowledge of the financial law and this has created some confusion in their proper functioning.

Presently, the money is in the hospital's special account, while it was in a separate account in the past. Staff are now considered as permanent staff and compensated for off-working hours and holidays. This overtime payment is, however, not enough to motivate staff.

### **3. OROMIYA REGION**

Oromiya, with an estimated population of 21.7 million, has 18 public hospitals, and 3 NGO hospitals (1 in Arsi and 2 in Welega). There is little progress in the implementation of the Strategy in the region. The region expects implementation guidelines from MOH. Nonetheless, some initiatives have been started in the area of SP and increasing drug availability at hospital level.

The other components of the Strategy are not started.

- Though no attempt to revise user fees so far, the understanding is to revise-expand and make it uniform.
- Retention of revenue at facility level is again not started and the region feels the need for thorough discussion.
- The share of free patients reaches to 80% in some places and 70% in others. The present procedure of poverty certificate issuance is not proper for screening.
- The establishment of the Regional Task Force for the Strategy is at the agenda of the RHB.

Following our discussion for piloting, the Head of Health Service Department proposed us to visit two zones in the region: East Shoa and Asella.

#### **3.1 East Shoa Zone**

The zone has full orientation of the Strategy and is trying to implement it partly. In a general sense they feel the level of poverty in the country will be the major challenge while implementing the Strategy. For instance, in East Shoa Zone almost 70-80% of the patients bring poverty certificate. Even the fee charged from fee-paying patients is extremely small (e.g. fee for card which includes consultation is 1 Birr in hospitals and 0.50 Birr in health centers)

The zone's experience in relation to health care financing is so far limited to the establishment of Special Pharmacies. The experience was first learnt from Addis Ababa Region. The reasons that force the zone to establish Special Pharmacies were:

- need for easy access to drugs for patients;
- to fill the short fall of the drug budget in the budget pharmacy;
- incentive to health professionals;
- to stabilize price of drugs in private pharmacies; and
- to supply medical equipment to hospitals and health centers in the long run.

So far the zone has initiated Special Pharmacies in Adama Hospital (October, 1999) and Mekie Health Center. This will be extended to Shashemene Hospital in the near future. The initial capital for the Adama hospital SP was 148,000 Birr – 100,000 Birr as a loan from the hospital and 48,000 Birr worth of drugs on credit from drug suppliers. At Mekie health center the initial capital was obtained from an NGO (Self Help).

The regional guidelines for the SP has been revised three times and finally approved by the RHB.

The two major problems encountered so far are: effective cash collection and audit. There are three dimensional control systems: the pharmacist record (quantity of drug procured and price for each drug), the stock record (store man) as well as monthly/quarterly internal and external audit.

### 3.2 Asella Zone

The Asella zone, with an estimated population of 2.5 million people, has the following government health facilities: 1 regional hospital, 10 health centers, and 103 health stations. More than 60% of patients come with poverty certificate. In implementing the Strategy the zone has done a good job with high prospect for improved future implementation. We have also observed good understanding and working relation between the zone health department and the hospital. The presence of Istituto per la Cooperazione Univercitari (ICU, an Italian bilateral donor) in the zone has helped them in getting access to initial working capital, training, equipment, etc. To mention some of the initiatives:

- It started a SP in Asella Hospital a year ago with initial grant of 64,000 Birr from ICU and continued assistance from the same donor in the form of an additional fund (about 84,000 Birr), computer training for staff and developing special software for this purpose, and equipment.
- The SP keeps working for almost 24 hours. The revenue collected is retained and deposited in a separate account. The zone finance department has not yet claimed transfers but rather proposed to impose profit tax as for private pharmacies. The experience so far witnessed an average daily sale of about 2,000 Birr and an average 4 round drug procurements per year under normal circumstance. During our visit, there was a stock of drugs with a value of roughly 20,000 Birr.
- The preparation to start the SP at the health center level - special drug store - has been finalized and will be started in a month time. This will be first introduced in six health centers (out of the total of ten health centers in the zone). The initial working capital for the special drug stores is already secured from ICU and drugs are ordered, according to the zonal health department people.
- To meet the hospitals' demand for IV fluid and if possible to supply nearby facilities, the necessary preparation is completed to establish an IV producing plant inside Asella hospital. Thus far, one person has been trained in Tanzania for two months, equipment is purchased and the room is ready.

The objectives of initiating Special Pharmacies are stated as:

1. To create a condition where fundamental medicine and medical tools can be provided to patients with out interruption/consistently/ in the hospital,
2. To extend the working hours of the medical services in the hospital that stay open including outside the regular working hours,
3. To equip the hospital with diagnostic facilities with the profit coming from the sale of medicine, to strengthen and upgrade the hospital, to buy ambulance vehicle and tanker car in order to get additional income that could motivate the employees, service buses, which could give transport services to employees and to pay overtime payment for employees, who work overtime.
4. To normalize and stabilize the rocketing price of drugs from private vendors by providing medicines to patients at a reasonable price.

To manage the SP the zone issued guidelines in August 1998. The SP is managed according to the guidelines and its accountability and reporting is to the hospital's m/director. It is also indicated in the guideline that an autonomous management committee consisting of nine people is managing the SP. The management committee members are:

- |   |           |
|---|-----------|
| 1. M/Director of the hospital                         | chairman  |
| 2. Zonal pharmacy section representative              | secretary |
| 3. Administrator of the hospital                      | member    |
| 4. Hospitals' medical health officer's representative | "         |
| 5. Head of the hospital finance section               | "         |
| 6. Internal auditor of the hospital                   | "         |
| 7. Head of health department pharmacy section         | "         |
| 8. ICU pharmacist                                     | "         |

9. Matron

The purchase of medicines, medical devices and instruments necessary for the SP is effected from state owned wholesale medical distribution agencies and in a second degree from private importers and distributors of medicines and medical devices in accordance with the hospital's list of medicine.

- ❖ Up to 1,000 Birr without bid, with the decision of the committee,
- ❖ Up to 10,000 Birr by licensed professional after collecting proforma from three state owned or well known private enterprises,
- ❖ Above 10,000 Birr by the bid committee.

