PN-ACR-163

Analytical Report # 3

Ensuring Financial Sustainability under the HSDP

March 2001

Prepared by:

Health Finance Team,
ESHE/JSI Project

Federal Democratic Republic of Ethiopia,
Ministry of Health

In collaboration with:

John Snow, Inc.

Abt Associates Inc.

Funded by:
United States Agency for International Development

A

Essential Services for Health in Ethiopia

USAID/Ethiopia's primary health sector intervention, Essential Services for Health in Ethiopia-I (ESHE-I) was launched in 1995. It represents a collaborative effort between USAID and the Government of the Federal Democratic Republic of Ethiopia (GFDRE) to (1) increase the use of integrated primary and preventive health care (PPHC) services in Ethiopia; and (2) contribute to the achievement of national sectoral goals, as articulated in the GFDRE's Health Sector Development Program (HSDP). .

Mission

The goal of ESHE-I is to create sustainable improvements in the overall health status of Ethiopians by slowing the rate of population growth and by improving the population's access to, and the quality and utilization of health care services. ESHE-I is comprised of policy, budgetary, and institutional reforms; family planning; STI/HIV/AIDS prevention and mitigation; and PPHC service delivery activities in the Southern Nations, Nationalities and Peoples Regional (SNNPR) State, each with the overall aim of strengthening the health service delivery system and thereby creating a demand in the utilization of PPHC services. ESHE-I is structured into four Intermediate Results (IR) focusing on (1) increasing resources to the sector, (2) improving access and utilization of family planning services, (3) HIV/AIDS prevention and control; and (4) strengthened health systems in the SNNPR.

Intermediate result (IR) 1, *"Increased resources dedicated to the health sector, particularly PPHC"*, is a key component that USAID aims to support the implementation of national policies which will increase resources to the sector, the implementation of a Health Care Financing (HCF) Strategy, and promotion of private investment in health care delivery. Also, support for increasing the MOH and RHB capacity for sectoral planning and budget development, relative to the Health Sector Development Program (HSDP). These objectives are meant to be achieved through:

1.1 Increased government budgetary allocations to health care, particularly PPHC;
1.2 Increased share of public health expenditure covered through cost recovery;
1.3 Increased government capacity at central and regional levels for resource; and
1.4 Increased private sector investment in health care delivery.

John Snow Inc. (JSI) is the prime contractor for ESHE-I under the USAID/GFDRE bilateral agreement. Abt Associates Inc. is the sub contractor supporting the "health care finance reform" activities constituted under IR1 of ESHE-I. To inform the reform process the HCF Secretariat of the Federal Ministry of Health and the Health Finance team have conducted a series of studies, study tours, analysis and interpretation of the information generated on different aspects of health care financing in Ethiopia. This report is part of a series studies and reports, with the aim of contributing data for policy development and implementation of the HCF strategy.

Recommended Citation
ESHE/JSI Project, Health Finance Team. 2001. *Ensuring Financial Sustainability under the HSDP*. Addis Ababa.
Acknowledgments : USAID Ethiopia
John Snow, Inc.
Abt Associates

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

Submitted to: Health, Population and Nutrition Office
USAID/Ethiopia
Activity Title: SO #2
IR 1: Increased resources dedicated to the health sector, particularly PPHC

For additional copies of this report, contact the HCF Secretariat & ESHE/JSI Health Finance Team at

B

Table of Contents

Introduction 1

1. Developing an Equitable and Acceptable Standard of Government Health Service 2

2. Promoting Greater Private Sector and NGO Participation in the Health Sector 7

3. Mobilizing Internal and External Resources (funding of the HSDP) 13

3.1 HSDP and the Budget Development Process 14

3.2 Mobilizing Additional Sources of Funding 16

4. The Health Care Financing Component 19

5. Conclusions 21

List of Tables

Table 1: Construction of new health facilities by type of facility and by region EFY 1984 to 1992 3

Table 2: Recurrent budgets by health center 5

Table 3: Budget allocation for construction, non-salary recurrent expenditures, and human resource development (EFY 1993) 6

Table 4: Distribution of roles and functions among various actors within the health sector in Ethiopia 7

Table 5: Health budgets EFY 1989 to 1993 13

Acronyms

ARM	Annual Review Meeting of the HSDP
ADF	African Development Fund
CJSC	Central Joint Steering Committee of the HSDP and ESDP
DFCBD	Development Finance and Capital Budgets Department (Ministry of Finance & Economic Development
EFY	Ethiopian Fiscal Year
EIA	Ethiopian Investment Authority
FP	Family planning
GFDRE	Government of the Federal Democratic Republic of Ethiopia
HCF	Health Care Financing
HMIS	Health Management Information Systems
HSDP	Health Sector Development Program
IDA	International Development Association (World Bank)
IEC	Information, education and communication
MCH	Maternal and child health
MEDAC	Ministry of Economic Development and Cooperation
MOFED	Ministry of Finance & Economic Development (previously MEDAC and MOF)
MOF	Ministry of Finance
MOH	Ministry of Health
MOH/PPD	Planning and Programmes Department of the Ministry of Health
MOH/HSTD	Health Services and Training Department of the Ministry of Health
MTEF	Medium-term expenditure framework
NGO	Non-governmental Organization
PAP	Programme Action Plan of the HSDP
PEP	Public Expenditure Programme
PHCU	Primary health care unit
PPD	Planning and Programming Department of the Ministry of Health
RHB	Regional Health Bureau
SNNPR	Southern Nations, Nationalities and Peoples Region
ZHD	Zonal Health Department

Introduction

In 1998, the Government of the Federal Democratic Republic of Ethiopia (GFDRE) embarked on a Health Sector Development Programme (HSDP) to implement a new Health Policy introduced in 1993. The HSDP serves as the overall framework for Government activity in the health sector. It aims at more effective Government interventions in health care and seeks to mobilize increased resources, from both external sources and the Government treasury, to implement such interventions. According to its Programme Action Plan (PAP), the HSDP was to adopt the following strategies to secure funding for the Programme and ensure financial sustainability of improved health service delivery.

- *Develop an equitable and acceptable standard of [Government] health service* that will reach all segments of the population within the limits of available resources.
- Promote the *participation of private sector and non-governmental organizations in health care.*
- Promote attitudes and practices conducive to the strengthening of national self-reliance in health development by *mobilizing and maximally utilizing internal and external resources.*
- Provide health care for the population through *a scheme of payment according to ability to pay*, with special assistance mechanisms for those who cannot afford to pay.[1]

The present paper analyzes progress in ensuring financial sustainability of HSDP interventions. In doing so, it considers the extent to which the above strategies have been implemented. Additionally, a section of the paper is devoted to review the implementation status of the health care financing component of the HSDP, which was developed to address issues of sectoral financing.

The paper is structured into six parts. The first four sections provide an analysis of progress and implementation issues related to the four strategies of the HSDP that aim to ensure financial sustainability of the Government's interventions in the health sector. This is followed by a close examination of implementation of the health care financing component of the Programme. Finally, concluding remarks are provided in the last section of the paper.

