PN-ACR-165

Trip Report #1

Ethiopia's Health Care Financing Experience: Report on the Status of the Implementation of the Health Care Financing Strategy

October 2000

Prepared by:

Health Care Financing Secretariat,
Ministry of Health

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 subcontractor 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

Federal Ministry of Health, HCF Secretariat. 2000. *Ethiopia's Health Care Financing Experience : Report on the Status of the Implementation of the Health Care Financing Strategy,* 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 eshehcf@telecom.net.et.

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 Copperzione 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

Executive Summary

The health care financing secretariat (HCFS) and the IR1 team of the Essential Service for Health in Ethiopia (ESHE) project conducted visits to five regions (Amhara, Oromiya, SNNPR, Harare and Tigrai) 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 the 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 the 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.. 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 to 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* with varying degrees of arrangements and performance *in almost all regions*. 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 anticipated. It is the belief of the visiting team that most of the piloting is already done by the regions, sometimes in their own special way. It is therefore more fruitful for the national level implementation to synthesize the best practices and scale up the intervention rather 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 patients 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.*[1]

These statements hold true at present. There is no systematic revision of the user fee structure to date. 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 with due emphasis on protecting those with not able to pay for services is something that should be implemented. however.

Some regions have done detailed studies 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 the 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 the higher level.
- In the Dire Dawa administrative council, a committee was formed to assess the experience of other regions and come up with a proposal for the administrative council. The committee submitted its proposal a year ago.
- RHB of Tigrai 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 samples of existing fee structures from different regions and levels (regional hospital, zonal hospital, health center). Considering the sensitivity of the issue and the impact that revision may have on utilization given the low 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

[1] 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.

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 structures. 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 it is easy for every one to come with the poverty certificate. As a result, in some facilities the rate of free patients reaches up to 95%. This is contrary to the intents of the Strategy as it clearly states that '... *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 together with fees for health care services while others are getting free services though they are able to pay. There should be some way to solve this problem by making those certificate providers accountable for their decisions. For example, include credit services by facilities and budget allocation for free patients every year under the municipality so that proper screening will be in place to determine who is poor and who is not.

The MOH has submitted a research proposal on *'Exemptions and waiver mechanisms that ensure equitable access to health care by the poor and vulnerable in Ethiopia'* to WHO for financing. The results of this study may 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 underlying 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:[2]

- All the income generated by health facilities from various income-generating activities (user fees, RDFs, private and community/employer based risk sharing

[2]Ministry of Health, Health Care and Financing Strategy, 1998, item 3.11

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:[3]

- There shall be one consolidated fund into which all public money shall be paid except 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 between the Strategy and the financial proclamation as a major obstacle to cost recovery.

[3] Proclamation No. 57/1996

Nevertheless, the SNNPR has introduced retention at the hospital level this fiscal year (1992 EC). All hospitals in the region are allowed to retain 50% of the revenue collected at the 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.[4]

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

The majority of regions have already introduced 100% retention at facility level in one very important area. This is in pharmaceuticals and it is done through the establishment of Special Pharmacies (SPs) at health facility level.

5. Special Pharmacies

Establishing and expanding Special Pharmacies through the impact of ensuring availability 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, the pharmacy technician's license is used. For the license of the pharmacist or pharmacy technician, a specified sum is usually paid on a monthly base. 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 on 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; Tigrai has adopted a regional guideline). Likewise, the HCFS and ESHE project

[4] 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.

are working on a model national SP guideline that could be adopted and modified to the situation of any particular region.

Generally, a 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 that oversees the function of the technical committee, 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)
- Pharmacist/pharmacy technician
- RHB/ZHD/WorHD representative
- Accountant of the facility

In all facilities, the SP functions are parallel to the budget pharmacy[5]. The SP is peculiar from the other by the following aspects:

- 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 incentives to staff, to improve the facility (equipment, building, ambulance...).

The functioning of SPs is encouraging and needs to be scaled up to increase impact. This however does not mean that operations are all in all smooth. There are challenges and problems facing Special Pharmacies that need to be worked on in order to ensure sustainability. The most important ones include:

1. The inconsistency between the financial proclamation and the Strategy needs to be overcome. In some cases, 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.

[5] 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 drugs 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.

2. The procurement guidelines need to be unified to enable health facilities undertake cost-effective procurement and have standardized management system. 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 strengthening of capacity in financial management, need to 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. In addition, 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 act as a springboard to the required financial autonomy (financial reform) of health facilities.

3. It will strengthen cost sharing principles in the health sector.

4. It will facilitate future revision of user fees, which currently is the government priority, through improving the quality of care at facility level. The surplus from SPs could be used to improve quality[6]. In effect it will contribute towards the revision and expansion of user fee charges that has not been revised for the last five decades..

To explore these potential advantages at present the HCFS and the ESHE Project have submitted a project proposal for financing[7]. The Special Pharmacy Project (SPP) aims to

[6] 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.