The decision of the bid committee should be confirmed by the hospital director.

The other components of the Strategy are not addressed yet. The user fee revision is believed to come from the federal government, and no progress has been made on health insurance.

#### 4. DIRE DAWA ADMINISTRATIVE COUNCIL

Dire Dawa, with an estimated population of 308 thousand people, has one hospital, two health centers and six health stations run by the administrative council health office. Unlike other regions we visited, Dire Dawa has not shown progress in the implementation of the Strategy. All the issues of HCF are not started except some experience sharing visits to other regions on SP. The plan was to start SP first in Dil Chora hospital and then in the health centers. The thinking, however, is to consider the establishment of SP as part of HSDP with capital investment requirement for constructing the necessary building.

In relation to user fees revision, the administrative council formed a committee a year ago to assess the fee structure in other regions. The committee submitted its findings/proposal, but they have not been implemented and there has been no further discussion.

We considered Dil Chora hospital as a case and discussed in detail issues related to financing with the M/Director and the administrator. They informed us that the hospital provides service to a wider population living in and surrounding Dire Dawa, including Djibouti and Somali. It has 250 beds. On average 90 - 95 percents of the patients came with poverty certificate. Even with this level of waiver, the hospital still collects a significant amount from paying patients. Monthly fee collection is on average 40,000 Birr. This collection is mainly from radiology and gynecology that are not effective in the private sector. Patient load per doctor is increasing progressively because of high attrition rate (the hospital lost 10 MD in a single year last year out of the total 23 MD). This fiscal year the budget allocated for the hospital was cut significantly compared to the previous years. Total budget of the hospital for this fiscal year (1992 E.C.) equals 2.4 million Birr, out of which 225,000 Birr (9.4%) for medical drugs, 225,000 Birr (9.4%) for food to the patients, 42,000 Birr (1.7%) for duty and profession, and 1,562,619 Birr (65%) for salary. Comparing the allocations of medical drugs and food in 1991 and 1992 clearly reveals the magnitude of the problem encountered by the hospital.

	1991 EC	1992 EC.
Medical drug	570,000 Birr	225,000 Birr
Food	575,000 Birr	225,000 Birr

According to the M/Director and the administrator, the hospital is now in short of life saving drugs and requested supplementary budget from the administrative council. Another problem mentioned was the status of the hospital. Dil Chora hospital has no status in the referral system. It is not labeled as referral, regional, or district hospital. Equally important is the fact that the administrative council is accountable to the federal government and decisions have to be made in consultation with the PMO.

## **5. HARARE REGION**

Harare region, covering 340 square kilometers, has five hospitals, out of which one is military and one is police hospital. The others are one regional hospital, one district hospital and one TB hospital. 60-70% of the patients come from Oromoyia and a large share of them have papers for free care.

The head of RHB was an active participant in the formulation of the Strategy and as a result our perception is that awareness of the Strategy could not be a problem, at least at the top management level.

Nevertheless, there is little progress in implementing the Strategy, which the RHB sees as part of the HSDP. It is considered as a sensitive part, e.g. increased user fees and insurance would require much sensitization. As for the retention, the region would prefer a national unified change of policy. The RHB was emphasizing the need for MOF and MOH to cooperate to change the financial regulation. They emphasized the issue of federal versus regional laws and the need for national laws on many of the Strategy issues. The region has not done much in terms of implementation of the Strategy. The attempt so far has been to establish Special Pharmacies in hospitals. Special Pharmacies are functioning in two hospitals at a relatively small-scale. The user fee revision and health insurance have not been attempted.

The team visited a SP in one hospital. The SP was working under modest conditions and unclear legal conditions. The original idea came from a previous private pharmacy. The initial capital was gained from the hospital and had by the time of our visit been tripled. No topping up was given to staff working in the SP. The next steps to take will be to settle the legal issues by action from the hospital, the RHB and the Regional Council.

The hospital has a share of about 60% free patients and collects about 84,000 ETB per year in fees, which are delivered to the RFB. The total budget for 1992 was 2.6 million ETB, out of which 0.5 million for drugs.

## 6. AMHARA REGION

The Amhara region, with a population of about 16 million, has 14 hospitals (6 zonal and 8 district hospitals), 66 health centers, 527 health stations and 353 health posts. The progress in implementing the health care financing strategy is encouraging with wide experience of Special Pharmacies and possible introduction of HFR retention soon. User fees are not revised yet, though some work has been started two years back to revise fee structures. A task force was established to study the issue closely and it submitted the proposal. The expectation is that the proposal will be revised and implemented soon. The free patient rate is very high, reaching up to 85%. However, to improve the system of waiver and exemption, the region is considering proposing the municipality to cover the costs of free patients through its annual budget. This will have indirect impact on the provision of poverty certificate. Besides, it needs proper definition of poor (who is poor?), awareness creation, community involvement, and service provision on credit. Health insurance is an untouched area except for a few employer-based insurance schemes.

The region has long years of experience in Special Pharmacies in different forms. However, it was started in its present setup two years back in seven hospitals, mainly to overcome the acute shortage of pharmaceuticals. The initial capital was obtained from regional and zonal councils. The initiative was well accepted by decision makers and meant to achieve the following objectives:

- ❖ to improve sustained availability of essential drugs;
- ❖ to reduce prices compared to the private pharmacies;
- ❖ to improve ease of accessibility (located in the facility); and
- ❖ to establish around-the-clock service.

A two days discussion workshop was conveyed to finalize the regional draft guidelines for Special Pharmacies, where seven zones participated. The report of the zones in the workshop showed the different modalities used in establishing and managing Special Pharmacies.

### 6.1 Bahir Dar Special Zone

The SP in the zone is based in Felege Hiwot Hospital. It existed as retail pharmacy before but was re-established two years ago with a total of 90,000 Birr (50,000 from the regional council and 40,000 from another source). The present capital is about 150,000 Birr with daily sales of about 1,200 Birr.