[1] FDRE/MOH, Program Action Plan for the Health Sector Development Program, Addis Ababa, October 1998

1. Developing an Equitable and Acceptable Standard of Government Health Service

The health policy of GFDRE introduced a four-tier health system in which the central service delivery point would be a primary health care unit (PHCU), comprised of a health center with five satellite health posts. A PHCU is expected to serve a catchment area of 25,000 people with primary health services and to promote preventive health care through a network of health posts staffed with frontline health workers, who are drawn from the communities that they serve and trained for nine months. The health post is not expected to provide curative care other than very basic treatment (e.g., assisted delivery, oral rehydration therapy, treatment of minor injuries). Health posts are intended to focus on mobilizing communities for promotive and preventive activities, to provide home based services and to refer patients requiring curative services to the health center.
The health center, as a next on line in the referral system, is to provide essential curative services. These include integrated MCH services; integrated patient care including diagnosis, treatment and follow-up services; handling of emergencies particularly operative procedures (appendectomy and caesarian section); minor physiotherapy; pharmacy services, etc. All cases that require more advanced treatment than essential health care are referred to a district hospital. The health center furthermore supports health posts with their promotive and preventive services. For example, it undertakes immunization and control of common communicable diseases including vector borne diseases, provides technical support for environmental health and IEC programmes, etc. Health centers also undertake in-service training for and supervision of the frontline health workers stationed at health posts. In addition to PHCUs and district hospitals, the Government health system includes two additional levels: zonal (general) hospitals and specialty hospitals, for more complicated cases.[2]

Based on functions determined for each level under the four-tier system, standards have been developed for the various types of facilities. These address staffing patterns, organizational structure, physical plant/facility, indicative budget, as well as medical equipment and drug inventories.[3]

The HSDP seeks to:

- expand the lower level of the Government health system (to improve coverage of primary and preventive services); and,
- to strengthen the referral system.

Accordingly, all regions invested in the construction of health facilities over the last ten years. The rate of expansion, particularly at the lower tier of the Government health system, was accelerated during the HSDP period. In order to meet the minimum standards set for service delivery, it is important that such expansion in facilities be equally matched by increasing investment in human resource development and increasing budgetary allocations for recurrent expenditures. Financial sustainability implies that a balance should be maintained between sectoral expansion and resource availability for additional expenditures resulting from such expansion. Given that the Government health system is

[2] Some regions namely SNNPR and Tigrai have also invested in regional hospitals, which provide some specialized services.

[3] FDRE/MOH, Health Services Standard: Health Center, Addis Ababa, January, 1996. FDRE/MOH, Health Center: HSDP Standard, Addis Ababa, December 1998. FDRE/MOH, District Hospital, HSDP Standard, December 1998.

financed through budgetary allocations, donor contributions and possibly cost sharing, it is important that expansion in the health system take into account the potential growth in these sources of financing.

Table-1: Construction of new health facilities by type of facility and By region EFY 1989 to 1992

Region	Hospitals			Health Centers	Health Posts	Health Stations
	Specialized	Zonal	District			
Tigrai	1	6	9	31	103	16
Afar	0	0	0	7	61	17
Amhara	0	0	4	40	361	138
Oromiya	0	5	2	73	126	144
Somali	0	1	1	10	7	16
Benishangul-Gumuz	0	0	0	11	60	0
SNNPR	1	3	7	75	170	54
Gambella	0	2	0	7	0	26
Harari	0	0	0	4	7	3
Addis Ababa	0	0	0	1	0	0
Dire Dawa	0	0	0	4	12	1
Federal	0	0	0	0	0	0
TOTAL	2	17	23	263	907	415

Source: GFDRE/MOH Health and Health Related Indicators, 1992

Note: Even though the Health Policy requires a phasing out of health stations, such facilities continue to be constructed in remote areas combining the functions of a health post with some of the functions of a health center.

Table 1 shows that there has been considerable expansion in the Government health system over the past eight years. According to the MOH standards, an additional 166 million birr (at 1995 prices) should have been allocated to run the newly constructed health centers and health posts. Yet, in EFY 1993, the total recurrent budget for the health center and clinics budget category was only about 146 million birr.[4] Similarly, for new health centers and health posts constructed from EFY 1984 to 1992 to have been staffed according to the MOH standards, it is estimated that about 9,000 to 10,000 new health professionals of various categories would have been required. At present capacity, training institutions (tertiary education, senior and junior training schools) produce about 2,400 a year. It was found during the mid-term review of the HSDP that the number of professionals trained each year has been insufficient to meet the growing needs of the sector resulting from such an expansion. [5] This is due to high rates of attrition and the need to replace staff in existing facilities, the staffing needs of new facilities, and the need to upgrade existing facilities to improve the quality of services. Consequently, the main instrument used to get the health facilities functioning is to ration the available resources. As a result, it has become difficult to operate as per the standards set, both in terms of human resources and operating budget.

[4] It is estimated that an additional 50 to 60 million birr may have been allocated for drugs in the capital budget financed by IDA loans. Nevertheless, given the budget needs of existing primary health facilities and 415 new health stations constructed during the period EFY 1984 to 1992, as well as positive inflation rates, even with the additional funding committed through the capital budget, allocations for recurrent expenditure falls short of requirements *per* the MOH standards

[5] GFDRE/MOH, Ethiopian Health Sector Development Programme 1997/98 – 2001/02 Report of the Mid Term Review Mission 7 February to 8 March, Addis Ababa, March, 2001

Availability of health professionals

The mid-term review of the HSDP documents that health facilities remain grossly understaffed and that human resource development has remained far behind infrastructural development and construction. Given this situation, expansion in the Government health system should be based on the availability of trained health workers *vis-à-vis* the need to replace staff in existing facilities lost to attrition; and, the additional needs required to realign present staffing with acceptable standards for each level of the health system. Total availability of trained health professionals is constrained by the current output of health training institutions and the potential for its growth, which in turn requires investment to increase capacity and quality of training institutions. To date there has been little correspondence between resources devoted to training (for greater capacity and quality) and to the growing manpower requirements of the health sector.

Moreover, skills of Government health professions are often inadequate for the position that they hold. For example, in many instances general practitioners or health officers, who head health centers, lack the ability to undertake emergency surgery such as for obstructed labor, which they are required to undertake. Another concern is evidence of declining quality in the training of health professionals. For example, the mid-term review of the HSDP found that junior health professional schools frequently use diploma holders as teachers, which is below the prescribed standards and that many teachers lack training in teaching methods. It was also noted that discrepancies exist between curricula, training practice, official job descriptions and health service needs The staffing situation is furthermore exacerbated by high attrition rates from the Government service. The mid-term review found that in certain regions the rate of attrition is such that when retirement, official transfers and deaths are included, those who leave the service exceed new entrants.[6]

Recurrent budgets

Table 2 provides an estimate of recurrent budget allocations per health center. The estimate holds the proportion of budget allocation between health centers and health posts constant and assumes, rather arbitrarily, that the budget allocation to the health centers and clinics recurrent budget code is equally divided between health centers on the one hand and health posts and health stations on the other. It is therefore only indicative. Nevertheless, it does show that in most Regions (with the exception of Addis Ababa), allocation per health facility at this level of the Government health system has declined since 1989. Even with an assumption that only 25% of budgetary allocations to the health centers and clinics budget code were directed to health posts and health stations, allocation of recurrent budgets in EFY 1993 per health center in almost all Regions remains below the 570 to 690 thousand birr that the MOH standards for a health center require. In many regions (e.g., Amhara, Oromiya, SNNPR, Harari, Dire Dawa) less than half of the funding required by the MOH standards have been allocated. Moreover, there is no scope to augment the recurrent budget from revenues collected. It is to be noted that the figures provided are under estimated as a budget for drugs has been provided in the capital budget to be funded through IDA and ADF loans. However, due to lengthy procurement and approval procedures of the lending agencies, resources allocated for drugs in the capital budget have not been reliable.