[7] Copies of the Special Pharmacy Project proposal can be obtained from the HCFS or the IR1 team of the ESHE project.

scale up SPs intervention through out regions 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 and the relatively harder management requirements of such schemes, 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 fledge health insurance, particularly in the urban areas. To introduce and develop health insurance at a reasonable speed, there is presently an urgent need for undertaking 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.

8. Facility Budgets: The Component of Increased Resources to the Sector

As one component of the strategy, the visiting team raised the issue of facility budgets and discussed with government officials at all levels. 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 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,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 as main constraints for the effectiveness of health care 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 the operations research proposal and search ways of funding such a project.

4. **User Fee Revision**: it recommended to selectively raise user fees only after the establishment of HFR and improvement of quality of service through the SP's in order to make sure that such reforms will not have 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**: new mechanism for screening and issue of certificates for service without fees for those with no ability to pay should be set

up in parallel with the increase 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.

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 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.

1. Background

In 1998, the Council of Ministers of the Federal Democratic Republic of Ethiopia adopted the Health Care Financing Strategy (the Strategy)[8] proposed by the Ministry of Health (MOH). The overall responsibility for the implementation of the Strategy was vested with a National Task Force, chaired by the Vice-Minister of Health. The day-to-day duties and the development of implementation guidelines for the Strategy were to be carried out by a Health Care Financing Secretariat (HCFS) in MOH.

The HCFS started to become operational during the first half of 2000. It is supported by technical assistance from the Essential Services for Health in Ethiopia (ESHE) project. In line with the current priorities of the MOH, the Secretariat and IR1 team of the ESHE project are working on the cost recovery component of the Strategy.

The field visit was conducted in five regions (Amhara, Oromiya, SNNPR, Harare and Tigrai) and the two administrative councils (Addis Ababa and Dire Dawa) during the months of June and October 2000. The visit was generally targeted at learning experiences of regions in implementing the Strategy and to identify possible sites for pilot testing of guidelines. The team[9] discussed issues related to HCF with regional officials at different levels (7 RHBs and 9 ZHDs) and health professionals at facilities (12 hospitals and 7 health centers).

The report starts with the section *Executive Summary*, preceding this *Background* note. The *Executive Summary* is based on a thematic structure according to the components of the Strategy. The following sections of the report are divided according to the visited places and facilities.

For readers who would be content by a review of the policy issues and the recommendation on the implementation of the Strategy, the *Executive Summary* should be sufficient reading.

As the reader will observe, the report that was originally started as a trip report, has turned into a general report on the implementation of the Strategy and on important factors in the environment for the implementation. The ESHE project would like to thank all the people for their cooperation and support. We are hoping that all these people will read this report and give us feedback in the form of comments and ideas for future action.

[8] Health Care Financing Strategy, MOH, 1998.

[9] The team has consisted of Ato Hailemichael Manore (June), succeeded by Dr. Yohannes Kebede (October) and Dr. Jan Valdelin, Health Care Finance Advisor and Ato Netsanet Walelign, Health Care Finance Specialist, both of the ESHE project.

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 the 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 for 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 the 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 seems to provide a large room for leakage to the non poor and need to be revisited.
- 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 that we visit two zones in the region: East Shoa and Asella.

3.1. East Shoa Zone

The zone is fully oriented and is trying to partially implement the Strategy. In a general, 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 motivate the zone to establish Special Pharmacies were:

- need for creating easy access to drugs for patients;
- to fill the short fall of the drug budget in the budget pharmacy;
- to provide 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, the source of which is comprised of Birr – 100,000 Birr provided as a loan from the hospital, and 48,000 Birr worth of drugs

obtained 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: lack of 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 Zonal hospital, 10 health centers, and 103 health stations. More than 60% of patients come with a 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 relations between the zone health department and the hospital. The presence of Istituto per la Copperzione 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 like 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.
-
- 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 and with consistency in the hospital,
2. To extend the working hours of the medical services in the hospital by staying opened 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 an ambulance vehicle and tanker car in order to get additional income that could motivate the employees, buy service buses, which could give transport services to employees and to pay overtime payment for employees.
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 is 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 308,000 people, has one hospital, two health centers and six health stations run by the administrative council's health office. Unlike other regions 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.

Dil Chora hospital was considered as a case and discussed in detail issues related to financing with the M/Director and the administrator. 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 a 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. The 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 has a shortage of life saving drugs and requested a 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 a military and another is a police hospital. There is also 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 the 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 been tripled by the time of the visit. 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, on the average, once in a month by the pharmacist. The procedure is to collect a 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. There is 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 the 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 the facility level, the license should be by a 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) is needed.