The management arrangement is composed of a two-level management committee. The board is responsible for major policy decisions, while the technical committee is in charge of the day-to-day management of the pharmacy.

#### SP board:

Social Affairs Head	Chairman
Health Department Head	Secretary
Health Department Administration and Finance	Member
Pharmacist	"
Felege Hiwot Hospital Accountant	"

#### SP technical committee:

M/Director of Felege Hiwot Hospital  
Pharmacist

#### Staffing:

Cashier  
Health assistants (2) (in rotation every week)

Procurement is done by the pharmacist on the average once in a month. The procedure is to collect proforma from Pharmid and procure when approved by the technical committee. Because of the unavailability of other suppliers in the town there is no bidding.

Considering Felege Hiwot Hospital as a case to look more closely at drug availability and free patient load, we found out that medical drugs accounted for 33.4% of the budget in 1991 E.C. Over half a Million Birr is spent on IV fluid. To minimize this cost the hospital is looking for local production of IV fluid. Almost 85% of the patients come with poverty certificate. There is no systematic rule of poverty certificate. Even with this high load of free patients, the hospital collects about 36,000 Birr/month on the average from fee-paying patients.

Felege Hiwot Hospital Budget  
(‘000 Birr)

	1991 E.C.		1992 E.C.	
	Amount	%	Amount	%
Salary	1,697	37.7	1,677	35.2
Food	414	9.2	460	9.7
Medical Drugs	1,500	33.4	2,200*	46.2
Others	886	19.7	423	8.9
Total	4,497	100.0	4,760	100.0

NB: \* this amount was expected from grant and did not yet materialize.

## 6.2 South Gondar Zone

There is one SP based in Debre Tabor Hospital in the zone. The pharmacist is from the zone health department. All tasks (dispensary, store keeper, cash collector) except procurement, however, are done by one health assistant. No store for drugs. The present capital is about 222,000 Birr. The daily sales amount is highly variable ranging from 60 to 300 Birr.

The management committee is composed of:

M/Director	Chairman
Administrator	Member
Matron	"
Finance and Administration Head	"
Pharmacist	Secretary

Debre Tabor Hospital Budget  
(‘000 Birr)

	1991 E.C.		1992 E.C.	
	Amount	%	Amount	%
Salary	1,068	46.6	1,078	70.7
Food	171	7.5	200	13.1
Pharmaceuticals	650	28.3	*	
Others	404	17.6	246	16.2
Total	2,293	100.0	1,524	100.0

NB: \* Pharmaceuticals was expected from grant and did not yet materialize and people at the facility do not know the amount.

## 7. SOUTHERN NATIONS, NATIONALITIES AND PEOPLES' REGION (SNNPR)

Generally, the performance of health care financing in the region is quite encouraging though the regional officials consider it less impressive because of the delay in the implementation guidelines. According to regional officials, health insurance needs further detailed study, performance of RDF greatly depends on the strength of the zone and the amount of initial capital, and the region even before the Strategy proclaimed user fee retention but implementation started only this fiscal year (1992 E.C.). It is introduced at hospital level, i.e. all hospitals in the region are allowed to retain 50% of the fee revenue collected. The remaining 50% will be transferred to the RFB.

The performance of Special Pharmacies varies from facility to facility and from zone to zone. We have also observed different arrangements in the management of Special Pharmacies in the region. Licensing is in two levels – facility level and zone wide. When licensing at facility level, the license should be by pharmacist. In case of zone wide licensing, the zone does the procurement based on the requirements of the facilities.

Procurement is usually made from Pharmid without bid and some times from private suppliers following the financial regulation. The price mark up falls in the range of 25% to 40% and to use the surplus for some other activities other than drug needs approval of the joint committee (members of joint committee are RHB, RFB and RPB).

### 7.1 Sidama Zone

The Sidama zone is one of those zones in the region that apply zone wide principles in establishing and managing Special Pharmacies. Based on the requirements of health centers and health posts the zone will perform drug procurement. Then drugs will be distributed to health centers and from health centers to health posts. Health posts are accountable to health centers. Normally there will be five health posts under a health center.

To expand Special Pharmacies the zone submitted its proposal to Irish Aid in 1997. Implementation was then started from 1998 on. Initially the seed money was set at 70,000 Birr per health center and at 3,000 Birr for a health post. Because of the increased demand for Special Pharmacies, the ceiling of seed money for health centers is now reduced to 35,000 Birr.

The price mark up is 25%. Sales revenue from Special Pharmacies will be put in a separate bank account.

Two health centers in the zone were visited: Leku and Cheko health centers.

#### *Leku Health Center*

The Leku health center special drug store was started in August 1998 with an initial capital of 67,336 Birr from Irish Aid. This capital was in kind (medical drugs). The mark up is 25% and all sales revenue will be deposited in a separate bank account by the name of the health officer and the druggist. License and procurement are by the zone pharmacist. The present capital of the drug store is 135,099 Birr, net surplus amounting to 17,000 Birr. The surplus has not been used for any other purpose than pharmaceuticals so far.

The drug store gives service on working hours and off working hours on call.

A committee from different offices manages the special drug store:

HC head  
WorHO representative

Chairman  
Member

WFO representative " "  
 HC accountant " "  
 Pharmacy technician " "  
 Woreda social affairs head Secretary

There are three staff members for the drug store (one druggist, one dispenser/health assistant, and one cashier/contract). The compensations for these staffs are 150 Birr for the druggist, 100 Birr for the dispenser and 200 Birr for the cashier.

The trend in budget allocation for the health center is presented below.

Leku Health Center  
(000 Birr)

	1991 E.C.		1992 E.C.	
	Amount	%	Amount	%
Salary	143.3	73.0	160.2	91.9
Recurrent	26.9	13.7	14.2	8.1
Pharmaceuticals	26.0	13.3	*	
Total	196.2	100.0	174.4	100.0

NB: Pharmaceuticals for 1992 was expected from IDA and not shown in the budget.