[6] Ibid. p 35

The HSDP has dual objectives of expansion and increasing quality of services. Yet, it is clear that sufficient resources have not been made available at the health facility level to maintain quality, let alone improve services. Moreover, meeting the budget levels suggested by the MOH standards, would inflate the recurrent budget to over twice its size in many regions (at least for the health center and clinics code). It is unlikely that such resources can be made available from budgetary sources alone. Clearly, new sources of funding are required if the HSDP objectives are to be fulfilled.

Table 2: Recurrent budgets per health center

in '000 birr

Region	1989	1992	1993	
			50% to HC*	75% to HC**
Tigrai	290.8	203.5	254.5	381.7
Afar	444.7	377.9	376.0	563.9
Amhara	220.5	181.9	180.7	271.1
Oromiya	255.0	218.7	208.9	313.3
Somali	138.3	258.3	264.1	396.2
Benishangul-Gumuz***	376.8	180.3	242.8	364.2
SNNPR	141.9	87.9	97.5	146.3
Gambella	307.6	-	-	-
Harari	-	162.8	196.7	295.0
Dire Dawa	236.4	250.8	213.0	319.5
Addis Ababa	386.5	460.7	562.7	844.1

Source: calculated from various sources

* Assuming the budget for the health centers and clinics code is equally divided between health centers and health posts/stations.

** Assuming only 25% of the budget for the health centers and clinics code is allocated to health stations/posts

*** For 1992 and 1993, allocations to Health Centers and Clinics are included in the budget category: woreda economy and health

The distribution of resources between construction, recurrent expenditures and human resource development suggests that HSDP implementation did not adequately consider the financial implications of constructing new health facilities. Table 3 indicates that in EFY 1993, for example, a large proportion of resources were allocated for facility construction and rehabilitation (around 30% in most cases) while in most Regions less than 20% and 3% was allocated to operating expenditures and human resource development respectively. As such, one can say that expansion has been achieved while the quality of service delivery has not been given due attention.

The implication of investment in new facilities on requirements for trained health workers of various categories and on recurrent budgets is calculated taking into consideration the functions of the facility, a projection of the potential workload involved, its relationship to other facilities, and a minimum acceptable standard. Whether or not to invest in new facilities must then be determined on the basis of whether such resources for such expenditures exist (and the potential for their growth). Such considerations are not apparent in HSDP implementation. Firstly, investment was guided by availability of a capital budget with insufficient analysis of the future resource requirements implied by the investment. Decisions on constructing new health facilities should be made only when the human and recurrent resources are ensured as per the standard. Indeed, given the serious shortages in recurrent expenditures experienced over the past three years, consideration must be given to shifting resources from the capital towards the recurrent budget.

Secondly, requests for health facility budgets are based on simple increments and allocations on resource availability, without a proper calculation of the requirements of each health facility based on quality determining factors. Another implication of the foregoing discussion is that, given the present low standard of health service in Ethiopia, additional funding generated from increased budgets and additional health professionals generated from the current training institutions should be absorbed in up-grading existing facilities.

Table 3: Budget allocation for construction, non-salary recurrent expenditures, and human resource development (1993)*

in '000 birr

Region	Total Budget	Operating Expenditures		Facility Construction and Rehabilitation**		Human Resource Development	
	Value	Value	% of Total	Value	% of Total	Value	% of Total
Amhara	193,302.20	50,516.4	26	45,205.00	23	3,150.40	2
Oromiya	298,192.50	59,903.9	20	117,080.40	39	7,744.20	3
Somali	72,370.31	8,842.7	12	24,555.56	34	2,037.30	3
Benishangul-Gumuz	33,489.60	5,914.0	18	9,430.70	28	460.00	1
SNNPR	226,463.47	36,650.4	16	101,329.37	45	3,646.12	2
Gambella	27,067.54	4,080.0	15	10,201.21	38	-	0
Harari	17,847.40	6,072.1	34	5,308.60	30	967.40	5
Dire Dawa	16,087.85	2,176.2	14	1,695.54	11	72.35	0
Addis Ababa	115,141.00	44,024.9	38	16,346.70	14	703.90	1
Federal	97,405.10	28,952.7	30	8,772.90	9	1,822.00	2

Source: HSDP/ARM 2001 Documentation , GFDRE.MOF, EFY 1993 Regional Recurrent Budgets, Part 1 & 2. Addis Ababa, Megabit 1993, GFDRE/MEDAC, EFY 1993 Regional Capital Budgets, (compiled from Regions) MOH/Finance for the federal operating budget

* Does not include the budget for Tigrai and Afar

** Construction budget does not include construction by ESRDF and NGOs that hand over projects to the Government system. It is therefore considerably understated

Finally, the experience with HSDP implementation suggests that there is a need to re-consider the function and standards for health facilities at different levels of the Government health system. It is observed that, because coverage levels remain low, it is unrealistic to expect the first point of contact of the Government health system to focus solely on preventive and promotive activities. Already Regions are diverting from the MOH standards in response to demand for curative services, as well as varying workloads at different health facilities. In most cases, such adjustments have required additional resources.[7] Yet, availability of trained workers and recurrent budget allocations are presently even below the MOH standards. It is believed that this has seriously affected the effectiveness of Government health service delivery in general, and the intended focus on preventive and promotive health care in particular. It appears that there is a need for better understanding of a minimum essential package to be provided by Government that is realistic, given limited resources; and, for engaging other actors in service delivery beyond this minimum package.

[7] Several regions (Tigrai, Amhara, Oromiya, SNNPR) have adjusted the standards of a health post assigning junior clinical nurses and up-graded primary health workers to replace frontline health workers. This is in response to the demand from communities that health posts provide curative as well as prevention functions since health posts have tended to be located far from health centers and not as part of a PHCU. This has tended to over-stretch available health professionals across facilities

2. Promoting Greater Private Sector and NGO Participation in the Health Sector

As the role of Government health system is redefined to increasingly focus on primary and preventive health, the participation of the private sector is essential to supplement the government system both in terms of financing and delivery of services, including strengthening the referral system. The health sector in Ethiopia engages various actors with different roles and functions. The MOH is involved in designing of health policies and guidelines for regulation and supervision of health facilities and formulating national programs. In addition, it facilitates drug imports and distribution, as well as the financing and delivery of curative services through its central referral hospitals. Regional Health Bureaus (RHBs) are involved in all aspects of the health system. The private for profit sector is more involved in the financing and delivery of curative services, plus retailing and to some extent in the manufacture and/or import of drugs. NGOs are involved in financing and delivery of both curative and preventive health services, and to a limited extent in the supply of drugs. In addition to the MOH, other ministries, such as the Ministries of Education and Defense, finance and provide curative services for their staff through their own facilities. Government bodies, such as the Disaster Prevention and Preparedness Commission (DPPC) or its equivalent Regional Bureaus, regulate and supervise the activities of NGOs. Finally, several government enterprises finance and provide curative services to their members.