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	Chairman
WorHO representative	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 casher/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 each card, which includes consultation. There are no free patients 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	"

There are five staff members and they are paid monthly (druggist 350 Birr, dispenser 80 Birr, cash collector 100 Birr, store man Birr 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	13.3	27.2	10.5
Pharmaceuticals	67.8	19.9	*	
Total	340.9	100.0	259.2	100.0

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

The 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% is retained, how is the revenue used? What about equity, i.e. facilities have different revenue raising capacities? 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 a period 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 a pharmacy technician, store man/health assistance, dispenser/health assistance, cash collector and an 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		
Total	2,324	100.0	1,560	100.0

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

The 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 the 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 services 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 members: 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 implications 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 a pharmacist's license, the zone uses two health centers as a 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, there is a 10% mark up from the purchase price and with retailers there is a 25% mark up. Other facilities will then add a 15% mark up when 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 an initial capital of almost 100,000 Birr obtained from Irish Aid in three rounds. It is distributed 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 because there are not any administrative staff in the HCs. It is completely managed by the WorHO. But that is not reason enough. This practice is not in line with the present move towards financial autonomy.

Embdeber 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 not a pharmacist in the HC. It sells at 25% mark up to patients from the purchased price (or 15% mark up from the wholesale price of Wolkete HC). Customers are complaining that the price is expensive. So far, four rounds of 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 in the infancy stage.

Like most other regions, there is progress in the establishment of Special Pharmacies[10]. Special Pharmacies were started seven years back. Today they exist in all the hospitals[11] 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. There is no single pharmacist in the region. Licensing by pharmacy technicians 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 gives 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 movement.

At present retention of revenue is not practiced outside the retail pharmacies. The 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 onto 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.

[10] There are also two retail pharmacies by Red Cross (Mekelle and Adigrat).

[11] There are 11 hospitals in the region (4 zonal and 7 district). One specialized hospital is under construction.

Mekelle Hospital

It is the only hospital in Mekelle with 220 beds. The daily patient load (including emergency) is about 150. The free patient proportion is about 85%. The hospital encounters difficulty because of low budget allocations 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 calls, etc. The comparison of 1991 and 1992 budget allocations for the hospital is given below.

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
Total	3097	100.0	2409	100.0

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[12]. The profit margin is 25%, revenue collection by separate receipt and deposited in a 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 350 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

[12] Previously it had its own guideline.

Amba private supplier. It provides services 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 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 staff members of the HC receive incentives 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 use the same store and store keeper. Sometimes when the SDS is out of stock it borrows from the budget pharmacy.

8.1. Eastern Tigrai 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 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 the Red Cross and local NGOs are assisting the displaced, there is a need for some help of the public facilities that has an 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 budget shortage including 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. It uses separate receipts and the sales revenues are deposited in a separate bank account. The profit margin is 25%. Procurement is from Mekelle, Pharmid and Amba private supplier, since there is 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	member
Administrator	"
Two staff	"

Incentives are 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
- Casher of HC
- Accountant of WorHO.

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

Sales revenues are 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[13]. 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[14]. 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 more 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

[13] This estimate probably include drugs provided by donor grants, but not the volume of illegally imported drugs.

[14] 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.

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, 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 interlocutors: 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	Pharmacist, South Gondar Zone Health Department;
26.	Dr. Bari Neberi	Acting M/Director, Deber Tabor Hospital;
27.	Ato Aragaw Tezazu	Head, Finance and Administration, Deber Tabor Hospital; and
28.	Ato Tesfaye Melaku	Dispenser and Cash Collector, Deber Tabor Hospital SP

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	Head, Finance and Administration, Cheko Health Center
35.	Ato Girma Kassa	Head, Technique division;
36.	Ato Hail Giorgis Abate	Head, Wolaita Sodo Health Center;
37.	Ato Mohammed Feleke Initiative Pharmacy;	Druggist, Wolaita Sodo Health Center, Bamako
38.	Dr. Kelemu Desta	M/Director, Wolaita Sodo Hospital;
39.	Ato Dagnachew Mersha	Pharmacy Technician, Woliata Sodo Hospital, SP;
40.	W/o Asegedech Ayano	Accountant, Wolaita Sodo Hospital;

41.	Dr. Endrias Linchamo	M/Director, Hossana Hospital;
42.	Ato Leggesse Genorie	Head, Finance and Administration, Hossana Hospital;
43.	Dr. Abdulselam Kelil Health Department;	Team Leader, Health Service Team, Gurage Zone
44.	Dr. Abdulsmed Sabir	Head, Wolkete Health Center;
45.	W/t Lemelem Adane	Pharmacy Tecnician, Wolkete Health Center;
46.	Dr. Abebayehu 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 Tigrai ZHD;	Head, Health Service and Training Division, Eastern
60.	Dr. Amanuel Gessesu	M/Director, Adigrat Hospital;
61.	Ato Mulu Atsbeha	Head, Adigrat Woreda Health Office;
62.	Ato Abdul Wassie Woreda Health Office;	Head, Health Service and Training Section, Adigrat

Public and private companies

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