Fee for card and consultation is two Birr. Average revenue from fee-paying patients is around 2,673 per month. The health center accepts poverty certificate issued by the woreda council and recently by kebeles. However, the number of free patients is limited.

#### *Cheko Health Center*

The Cheko health center special drug store was started in June 1999 with an initial capital of 35,000 Birr obtained from Irish Aid. This capital was in kind (medical drugs). The promised capital was 70,000 Birr and they are now waiting for the remaining 35,000 Birr. The price mark up is 25%. The surplus is estimated to be on the average 988 Birr/month.

The management committee consists of:

HC head Chairman  
 WorHO head V. Chairman  
 Store man member  
 WorEO (high school) "  
 HC accountant "  
 Woreda social affairs Secretary

There are three staff members for the special drug store (dispensary/health assistant, store man/health assistant, and cashier/contract). The salary for the cashier is 200 Birr/month and other staff members are not paid.

The trend in budget allocation for the health center is almost same as that of Leku health center. Same amount of drug budget in 1991 E.C. and for 1992 it was expected from IDA.

The health center charges one Birr for card, which include consultation. There is no free patient in the facility. On the average, the health center collects 3,127 Birr/month from patients.

## 7.2 North Omo Zone

The team visited two SPs, one based in a health center and the other in a hospital.

#### *Wolita Sodo Health Center*

Wolita Sodo health center has a Bamako initiative pharmacy established in 1996, with an

initial capital of 46,000 Birr obtained from UNICEF/WHO. Since then, the pharmacy got additional capital in two rounds amounting to 133,000 Birr. All these capitals were given in kind. The mark up is 25%. Sales revenue will be deposited in a separate bank account by the name of the head of the HC and the cash collector. At present, the pharmacy has a capital of over 300,000 Birr.

The pharmacy gives service to all patients, including those from private clinics. So far, the surplus is not utilized, as it has to be approved by the zone. However, there is the intention to use this money for MCH services out-reach.

The management is in two layers. The management committee consists of:

Woreda council social affairs  
 WorHO representative  
 Municipal representative  
 Elders as representative of the committee

The problems with the management committee are first that it is difficult to convey meetings and second that there is high turn over of committee members.

The technical committee is composed of:

HC head	chairman
Druggist	secretary
MCH coordinator	member
Health education head	"

The staff members are five and are paid monthly top-up as compensation (druggist 350 Birr, dispenser 80 Birr, cash collector 100 Birr, store man 70, and accountant 70 Birr). License for the pharmacy is by the druggist. The average daily patient load is about 60 people. Procurement is made once a year.

The trend in budget allocation for the health center is presented below.

Wolita Sodo Health Center  
(000 Birr)

	1991 E.C.		1992 E.C.	
	Amount	%	Amount	%
Salary	227.6	66.8	232.0	89.5
Recurrent	45.5	13.5	27.2	10.5
Pharmaceuticals	67.8	19.9	*	
<b>Total</b>	<b>340.9</b>	<b>100.0</b>	<b>259.2</b>	<b>100.0</b>

NB: Pharmaceuticals for 1992 was expected from IDA and not shown in the budget.

Free patient load including prisoners of the HC is about 25-30%. Poverty certificate is issued by kebeles. The HC on average collects 2,237 Birr/month.

***Wolita Sodo Hospital***

The M/director raised some concerns about the present retention experience in the region:

- ❖ No clear definition of revenue,
- ❖ No understanding on the utilization of the retained revenue, and
- ❖ No guideline.

Even if 100% retention for what purpose to use the revenue? What about equity, i.e. facilities has different revenue raising capacity? What about the human element, i.e. incentive to health workers? Facilities have no autonomy.

Sodo hospital SP was started in December 1998 with an initial capital of 78,000 Birr (50,000 from Australian Aid and 28,000 from Children cross connection). The mark up was 20% for long time and recently rose to 30%. The capital of the pharmacy is now over 200,000 Birr. The revenue is not used thus far for some other purposes other than increasing the working capital.

The management committee consists of:

M/director	chairman
Hospital pharmacist	secretary
Hospital accountant	member
Hospital auditor	"

Staff members are composed of pharmacy technician, store man/health assistance, dispenser/health assistance, cash collector and accountant with a corresponding monthly compensation of 400, 75, 75, 30, and 75 Birr.

Wolita Sodo Hospital  
(\*000 Birr)

	1991 E.C.		1992 E.C.	
	Amount	%	Amount	%
Salary	1,057	45.5	960	61.5
Recurrent	617	26.5	600	38.5
Pharmaceuticals	650	28.0		
<b>Total</b>	<b>2,324</b>	<b>100.0</b>	<b>1,560</b>	<b>100.0</b>

NB: Pharmaceuticals for 1992 was expected from IDA and not shown in the budget.

There proportion of free patient is very high in the hospital. Nonetheless, revenue collected from fee-paying patients was as high as 42,000 Birr/month in 1991 E.C.

### 7.3 Hadiya Zone

The team visited the SP based in Hossana hospital.

#### *Hossana Hospital*

The SP in Hossana hospital was first piloted in 1994 and formally started the following year with a capital of 30,000 Birr worth of drugs obtained from Mekaneyesus Sinodus. It was then restarted again in 1999 with additional capital of 18,000 Birr. The mark up is 25% and the present capital is about 70,000 Birr. Sales revenue has been deposited in a separate bank account by the name of the M/director and the cashier. The pharmacy gives service during working hours.

The management committee consists of:

M/director	chairman
Hospital administrator	secretary
Hospital accountant	"
Hospital internal auditor	"
Hospital general service head	"
Hospital pharmacy head	"
Hospital laboratory technician	"
Hospital x-ray technician	"

The SP has three staff; pharmacist, cash collector, and dispenser with a corresponding monthly compensation of 300, 100 and 150 Birr.

Procurement is only from Pharmid. The problem is that sometimes, not all the required drugs are available from Pharmid.

The proportion of free patient is very high in the hospital. For instance in 1991 E.C fee revenue was 424,588 Birr while the value of free patient amounted to 909,889 Birr. This rate of free patient had implication for the current year drug budget in the sense that the hospital now uses up to 50% of its revenue last year to cover its drug cost. As a result, there is strict control of free patient this year.