Table-4:Distribution of Roles and Functions among Various Actors within the Health Sector in Ethiopia

Actors	Functions						
	Policy	Regulation & Supervision	Financing		Services Delivery		
			Preventive	*Curative*	*Preventive*	*Curative*	*Drug Supply*
MOH	√	√		√		√	√
RHB/ZHD*		√	√	√	√	√	√
Other ministries/agencies		√		√		√	
Private sector				√		√	√
NGOs			√	√	√	√	√
Parastatals				√		√	

*Zonal Health Departments

Source: GFDRE, Ethiopia: Contracting Government Health Services in the Health Sector, Addis Ababa, 2001

Table 4 shows that although the Government remains active in all aspects of health service provision in Ethiopia, the private sector and NGOs supplement the Government effort in both the financing and delivery of curative health services and in drug supply. NGOs furthermore extend preventive services. The private sector is small and, compared to other African countries, NGO involvement in health care delivery is limited (it is estimated that about 10% of the total health care of rural communities is provided by NGOs). However, there is enough dynamism within the private sector (both NGOs and for-profit operators) to suggest a potential for tapping into this sector to improve health outcomes in Ethiopia. At the start of the 1990s, there were no licensed private health facilities, since the policy at the time did not allow private enterprise to operate in the sector. As restrictions were relaxed, such facilities have grown to 1,122 over the ensuing ten years. Moreover, over the five-year period from 1995 to 2000, private health facilities have shown an overall increase of

77%. Similarly, private drug outlets grew by 56% in the same period. Furthermore, statistics from the Ethiopian Investment Authority (EIA) reveal that 167 large health projects (hospitals, higher clinics, drug manufacturing, etc) were approved for investment during the period from 1992 to 2001; 26 of which were operational in January 2001[8].

Although the Health Policy and the HSDP recognize the importance of the private sector and NGOs in extending health services to the Ethiopian population and seek to promote the involvement of such actors in the sector, there is *little articulation* of how to encourage more active private/NGO participation in the sector. The HSDP/PAP document is extremely tentative in this regard, limiting Government action to "undertak[ing] a series of studies to analyze the potential impact of and modalities for [*inter alia*] the encouragement of private sector/NGO participation in health service delivery".[9] Two key studies have been undertaken, as background analyses to the development of new approaches to health service delivery in Ethiopia, in which both the private sector and NGOs are engaged more actively.

i. *Ethiopian Health Care Delineation Study:*[10] The study assessed the potential roles for private enterprise, NGOs and the government in health care delivery in Ethiopia. It confirms the need to identify *an essential health service package* on which public provision would concentrate. Given that the private and NGO sectors are still small in Ethiopia, the Government would continue to provide services beyond the essential package. Identification of an essential health service package would, however, enable the Government to take care that its activities beyond the essential package do not crowd out the private and NGO sector. Reforms related to fee structures within the Government health system, incentives packages for the private sector, the use of government facilities for private practice through the establishment of private wards, etc. would thus be designed to gear private sector and NGO participation towards services that complement the Government's essential package.

ii. *Ethiopia: Contracting Government Services in the Health Sector:*[11] The study reviewed varied experiences in contractual and more informal arrangements for public-private/NGO partnerships in the delivery of both health and health related or support services (such as construction of health facilities) within the Government health system. A gradual approach for moving ahead in this area is proposed. Focusing first on policy measures required for expanding contracting in support services where competition, private sector capacity and interest are higher. For medical services, there is scope for enhancing the Government health system through stronger partnerships with NGOs and in the long run, with the private-for-profit sector. Nevertheless, some issues need to be resolved as contractual arrangements are considered for the delivery of Government health services. This is particularly in the area of *Government capacity for contract management, the strategic use of contracts as management tools, decision-making autonomy* within different levels of the Government health system, *institutional and legal support systems*,

[8] The EIA licenses investments with a minimum capital of 250,000 Birr and the statistics provided are therefore only limited to projects with a capital of over this amount.

[9] FDRE/MOH, Program Action Plan for the Health Sector Development Program, Op. Cit. p. 20.

[10] Ministry of Health, Ethiopian Health Care Delineation Study, Addis Ababa, April, 2001

[11] FDRE/MOH, Ethiopia: Contracting Government Service in the Health Sector, Addis Ababa, October, 2001

confidence/trust between the Government and the private sector and/or NGOs; and, uneven private sector capacity.

Generally, initiatives towards developing a health system that involves greater private sector and NGO participation in Ethiopia are constrained by an uncertain environment in which such actors are presently operating. Clearly, policy statements suggest that the Government is expected to both monitor and facilitate the operations of NGOs and private providers in the sector. However, this is not considered a priority function for RHBs that are the prime responsible institutions for such functions. RHBs are more concerned with service delivery in the public sector, since this is the basis on which officials are evaluated. Thus, for example, adequate attention is not given to ensuring that Government support is provided to NGO health projects. Delays in project development, laxness in monitoring and a reluctance to facilitate NGO endeavors appear to be tolerated (and associated problems disregarded) causing an unfavorable environment for NGO activities in the sector. Similarly, monitoring of private health providers and retailers of drugs raise issues of cumbersome licensing procedures, inadequate supervision focused on physical inputs rather than quality of service provided, and a general attitude of control and fault finding rather than support.

Many of the challenges arise from a history of restriction on private enterprise in all sectors of the Ethiopian economy. Given the nature of health care, that requires considerable regulation and monitoring to protect the public from inappropriate practices, such restrictions have only slowly been relaxed in the health sector. Moreover, there is little capacity within Government for regulation. The Government has little experience in regulating health care and appropriate capacity has not been developed among Government staff for efficiency in this regard. Neither, is there any self-regulation by private providers. Procedures for supervision, feedback, renewal of various permits/licenses, and action in case of irregularities are therefore not effective.[12] For example, discussions with private providers reveal that supervision is based on standards for private practice that do not provide a good means of evaluating if quality service is being provided, as they focus on physical inputs rather on services. Moreover, there are cases in which the standards are inconsistent and do not take into account the conditions under which private practitioners operate. In other cases, as for pharmaceutical supply, regulations have tended to be restrictive, considerably curtailing private sector activities. As a result, serious shortages are apparent and a lucrative black market has stepped in to fill in the gap. Thus, to the extent that the black market is able to evade Government controls, regulation introduced to protect the general population from abusive practices has been rendered ineffective by its very restrictiveness.

Nevertheless, the MOH and other regulatory bodies, such as the DPPC in the case of NGO projects and the Ethiopian Investment Authority in the case of large private investments, have introduced important measures to provide a better environment for private/NGO involvement in health care.

[12] If supervision is to be effective standards can only serve for general guidance and supervisors need to be able exercise judgment, engage in a dialogue and justify the various requirements that private clinics need to fulfill. This is not so and decisions are therefore perceived to be arbitrary.

Modification of licensing requirements for private clinics and hospitals

In 1994, the MOH issued a set of Guidelines to serve as a regulatory mechanism for private provision of health services, as restrictions on private investment in health care delivery were eliminated. More specifically, the aim is to protect both the users of health care and the private providers, to control the quality and distribution of health care by private providers, and to clarify the role of the MOH, RHBs and the EIA in the licensing of private health institutions. The Guidelines delineate different types of private health institutions into hospitals and higher/ medium/ small/ and special clinics. They also outline the requirements for obtaining licenses to operate the different types of health facilities. Additional guidelines for the private sector's involvement in drug trading have been developed by the Drug Administration and Control Authority, in which drug retail outlets are delineated as pharmacies, drug shops and rural drug vendors. The guidelines outline required standards for the three types of drug retail outlets and set conditions for obtaining a certificate of competence on which licenses are dependent.

In 1997, the MOH issued revised guidelines for licensing of private hospitals. In 1998, the ministry assessed the effectiveness of its guidelines for licensing of private clinics, and decided to revise these guidelines after extensive discussions with stakeholders on the outcome of the assessment. The drafting of revised guidelines has been participatory - engaging representatives from the MOH and the private sector. Thus a process has been initiated, that includes multiple stakeholders. for the review, discussion and revision of guidelines

Guidelines for NGO health projects

In 1995 the DPPC issued "*General Guidelines for Implementation of the National Policy on Disaster Prevention and Management (NPDPM)*". These guidelines serve as the framework for NGO activities in Ethiopia and outline procedures for the development, approval, monitoring, evaluation of performance, and financial audits of NGO projects for relief, developmental and social support activities.[13] As such, an approach in which NGOs are recognized as contributing to the Government's development and/or relief efforts has been elaborated. Accordingly, the guidelines suggest that while an NGO's project idea is to be developed by the NGO itself, the development of a project agreement (proposal) must be undertaken jointly by the NGO and the relevant line bureau of Regions in which the NGO expects to undertake its activities to ensure that the NGO's activities complement to the Regional Government's activities. It is, however, to be noted that NGO guidelines are general and not specific to any sector. Therefore, operational issues for health service delivery (such as whether NGO facilities should follow Government or private sector standards) are not included in the guidelines and therefore remain ambiguous and subject to frequent changes. Project approval or renewal, being subject to resolution of operational issues, therefore becomes uncertain. The MOH recognized the issue and studies are being conducted to address the issue (see below).

[13] NGO activities are considered in the context of disaster prevention and management because historically NGO engagement in Ethiopia was in response to the humanitarian emergencies of the mid-1980s. As NGOs have diversified their activities towards development interventions, so have the guidelines for disaster prevention and management also provided for such diversification. Separate guidelines have not been developed.

Investment incentives

In 1996, the Government of Ethiopia established the EIA with authority to issue investment licenses in all sectors, including health, and to authorize financial incentives for priority investments projects. Health projects include hospitals and diagnostic centers outside Addis Ababa; manufacturers of pharmaceuticals and medicinal chemicals as *'pioneer'* investment activities provided with up to five years tax holiday; and, hospitals and diagnostic centers in Addis Ababa as 'promoted' investment activities provided with up to 3 years tax exemption. The authority also authorizes exemption from custom duties for machines and equipment deemed essential for the establishment of private investment projects in health care. Such projects are, however, limited to projects with a capital of not less than 250,000 birr for domestic investors, 500,000 USD for foreign investors, 300,000 USD for foreign investor contributing to joint investment, and 100,000 USD for foreign investor reinvesting profit or dividends. Discussions with private investors in health care have indicated that the process for obtaining investment licenses and the associated incentives are fairly straightforward. Difficulties arise in obtaining *operating licenses and meeting changing standards,* as well as accessing land and working capital.

Studies

Two studies are presently underway, that review the current environment in which NGOs and the private sector operate in the health sector in Ethiopia. The studies recommend actions to be undertaken by the MOH and RHBs, that would improve the environment for private and NGO involvement in health care delivery in Ethiopia. These may be summarized as follows:

Regarding NGOs

- *Developing more appropriate guidelines governing NGO activities in the health sector.* This would include (i) elaboration of the guidelines to address sector specific concerns, (ii) streamlining of the licensing process, which would follow from clearer guidelines for NGOs providing health services as greater delegation of licensing responsibility to RHBs would be facilitated; and (iii) developing mechanisms for greater flexibility and phasing in of new guidelines. For example, there is a need to devise a system for gradual integration of NGO services into the new four-tier health system.

- *Strengthening support systems to back NGO activities.* This would include (i) greater attention to monitoring and evaluation of NGO health services. The absence (or delays) has tended to weaken the partnership between NGOs and the Government, creating an atmosphere of mistrust between the two parties. (ii) provision of essential supplies, including drugs on a cost sharing basis or alternatively (given limited Government logistics capacity to ensure a continuous supply of drugs) revision of restriction on direct purchase of such supplies by NGOs (iii) articulation of a policy for Government-NGO partnership, in which the Government could cover salary cost, provide medical professional to NGO health facilities, provide assistance in staff training, facilitate procedures etc.

Regarding the private-for-profit sector

- *Articulating policy. This would include* (i) elaboration of the Policy to provide greater insight on the Government's approach to promoting private participation in the sector, (ii) as a follow-on to the policy statement, sensitization of Government officials on the potential contribution of the private sector to the Government health system and overall health care in the country; and, (iii) development of a strategy for engaging the private sector in health care delivery.

- *Facilitating dialogue between the Government and the private sector. This would* include the establishment of a Private Providers Association that would participate in the articulation of policy, provide some self-regulation, periodically review and provide suggestions for modification of licensing requirements and standards of private service provision, etc.

- *Developing mechanisms for more effective regulation of private initiatives in the health sector. This would include* (i) final revision of licensing guidelines, (ii) introduction of more flexible approaches to off duty work by health professionals employed within Government facilities.

Within the framework of the new Health Policy and the HSDP, only tentative steps have been taken so far to promote an enabling environment for private sector participation in the health sector. These are mostly discrete/independent initiatives that need to be incorporated into a more systematic approach. The starting point would be for Government policy to articulate more clearly Ethiopia's approach to private sector and NGO participation in the health sector. Establishment of a modality to evaluate health managers, particularly regional health bureaus based not only on the effectiveness of public (government) service delivery but also by their achievement in the area of public private partnership is a step in the right direction. Background studies have been undertaken that would provide input to such a policy, and options for a better public-private mix in health care delivery have been elaborated.

3. Mobilizing Internal and External Resources (funding of the HSDP)

The sources of funding for the Government health system are budgetary allocations and cost recovery. Accordingly, an underlying tenet of the HSDP is the expectation of budget reforms to allow a significant increase in the budget for health; a commitment by donors to provide financial assistance for improvements in the sector; and, a nominal increase in revenues generated and retained by health facilities. The HSDP anticipates funding to the sector of up to 5 billion birr over five years, drawn from these sources: i.e.,

- Government treasury 55.4%;
- External assistance (loans and grants) 42.5%;
- User fees[14] 2.1%.