#### **7.4 Gurage Zone**

A number of donors are involved in financing and establishing Special Pharmacies/drug stores in the Gurage zone. Action aid, Irish aid, Self-help, Kalehiwot church, and Save the Children are some of them. To overcome the requirement of pharmacist for license, the zone uses two health centers as wholesaler to other health centers and health posts. The two health centers (Wolkete and Butajera) serve both as wholesalers and retailers. As wholesalers to other facilities at 10% mark up from purchase price and as retailers with 25% mark up. Other facilities will then add 15% mark up while selling to patients. This network is taken down to health post level.

The zone is trying to transfer the follow-up of these pharmacies to Woredas. The challenge faced by these pharmacies is absence of banking system around facilities in the rural areas. Right now sales revenue from pharmacies is kept in WorHO when no bank is available.

Sales revenue from SPs is collected in separate receipts and the zonal council is aware of this practice and has no problem with the ZFD.

The guideline is used by all facilities in the zone. The management committee is composed of five members at Woreda level and seven members at facility level. Staffing at HC consists of three people (pharmacist, dispenser, and cash collector).

##### **Wolkete Health Center**

The SP in Wolkete HC was started around May 1999 with initial capital of near 100,000 Birr obtained from Irish Aid in three rounds. It is distributor to six woredas and procurement is usually made every two months. The present capital is approximately 130,409 Birr.

Surprisingly enough, there are no free patients in the facility, including prisoners. The head of the HC doesn't know the annual budget breakdown. It is completely managed by the WorHO. The reason is that there is no administrative staff in the HCs, but that is not reason enough. This practice is not in line with the present move towards financial autonomy.

##### **Emdeber Health Center**

The SP in Emdeber HC was established around May 1999 with an initial capital of 14,319 Birr obtained from Irish Aid. Procurement is done through Wolkete HC because there is no pharmacist in the HC. It sells at 25% mark up to patients from purchased price (or 15% mark up from the wholesale price of Wolkete HC). Customers are complaining that the price is expensive. So far, four round procurement have been made including the initial investment. The present capital has reached about 21,000 Birr. The money is put in the WorHO, as no banking system is available around the facility.

On average about 20 – 25% of the patients are free patients. The woreda council issues poverty certificate. The WorHO manages the budget for the facility.

## **8. TIGRAI REGION**

The region has started implementing one component of the Strategy while detailed studies have been conducted for the other components. The RHB officials indicated that all the components of the Strategy have been touched though they are at infancy stage.

Like most other regions, there is progress in the establishment of Special Pharmacies<sup>10</sup>. Special Pharmacies were started seven years back. Today they exist in all the hospitals<sup>11</sup> and in 50 to 60 percent of the 29 health centers of the region. Governed by a region wide guideline. The major problem in this regard is manpower. No single pharmacist in the region. License is by pharmacy technicians, which is against the law. So far no request from the Finance Bureau for transfer of the revenue collected. It is 100% retention, collection by separate receipt and deposit in a separate bank account.

Currently user fee charges are not uniform through out the region. Facilities charge different fees. To standardize and revise user fee in the region, the RHB did a study three years ago, which was later presented and discussed in a workshop. The proposal is now in the regional council waiting for decision. However, revision of fees requires detailed study of willingness and ability to pay as well as improvement of service quality. From a study made by the RHB the results indicated willingness to pay and to a certain extent ability to pay. For instance, with quality improvement 89% of the sampled are willing to pay a per capita of Birr 15 per annum for health care.

The objective indicated in the regional HSDP is to recover 30% of recurrent cost, which stands at 10% currently. The regional government give strong support to cost recovery. There should, however, be a mechanism in place to protect the poor. The user fee proposal has also addressed exemption and waiver issues. Looking at the proportion of facility revenue (78% from sales of pharmaceuticals and 28% from medical services) and ease of management pharmaceuticals is the most feasible for cost recovery at the moment.

At present retention of revenue is not practiced outside the retail pharmacies. Finance bureau argues for consolidated fund. There is on going discussion between the RHB and RFB. The management capacity of facilities should also be considered before embarking on to implementation.

Private sector involvement is governed by the national guideline. Two private for profit hospitals are under construction in the region.

Little has been done on the area of health insurance. Considering the community participation and strong community associations, there seems high hope for the introduction of community based health insurance schemes.

### **Mekelle Hospital**

It is the only hospital in Mekelle with 220 beds. The daily patient load (including emergency) is about 150. Free patient proportion is about 85%. The hospital encounters difficulty because of the low budget allocation resulting in shortage of food, pharmaceuticals for free patients, and less maintenance. Usually the annual budget is consumed in four to five months. The hospital has no car for emergency call, etc. Comparison of 1991 and 1992 budget allocation for the hospital is given below.

---

<sup>10</sup> There are also two retail pharmacies by Red Cross (Mekelle and Adigrat).

<sup>11</sup> There are 11 hospitals in the region (4 zonal and 7 district). One specialized hospital is under construction.

Mekelle Hospital  
('000 Birr)

	1991 E.C.		1992 E.C.	
	Amount	%	Amount	%
Salary	1303	42.1	1788	74.2
Food	318	10.3	276	11.5
Pharmaceuticals	584	18.9		
Others	892	28.7	345	14.3
<b>Total</b>	<b>3097</b>	<b>100.0</b>	<b>2409</b>	<b>100.0</b>

NB: Pharmaceuticals for 1992 was obtained from the RHB on an irregular basis.

The SP in the hospital was established five years ago with an initial capital of 30,000 Birr obtained from the RHB. It gives 24 hours service including holidays. It is managed by the guideline issued from the RHB<sup>12</sup>. The profit margin is 25%, revenue collection by separate receipt and deposited in separate bank account. The monthly average sales revenue is about 12,000 Birr. The present capital is about 300,000 Birr (200,000 cash and 100,000 stock). The management committee of the SP decides on the use of the surplus. So far the objective was to increase the working capital of the SP, as a result limited amount of the surplus was used for other services of the hospital. The management committee is now considering buying an emergency call car from the surplus.

Incentive to staffs of SP ranges from 100 to 500 Birr (pharmacy technician 350, dispensers (2) 200 each, store keeper 100, accounts 100, cashier 100 and daily cash collector 100).

The major problems of the SP include pharmacist and auditing system.

#### Mekelle Health Center

Mekelle health center is one of the three health centers in Mekelle (the other two are new). Its daily patient load is estimated at 200 persons with a proportion of about 70% free patient.

The Special Drug Shop (SDS) was established a year and nine months ago with an initial capital of about 50,000 Birr worth pharmaceuticals obtained on credit from Pharmid and Amba private supplier. It gives service during working hours and on holidays including Saturday and Sunday. It is governed by the regional guideline for SPs with some amendments on the payment of incentive to staffs working in the SDS (payment is a certain proportion of monthly sales revenue). The profit margin is 25%, revenue collection is in a separate receipt and deposited in a separate bank account. Up to last June it gave service to 32,000 patients (88 people/day). An estimated daily sale is over 1,000 Birr. Procurement is on average made once in a month. At present the capital has reached 140,000 Birr (100,000 cash and 40,000 stock). Part of the surplus will be used in the future to improve the services of the health center.

The management committee is composed of:

Health center head	Chairman
HC pharmacy head	
HC administrator	
HC technique head	

Six staffs of the HC get incentive for their service to the SDS (Pharmacy technician-license, cash collector, dispenser, store keeper, finance and administrative head, and accountant).

The dispenser is different from the budget pharmacy. However, the two uses the same store and store keeper. Sometimes when the SDS is out of stock and no stock in suppliers it borrows from the budget pharmacy.

<sup>12</sup> Previously it had its own guideline.

## 8.1 Eastern Tigray Zone

There are two hospitals (1 zonal and 1 district) and five health centers in the zone. Special Pharmacies are established in all the hospitals, all health centers and in some of the clinics. Because the zone was partly a war front in the last two years the performance of SPs is not as expected. Budget allocation to facilities is not sufficient for the fiscal year. Usually it lasts in three to four months. The situation was further aggravated by the war. Because of the displaced people from neighboring zones and the land mines the number of patients increased quite significantly. Even though Red Cross and local NGOs are assisting the displaced, there is a need for some help of the public facilities that has impact on the budget.

### Adigrat Hospital

Adigrat hospital with 120 beds has a daily patient load of 100 people where about 70% are free patients. It has severe shortage of budget including for the basic items like food and essential drugs for free patients. For instance the food per capita budget is 4.00 Birr but in reality the food cost in Adigrat is 6.00 Birr. This difference is financed from NGOs participating in the region mostly from Irish Aid. The budget comparison for 1991 and 1992 is presented below.

Adigrat Hospital  
('000 Birr)

	1991 E.C.		1992 E.C.	
	Amount	%	Amount	%
Salary	829	55.2	915	71.7
Food	212	14.1	156	12.2
Pharmaceuticals	283	18.8		
Others	179	11.9	205	16.1
Total	1503	100.0	1276	100.0

NB: Pharmaceuticals for 1992 was obtained from the RHB on an irregular basis.

The SP was established four or five years ago with an initial capital of 10,000 Birr from the ZHD. It follows the guideline issued by the RHB. Uses separate receipt and sales revenue is deposited in a separate bank account. Profit margin is 25%. Procurement is from Mekelle, Pharmid and Amba private supplier, since no supplier in Adigrat. The daily sale is on average about 300 Birr. One major factor for this low daily sale is the distance of the hospital from town. Currently the capital of the SP is around 176,000 Birr (96,000 cash and 76,000 stock).

The Management committee of the SP consists of:

M/Director	Chairman
Matron	
Administrator	
Two staff	

Incentive is provided to staffs working in the SP on a monthly basis (pharmacy technician 250 Birr, dispensers (2) 150 Birr each, and store keeper 100 Birr).

Surplus from the SP has been used for some other services of the hospital. Now it is decided not use the surplus with the objective of increasing working capital and drug availability.

### Adigrat Health Center

The special drug shop in Adigrat health center is recently (a month ago) closed and moved to the clinic in one of the woredas. It was closed because another retail pharmacy by Red Cross was located adjacent to the SDS of the health center. Red Cross has better access to drugs and can serve the population of the area, so there is no need to compete.

The SDS was established in 1991 EC, with 64,400 Birr worth pharmaceuticals from Irish aid. The WorHO staff managed the SDS:

- Pharmacy technician
- Dispenser
- Cashier of HC
- Accountant of WorHO.
- 

So far no payment for staff services has been made, not even for license.

Sales revenue is collected by a separate receipt and deposited in a separate bank account. The store is open on working hours. Daily cash collection was previously 5,000 Birr, while estimated at 1,500 Birr in its new location at the clinic. At present, the capital is about 96,000 Birr (56,000 cash and 40,000 stock).

## **9. MARKET FOR PHARMACEUTICALS AND MEDICAL SUPPLIES**

As demonstrated above, the supply of medical drugs and medical supplies is a crucial factor for the implementation of the Strategy. Improved supplies is a necessary ingredient in any improvement of quality, which is in turn a prerequisite for increased cost recovery through user fees or insurance. A workable market for imports and distribution is also a factor to be considered in the procurement and management of a national SP project.

As part of the collection of experience the team also visited public and private companies for import and distribution of pharmaceutical and medical supplies to provide information on the existing market situation.

The size of the total Ethiopian market for drugs this year, is probably between 800 million ETB and one billion ETB<sup>13</sup>. The sheer magnitude of the market seems to be larger than what studies of household expenditure would so far have indicated. Assuming a population of 63 million people and taking the middle range of the above market estimate, i.e. 900 million ETB, we would arrive at a total consumption per capita of around 14 ETB this year<sup>14</sup>. This figure includes drugs consumed in public and private facilities, drugs sold in all kinds of retail drug outlets as well as drugs distributed freely by public pharmacies.