Table 5: Health Budgets EFY 1989 to 1993

in million birr

Year (EFY)	Regular Budget	Supplementary Budget	Total	Percentage Growth	
				(1)	(2)
1989	694.07	0.00	694.07	-	-
1990	776.15	0.00	776.15	12%	12%
1991	813.74	345.32	1,159.06	5%	49%
1992	802.68	388.63	1,191.31	-1%	3%
1993	1,228.24	n.a.	>1,228.24	53%	3%

Source: ARM 2001 Documentation

(1): growth in regular budget, (2): growth in total allocations

Overall, budgetary allocations to the health sector have steadily increased over the first four years of the HSDP, EFY 1990 to 1993. The total funding expected for HSDP implementation was slightly more than 1 billion birr per year from EFY 1991 to 1994. This constitutes a 30% increase over the projected funding for EFY 1990 and a 44% increase over budgetary allocations in EFY 1989 (the year prior to HSDP implementation). Budgetary allocations (regular plus supplementary budget) in EFYs 1991, 1992 and 1993 exceeded the 1 billion birr target set in the HSDP for these years. However, about 30% of the health budget was provided through supplementary allocations. The supplementary budget, in EFY 1991 and EFY 1992, consists of external resources (particularly the IDA loan) that were made available after the budget was approved. Such finding was provided late in the year and consequently utilization within the fiscal years specified was low (for example only 6% and 13% of the IDA loan was spent in EFY 1991 and EFY 1992 respectively). There is, therefore, a need for caution in considering the supplementary budget as additional funding. A large proportion is rolled over into from one year to the following year's budget and cannot be taken entirely as an additional resource.

The HSDP thus remains under-funded and with cut backs, allocations have tended to diverge from HSDP targets and focus areas. Allocations to the components of the HSDP that are of a supporting nature (monitoring and evaluation; health sector management,

[14] Revenue from user fees and other services (including sale of drugs where a revolving drug fund has not been established) are in most part not retained within the health sector. Rather, such funds are considered as part of Regional Government's overall revenue and treated more or less like taxes. Therefore, with a few exceptions, user fees at present do not contribute to the funding of the HSDP. However, discussions are underway to establish a health fund in which such funds may be retained at the facility level and used for specific purposes in line with the HSDP. Health facilities' revenue would be additional to budgetary allocations.

HMIS and operations research; and, health financing initiatives) have been extremely low. Related activities are therefore slowed down with consequent delays in reforms supporting HSDP implementation.

3.1 HSDP and the Budget Development Process

Government treasury and external assistance are the major sources of funding for the Government health system. In accordance with the 1997 Financial Regulations, all funding from the two major sources of funding should be included in the Consolidated Budget and drawn through appropriations to the health sector provided by the House of Peoples' Representatives. Adequate financing of the HSDP therefore depends on its proper integration into the budgetary process, and the strength of the budgetary process. During HSDP implementation, limitations have been observed in both areas.

HSDP and the budget

Although the HSDP has been developed as the key planning mechanism for Government interventions in the health sector, it was formulated without a proper projection of available resources. Also, the HSDP does not take into account the normal structure of the Government budget. Therefore, differences are observed in the structure of the HSDP and the budget's chart of accounts. The budget chart of accounts follows cost centers, which are accountable for a certain blocks of money. This, however, is not the case for the HSDP. For example, the HSDP does not include general administration as part of its budgetary projections and several budget categories (e.g., the pharmaceuticals component of the HSDP) cut across several budget categories. In general, it has been difficult to translate the HSDP plans into annual budgets to ensure the funding of the Programme according to its priority activities.

The budget process

A review by the Civil Service Reform Programme has identified *inter alia* the following two key weaknesses of the budget development process that are of importance to the funding of the HSDP. [15]

1. *Separation of the capital and recurrent budgets.* Separate institutions prepare the capital and recurrent budgets.[16] This has hindered the development of budgets that adequately balance capital and recurrent expenditures. Moreover, certain practices favor the capital over the recurrent budget: (i) the ceiling of the capital budget is flexible, while that of the recurrent budget is rigid; (ii) budgeting of the externally financed portion of the capital budget is lax; (iii) non-wage recurrent expenditures tend to be grossly under-financed and are not appreciated to be complementary and ensure sustainability of capital expenditure.

[15] The Government of Ethiopia launched a broad Civil Service Reform Programme in 1996 with five components: (i) expenditure management and control, which *inter alia* seeks to improve the budget development and administration process. (ii) human resource management, (iii) service delivery, (iv) top management systems; and (v) issues of ethics.

[16] Recently, the Ministries of Finance and Economic Development & Cooperation have been merged. It is also expected that the Regional institutional structure will follow suit and the Bureaus of Finance and Planning & Economic Development may also be merged. The capital and recurrent budgets will therefore be developed by one institution. It is, however, as yet unclear whether the processes for the development and approval of the capital and recurrent budgets will be unified.

2. *Lack of systematic incorporation of external resources into the government budget.* This has resulted in an overall budget that is both uncertain and incomplete.
    - Considerable off budget financing of capital expenditures exist as many donors provide resources directly to government projects/programmes, by-passing the budget development process. Even when a project is listed in the budget, disbursement may be outside the levels provided for.
    - The availability of external assistance and loans is often not well known. Even after an agreement has been signed with the responsible Government Ministry, the annual flow of external funds is not accurately projected.

These weaknesses are reflected in the financing of the HSDP. The budget for health is developed in three separate processes. Initially, budget requests consider capital and recurrent expenditures in unison and do not differentiate between sources of funding. However, approvals are provided separately for the recurrent budget, the capital budget financed through treasury resources; and, the capital budget financed through loans and/or external assistance.

Sub-programmes for externally funded expenditures are developed by the Regional Health Bureau (RHB) on the basis of ceilings and earmarks passed down from the Ministry of Economic Development and Cooperation now the Ministry of Finance and Economic Development (MOFED), and requests received from the Zonal Health Departments and adopted by the Regional Council in its capital budget with a matching fund allocation (if required by the donor/lender) from its own resources. According to the degree of fiscal decentralization within a region, the region's remaining resource envelope is either distributed as a ceiling to zones, with no determination of inter sectoral allocations (with some resources kept back for regional expenditures), or allocated between sectors. Regional councils and/or zonal administrations review budget requests. This review decides on cuts in budget requests by public spending agencies. In doing so, recurrent and capital budgets are considered separately. The capital budget for health is considered by HSDP component; expenditures approved in light of the region's entire investment portfolio. Allocations for recurrent expenditures look to past allocations and utilization levels, with little consideration to the budget norms and methods applied in the initial request. A similar process is followed at the federal level. The MOH prepares a capital and recurrent budget, which are reviewed and presented for approval separately.

As a result of these separate budget processes, cutbacks are determined almost entirely outside the HSDP planning framework. There is little room for relating annual budgets to HSDP outputs and objectives, which integrate all three segments of the budget discussed above. Also, there is little room for prioritizing intra-sectoral expenditures during shortages in funding, particularly between the different segments of the budget. The sector has an opportunity for redressing glaring gaps during budget hearings and, as a priority sector, often receives additional resources through supplementary budget allocations depending on performance. But there appears to be no systematic practice that is applied for relating the budget to the HSDP annual plans.