Leaving grants aside, the total Ethiopian market consists of about 50% domestic production and the same share for imports. Including grants, we would roughly estimate a market share of one third for imports, grants, and domestic productions.

During the previous government imports, production and distribution were strongly dominated by a public company. This company has now been divided into production unit and import-distribution unit. Since 1991, about 66 private companies have been licensed to import pharmaceuticals, but only about 8-10 are operating as viable commercial companies. Each licensed company has to be registered representatives of foreign companies. The foreign companies may only have one registered representative in the country. Registration used to take up to two years, but is now efficient.

During the previous arrangements the Ethiopian Red Cross Society and the public company were exempted from import duties, but presently the same conditions apply to all importers. The total of duties and taxes may reach 35% on drugs.

In cases of international bidding, e.g. in the case of credits, both domestic and international firms may compete, depending on the situation. Among the Ethiopian companies only the public distribution company could compete on a broad range of products. They would not be very competitive, however, due to the fact that it is a service company only providing logistics and distribution. Combinations with foreign companies would be more effective.

Domestic production is currently provided in two factories. Two new factories are under way, one with Chinese and public capital, one with private Ethiopian capital. Further, one factory for veterinary drugs is expected to be operating soon. As for the special product of IV-fluids, three new factories are being projected.

On the distribution side, the public company still has a strong market share, but competition exists. There is competition among brands and there are generic products as well. The volumes procured and the number of suppliers that the public company has, gives a cost advantage at the procurement level.

It has been noted that illegal and fake drugs are currently on the market in Ethiopia,

---

<sup>13</sup> This estimate probably include drugs provided by donor grants, but not the volume of illegally imported drugs.

<sup>14</sup> In Valdelin, Netsanet, Fairbank, October 2000, it was estimated that the annual out-of-pocket expenditure per capita in the year of 2000 was about 14 ETB. This order of magnitude is the same as the present estimate.

particularly products which are deleted from the essential drugs list. The recent new rules for drug sellers have allowance for high punishment for abuse. A study of drug use in Ethiopia will be conducted by the ESHE project during 1993 EFY, hopefully giving indications as to the size of the problem.

On the retail side, it seems that budget pharmacies generally buy generic products and that they are instructed to buy from the public distributor only, with the exception of cases when the public company is out of stock. Special pharmacies usually buy generic and branded drugs from public and private sources. The customers of the private drug supplies companies are therefore mostly private pharmacies and private facilities, and the special customers like Kenema pharmacies and Special Pharmacies. Most public facilities and budget pharmacies rely upon the public sector companies. The choice of drugs at the pharmacy level, especially at hospitals, involves a tough trade-off between quality and price: the qualified pharmacist should therefore have the right to make decisions on all products, according to industry suppliers. Seen in the light of the current lack of pharmacists in the public sector, this points to a serious problem in the facilities of the public sector.

Two problems were mentioned by all interlocuteurs: one is the international procurement of drugs with multilateral funds, the second is the managerial capacity at the introduction of Special Pharmacies as proposed by the ESHE project.

The 1992 EFY may be a particular year, but serves as an illustration to problems that may occur when international procurement is called for. As the team noted during its visits to health facilities, almost all were without actual budget for 1992, or more specifically there were no government funds for the drug budget, only a credit that was not yet converted into actual supplies. The idea of replacing government funds with IDA procured drugs in kind was not translated in to necessary time lags relating to EFY 1992 and the only backup in case of delayed procurement was the RHB's. The actual delay of the procurement left the facilities without drugs and the public distributor, who had not been informed, with big stocks of drugs. The broader issue of donor funding and grants is often associated with duplications, increased number of expiries, due to lack of integration of the different supplies.

As for the SPs and a planned introduction of SPs on a national scale, the drug suppliers were all united in ringing an early warning for the management capacity of the future SPs. The emphasis was particularly on the liberalization of the present financial constraints and on the autonomy of the SP, even within the health facility where it is based.

**ANNEX 1: LIST OF PEOPLE CONTACTED**

**Addis Ababa Region**

- |                         |                                       |
|-------------------------|---------------------------------------|
| 1. Ato Kiros Belachew   | Head, Health Service Department. RHB; |
| 2. Dr. Berhanu G/Mariam | M/Director, Zewditu Hospital;         |
| 3. Dr. Teshome          | M/Director, Yekatit 12 Hospital; and  |
| 4. Ato Fekade           | Administrator, Yekatit 12 Hospital.   |

**Oromiya Region**

- |                        |   |
|------------------------|---|
| 5. Dr. Ibrahim Hussein | Head of Health Service Department. RHB; |
| 6. Dr. Tadesse Ayalew  | Deputy Head, East Shoa ZHD;             |
| 7. Ato Shoa Abera      | Head of Pharmacy. East Shoa ZHD;        |
| 8. Dr. Abera Degefe    | M/Director, Adama Hospital;             |
| 9. Dr. Kedir Wajiso    | Head, Arsi Zone Health Department;      |
| 10. Ato Shalo Daba     | Administrator, Asela Hospital;          |
| 11. Dr. Desta          | M/Director, Asela Hospital; and         |
| 12. Ato Biruk Bitew    | Pharmacy Technician, Asela Hospital.    |

**Dire Dawa Administrative Council**

- |                        |                                       |
|------------------------|---------------------------------------|
| 13. Dr. Tesfaye Yacob  | Deputy Head, Dire Dawa Health Office; |
| 14. Ato Yacob Yisak    | Head, Health Service Department;      |
| 15. Dr. Tesfaye Motera | M/Director, Dil Chora Hospital; and   |
| 16. Ato Girma Balis    | Administrator, Dil Chora Hospital.    |

**Harare Region**

- |                           |                                      |
|---------------------------|--------------------------------------|
| 17. Dr. Wehib Bekri       | Head, Harare RHB;                    |
| 18. Dr. Elias Ahmed       | Head, Health Service Department; and |
| 19. Dr. Rehana Abdurhaman | M/Director, Hiwot Fana Hospital.     |