Funding for the HSDP has also been affected by problems relating to the flow of external funding. The Ethiopian Government operates on a one-year budget. It is therefore important that approval of the budget, including the sub-programmes for external funding.

is obtained at the outset of the fiscal year so that allocations may be utilized within the year and that planned activities are not slowed down due to delays in resource availability. Yet, this is often not the case. For example, approvals for the IDA sub-programmes have, to date, been obtained after the first quarter of the fiscal year. Moreover, cumbersome procedures that are unfamiliar to Government implementers and that involve many actors (whether in the case of procurement, construction or training) have caused significant delays in realizing funding even after resources have been made available. The result has been that the budget is not utilized and planned activities have been delayed, causing serious shortages within the health system. In several instances Regional Governments have had to canvass resources from other sources to cover the shortages. For example, in EFY 1992 many Regional Governments provided additional allocations for drug procurement in a supplementary budget to cover, albeit partially, the shortage resulting from delays in IDA drug procurements. The experience has been that realizing donor funds requires more than the twelve-month period of the budget cycle. *There is therefore a critical need to align donor programming with the budgetary process*. Since this is not done effectively, channel I resources figure in the budget repeatedly over several years but are under-utilized.[17] Channel II and III resources may figure in the budget in the year when the assistance is initiated, but are often under-utilized. When the activity is finally realized, it is off budget. Suggestions for addressing constraints discussed above are found in the action plan developed for implementation of the HCF Strategy.[18]

3.2 Mobilizing Additional Sources of Funding

Health service provision in Ethiopia is based on cost sharing between the service provider (whether Government, NGO or the private sector) and the receiver of services, with waivers and exemptions provided for selected services and sections of the population in the Government and NGO sub-sectors. In the existing Government health system, such cost sharing does not represent an additional source of funding for health care delivery, as almost all revenues generated by health facilities are transferred to the Government treasury. Yet, resources from cost sharing (i.e., revenues generated from user fees, sale of drugs and medical supplies, and/or community contributions) are an important source of additional funding for the sector. The PAP projects that about 2% of total HSDP expenditures should be covered through user fees. Other estimates suggest that resources from cost recovery could contribute over 70% of the current recurrent costs allocated to Government health facilities.[19] Given that cost sharing is a significant source of additional funding, the HCF Strategy introduces the concept of the "Health Facility Revenue", which will be:

- additional to the government budget,
- retained and used by the health facility that generates it,
- deposited in a special account opened by the respective health facilities.
- used to improve the quality and quantity of health services; and,
- subjected to appropriate control and audit by authorized government bodies as per the new financial regulation.[20]

[17] Donors use three methods (channels) to provide aid to Ethiopia:
Channel 1: funds flow through the Ministry of Finance and are accounted for through to the Government's regular financial systems. The assistance may be provided under several arrangements, including special donor accounts, counter part fund accounts, joint signatory accounts or as re-imbursement for expenditures already undertaken.
Channel 2: funds are provided directly to sector ministries or regional sector bureaus.
Channel 3: funds are disbursed to a contractor of the donor agency who is responsible for administering the assistance. Thus the beneficiary institutions receive aid-in-kind.

[18] ESHE/JSI Health Finance Team, Health Care Financing in Ethiopia, Implementation Status – Future Action. Addis Ababa. June. 2001

[19] FDRE/MOH, The Health Care and Finance Strategy, Op. Cit.

[20] Ibid.

However, making such resources available to the health sector requires legislative action to establish a Health Fund, as the Financial Regulation of 1997 does not allow for the retention of revenues by health facilities. Rather, funding for Government health service delivery is provided almost entirely by budget appropriations from the Government's Consolidated Fund. Following the legislation, if a Health Fund is approved, guidelines on the management and use of the fund will also need to be developed. In addition, appropriate management and accounting systems for better accountability on the use of the funds need to be introduced, and fee structures periodically reviewed to ensure that appropriate fee levels are maintained. The HSDP is now in its final year of implementation and although mobilizing resources for the sector was a central concern of the programme, *decision on retention of health facility revenues is still outstanding*. Consequently, significant resources have been lost to the sector. It has been argued above that the HSDP's dual goals of sectoral expansion and quality improvements can only met through ensuring a growing resource base if expansion is not to compromise quality. The rate of expansion actually achieved during HSDP implementation took place without a commensurate increase in the flow of resources to the sector, and was thus not accompanied by improvements in quality. Retention of revenues would have improved the capacity of Government health facilities to maintain better quality in the delivery of health services as sectoral expansion was accelerated under the HSDP.

Revising the Payment Scheme for Government Health Services

One of the avenues that HSDP is considering to increase resources to the sector is revising user fees. The current user fee structures have serious limitations. Fee structures for Government health services have not been systematically revised in the past 50 years. Given inflation, more complex health treatments introduced with technological developments, and expansion of the health system into new areas, it is believed that current user fees are both low and uneven among facilities, especially at the tertiary level. Similarly, the price mark-up on drugs and medical supplies sold by Government outlets has been kept low to ensure affordability of such goods to the general population. Additionally, there has been a rising trend in the number of patients treated at no cost. Clearly, the system of exemptions as well as fee structures need to be reviewed and revised in order to enhance the financial sustainability of the Government health system. However, increases in user fees and drug prices can have a negative impact on utilization of health services (this assumes, of course, that resulting revenues will be retained). Thus, a step-by-step approach has been adopted to implement this important reform. The first step being to undertake studies to (i) assess the potential impact of increased user fees on utilization of health services, (ii) project potential revenues from changes in user fees; and, (iii) develop alternative modalities for waivers and exemptions.

Accordingly, over the past year, two studies have been undertaken: *'Estimating Willingness to Pay for Medical Care in Ethiopia: Research Results and Analysis'* and *'Improving the Quality of Services and Adjusting User Fees at Ethiopian Government Health Facilities'*.[21] The studies conclude that a significant proportion of present users of Government health services are willing to pay higher fees for better quality of health care. Indeed, better quality of services is likely to result in increased utilization, even with higher user fees if

[21] Ministry of Health, Estimating Willingness to Pay for Medical Care in Ethiopia: Research Results and Analysis, Addis Ababa, July 2001
Alan Fiarbank, Improving the Quality of Services and Adjusting User Fees at Ethiopian Government Health Facilities, Addis Ababa, November 2001

implemented in a systematic manner. The studies furthermore indicate that improved quality is perceived as increased availability of drugs, better diagnostic services, reduced waiting time and greater attention from health professionals. It is also suggested that, at present levels of utilization, a significant increase in user fees (e.g., doubling of fees) would still yield only a marginal increase in health facility revenue; and, given the present exemption system, increasing user fees will have a limited impact on revenues generated. Two reform measures must therefore precede the revision of user fees:

- Legitimizing and implementing retention of health facility revenue (or significant increases in recurrent budget allocation per health facility) to allow increased resources for improvements in quality of services provided.

- Revision of the waiver and exemption system formulated by fully addressing the issue of equity through better targeting free services to public health services and to those that cannot afford to pay for services.[22]

Such reforms must also be supported by capacity building to strengthen management and financial practices, both for efficiency in service delivery and improvements in quality of care as well as for greater financial accountability at the health facility level that would be necessitated by the increased financial autonomy resulting from retention.

Health facility revenues represent a significant potential source of revenue for the Government health system. Because such revenues are generated at the facility level, and if retained at source, they fill an important resource gap by increasing funding for facilities' recurrent expenditures that have been shown to be declining. Progress on the introduction of a Health Fund, revision of the waiver and exemption system, and associated capacity building (including the introduction of new management systems) has, however, been slow

[22] A study to review the present waiver and exemption systems as well as to recommend alternative modalities is expected to be undertaken during the first quarter of 2002.

4. The Health Care Financing Component

The health care financing component has been developed to ensure that the programme includes specific actions by the Government to guarantee financial sustainability. The actions identified revolve around a series of background studies that would allow an informed reform process to enable a greater flow of resources to the sector. Reforms considered include (i) increase in user fees, (ii) retention of facility revenue piloted through revolving drug funds (iii) promotion of various forms of risk pooling mechanisms and social financing; and (iv) encouragement of private sector/NGO participation in health service delivery. Several studies have been undertaken in this respect some of which have already been discussed in previous sections.

Increase in user fees

- Estimating Willingness to Pay for Medical Care in Ethiopia: Research Results and Analysis
- Improving the Quality of Services and Adjusting User Fees at Ethiopian Government Health Facilities
- Survey of Fees for Different Services in Public Facilities.
- Exemption and Waiver System Study (planned for first quarter of 2002)

Retention and revolving drug funds

- Assessment of Revolving Drug Funds in Ethiopia
- The Policy of Retention and its Implementation in SNNPR: The Experience of Government Hospitals
- National Drug Use Baseline Study (on-going)

Risk pooling

- Health Insurance and Prepayment: Principles. Concepts and Features in Developing Countries, Prospects for Ethiopia
- Feasibility of Pre-payment Schemes in Two Pilot Areas (planned for first quarter of 2002)

Private/NGO participation in health service delivery

- Assessment of MOH Guidelines for Private Clinics
- Constraints and Opportunities for Private Participation in Health Care in Ethiopia
- Ethiopian Health Sector Delineation Study
- Private Health Expenditure Review
- Ethiopia: Contracting Government Services in the Health Sector
- Private Sector Participation in Health (on-going)
- Creating a Collaborative Environment between the Government and NGOs in the Health Sector (on-going)
- Proposal for Public-Private Mix in St. Paul Specialized General Hospital

The above studies were undertaken in the context of the HCF Strategy. Following from the studies, an action plan has been developed elaborating the major issues to be addressed in

relation to all areas of reform incorporated in the Strategy, and identifying actions for moving ahead with its implementation. In addition to the studies, a concerted effort has been made to introduce the HCF Strategy and its major principles to various stakeholders active in the health sector, particularly at the regional level. Furthermore, institutional arrangements are being created at the federal and regional levels to support the initiatives incorporated in the Strategy. Finally, there are scattered initiatives to reform health sector financing in several regions, particularly in the area of retention and user fee revisions. For example, the SNNPR has allowed hospitals to retain 50% of collected fees. A review of the experience found that procedures for retaining revenues were overly cumbersome and, as a consequence, many hospitals were either unable to use such resources or, where revenues were made available, they were used to replace budget allocations (e.g. for the purchase of drugs when IDA drug procurements were delayed). The initiative has triggered dialogue on the issue of retention between the RHB/ZHDs, Regional/Zonal Finance Bureaus or Departments, health facility managers, and the Regional Council. It is expected that modalities for retention of facility revenues, whereby such revenues will be additive to health facilities' budgets and effectively used for quality improvements, may be developed and tested in the SNNPR. Such modalities may then be applied for the implementation of the Health Fund when and if the Health Fund is approved.

Other initiatives include a number of regions that have surveyed the fee structure and presented proposal for revisions, either to the Regional Council or to the MOH for comments. Some regions have unified the fee levels of the facilities in the respective regions and have initiated cost studies of various services. However, the most important pilots for retention are the special pharmacies, whereby revolving drug funds are established and the income from the sale of drugs is used for the purchase of drugs and for other expenditures that are deemed essential to improve quality of services provided by the health facility. Results from the existing cases are encouraging. Significant increases have been observed in the availability of drugs and medical supplies, including anesthetics for running of surgical services and emergency drugs that are often not readily available at government facilities. Given such results, the MOH and RHBs are expanding special pharmacies in government hospitals and health centers through out the country with support from USAID and other donors. As part of this initiative, an initial package of drugs is to be provided to facilities. National guidelines have been developed, based on the experience of regions, to effectively manage special pharmacies. Technical assistance and training on drug management will be provided to facilities where special pharmacies are introduced, and mechanisms are being developed to monitor special pharmacies and to evaluate their impact on service delivery. It is expected that drug availability within the Government health system will improve significantly as a result of this initiative.

5. Conclusions

The HSDP identified sectoral financing as a key area of Government concern for the health sector over the period 1998 to 2002. However, during the design of the Programme, the Government's HCF Strategy was still under development. Therefore, the Government's action in this regard was not fully articulated as part of the HSDP. Moreover, even though the HCF Strategy was endorsed soon after the HSDP and a HCF Task Force was established in 1998, [23] a considerable lag occurred in initiating the implementation of the Strategy. An *ad hoc* Secretariat for the Task Force was established only in 2000, when the MOH assigned a HCF Focal Person to work full time on health care financing issues. In addition to the focal person, a team of experts (from various departments of the Ministry, the Drugs Administration & Control Authority and the administrator of ALERT hospital) have been functioning as the HCF Secretariat. This Secretariat, with support from the ESHE/JSI Project, has been working in the past two years to regain the momentum lost during the period of inactivity. In this respect, a series of sensitization workshops, to familiarize major stakeholders at both the federal and regional levels with the HCF Strategy, have been held. Background studies to inform a process of reform, necessary to improve financing to the health sector, have been undertaken.

Thus, addressing issues of financial sustainability have come off to a late start. The first five-year period of the HSDP is now in its final year of implementation and, with respect to health care financing, the first phase of the Programme only achieved a better understanding and articulation of the issue. Significant measures have been taken in the analysis of issues, articulation of challenges, and identification of next steps. There is a need however, for such efforts to be complemented by policy decision so that the reform process can move from an analysis stage to implementation and/or piloting of reforms. Clearly reforms are necessary if financial sustainability is to be achieved. Such reforms are still under discussion within the MOH. It is, however, expected that as a second phase of the HSDP is designed, action towards implementing reforms will be included in the Programme. Financial sustainability will depend on the extent to which reform measures identified in the action plan for implementation of the HCF Strategy will be incorporated into the second phase of the HSDP, and carried through during its implementation.

Implementation of health care financing reforms will need to be supported by continued policy analysis related to resource mobilization, allocation and efficient use. Since most related activities are new initiatives, their impact requires close follow-up and monitoring. Moreover, guidelines and regulations to support reforms will need to be developed, etc. Greater attention must be given to the institutionalizing of analytical support functions for the implementation of the HCF Strategy and other reforms associated with the HSDP. It is therefore proposed that a Health Economics and Policy Unit be established within the MOH to serve as an advisory and technical body on issues related to health finance.

[23] The organizational set up for implementing the HCF Strategy as provided in the strategy document requires the establishment of a central body responsible, the HCF Task Force, for policy development and overall monitoring of the implementation process. The Task Force includes 21 members with the Vice-Minister of MOH as chairperson and the following members: RHB heads, MOF budget department head, MOH's Drugs Administration & Control department head, the MOH's Women's Affairs department head, MOH/PPD head, MOH/HSTD head, a representative from the Ministry of Labor and Social Affairs, a representative from MEDAC, a representatives for NGOs and a representative for the private sector, a representative from organized health service consumer groups (if any). The HCF Strategy also requires that the Task Force have a Secretariat supported by four experts and a secretary.