**Amhara Region**

- |  |   |
|--|---|
| 20. Dr. Tizazu Tiruye                  | Deputy head, Amhara RHB;                        |
| 21. Ato Getahun Sisay                  | Acting head, Health Service Department;         |
| 22. Ato Solomon Abebe                  | Head, Bahir Dar Special Zone Health Department; |
| 23. Dr. Ferew Kebede                   | M/Director, Felege Hiwot Hospital;              |
| 24. Ato Abdu Dawed                     | Head, South Gondar Zone Health Department;      |
| 25. Ato Gashaw Shiferaw<br>Department; | Pharmacist, South Gondar Zone Health            |
| 26. Dr. Bari Neberi                    | Acting M/Director, Deber Tabor Hospital;        |
| 27. Ato Aragaw Tezazu<br>Hospital; and | Head, Finance and Administration. Deber Tabor   |
| 28. Ato Tesfaye Melaku<br>Hospital SP  | Dispenser and Cash Collector, Deber Tabor       |

**SNNPR**

- |   |   |
|---|---|
| 29. Dr. Zeleke                          | Deputy Head, SNNPR RHB;                                 |
| 30. Ato Meskelle                        | Pharmacist, SNNPR RHB;                                  |
| 31. Ato Paulos Markos                   | Head, Sidama Zone Health Department;                    |
| 32. Ato Moges Tadesse                   | Acting Head, Leku Health Center;                        |
| 33. Ato G/Selassie Gulti                | Accountant, Leku Health Center;                         |
| 34. Ato Getahun Fisseha<br>Center,      | Head, Finance and Administration, Cheko Health          |
| 35. Ato Girma Kassa                     | Head, Technique division;                               |
| 36. Ato Hail Giorgis Abate              | Head, Wolaita Sodo Health Center;                       |
| 37. Ato Mohammed Feleke<br>Pharmacy;    | Druggist, Wolaita Sodo Health Center, Bamako Initiative |
| 38. Dr. Kelemu Desta                    | M/Director, Wolaita Sodo Hospital;                      |
| 39. Ato Dagnachew Mersha                | Pharmacy Technician, Wolaita Sodo Hospital, SP;         |
| 40. W/o Asegedech Ayano                 | Accountant, Wolaita Sodo Hospital;                      |
| 41. Dr. Endrias Linchamo                | M/Director, Hossana Hospital;                           |
| 42. Ato Leggesse Genorie<br>Hospital;   | Head, Finance and Administration, Hossana               |
| 43. Dr. Abdulselem Kelil<br>Department; | Team Leader, Health Service Team, Gurage Zone Health    |
| 44. Dr. Abdulsmed Sabir                 | Head, Wolkete Health Center;                            |
| 45. W/t Lemelem Adane                   | Pharmacy Technician, Wolkete Health Center;             |
| 46. Dr. Ababayehu Assefa                | Head, Emdeber Health Center; and                        |
| 47. W/o Denber-yelesh Ageta             | Cash Collector, Emdeber Health Center, Pharmacy         |

**Tigrai**

- |                          |   |
|--------------------------|---|
| 48. Dr. Tewodros Adahnom | Acting Head, Tigrai RHB;  |
| 49. Dr. Seged T/Himanot  | Head, HSTD,RHB;   |
| 50. Dr. G/Kidan          | Head, PPD, RHP;   |
| 51. Dr. Mengestie        | Head, ;????, RHB;   |
| 52. Ato Berhane Yabw     | Acting Head, Pharmacy Department, RHB;                                      |
| 53. Dr. Atakilte G/Kidan | M/Director, Mekelle Hospital;   |
| 54. Sister Alganesh      | Matron, Mekelle Hospital;   |
| 55. Ato Mekonnen         | Pharmacy Technician, Mekelle Hospital;                                      |
| 56. Dr. Yoseph Adane     | Head, Mekelle Health Center;  |
| 57. Ato Adane K/Mariam   | Administrator, Mekelle Health Center;                                       |
| 58. Ato Yoseph T/Himanot | Accountant, Mekelle Health Center;  |
| 59. Dr. Tasew Tesfaye    | Head, Health Service and Training Division,<br>Eastern Tigrai ZHD;          |
| 60. Dr. Amanuel Gessesu  | M/Director, Adigrat Hospital;   |
| 61. Ato Mulu Atsbeha     | Head, Adigrat Woreda Health Office;   |
| 62. Ato Abdul Wassie     | Head, Health Service and Training Section, Adigrat<br>Woreda Health Office; |

**Public and private companies**

- |                              |   |
|------------------------------|---|
| 1. Ato Eyasu G. Abzgi        | General Manager, Eyasu Drugs and Medical<br>Supplies (Importer and Distributor)       |
| 2. Ato Kassahun Demeke       | Deputy Manager, Beza International PLC.   |
| 3. W/ro. Aster Zewdie        | Division Manager, Pharmaceutical & Medical<br>Supplies, Equatorial Business Group PLC |
| 4. Ato Teklu Alemayehu       | Pharmaceutical Dept. Manager, Equatorial Business<br>Group PLC                        |
| 5. Ato Tegegne Masresha      | Protection Officer, Nyala Insurance Co.   |
| 6. Ato Abate Fantaye         | General Manager, Nice Insurance Co.   |
| 7. Ato Tilahun Moges         | Head, Underwriting Dept., Ethiopian Insurance Co.                                     |
| 8. Ato Yemane Berhan Tadesse | Commercial director, Pharmid  |
| 9. Ato Dawit Negassa,        | Junior Life Underwriter, Awash Insurance<br>Company                                   |

**ANNEX 2: REFERENCES**

- Ministry of Health, Health Care and Financing Strategy, Addis Abeba 1998.
- ESHE project, IR1, Special Pharmacy Project proposal, Addis Abeba, September 2000
- Valdelin, J., Netsanet, W., & Fairbank, A., Private health expenditure trends and implications for health systems financing, Addis Abeba, October 1998.
- Federal Government of Ethiopia, Financial Administration Proclamation, No. 57/1996