



HSFR/HFG Project Activities and Results Summary

August 2013 through December 2016

The USAID-funded Health Sector Financing Reform/Health Finance and Governance project (HSFR/HFG) has been the lead partner supporting the Government of Ethiopia (GoE) to roll out and implement its wide range of health care financing (HCF) reforms at the national, regional, woreda (district), and health facility levels. These reforms include:

- ◆ Introducing and expanding health insurance;
- ◆ Improving revenue retention and utilization (RRU) and the quality of services at health facilities;
- ◆ Improving the fee waiver system and standardizing the exemption system to protect the poor;
- ◆ Strengthening health facility autonomy through the establishment and operationalization of health facility governing boards; and
- ◆ Outsourcing non-clinical services and establishing private wings in public hospitals to create efficiencies and retain specialized doctors in public hospitals.

HSFR/HFG has provided technical and financial assistance to the Federal Ministry of Health (FMOH), regional health bureaus (RHB), the Ethiopian Health Insurance Agency (EHIA), woreda health offices, and health facilities.

The overall goal of HSFR/HFG project support in Ethiopia is increased utilization of health services. Program objectives are to:

- ◆ Improve the quality of health services;
- ◆ Improve access to health services;
- ◆ Improve governance of health insurance and health services; and
- ◆ Improve program learning.



In collaboration with the GoE, the HSFR/HFG project team has made a significant impact. Key activities and results include:

Trained health facility staff and local government officials on HCF reforms. The HSFR/HFG project has trained 1,035 health facility staff, woreda administration officials, and other officials on HCF reform implementation. Training topics included fundamental aspects of the GoE HCF reform strategy, and legal and implementation frameworks; and the HCF reform components.

Built capacity of hospitals and health centers to retain and use revenue for quality improvements, and manage revenues and expenditures responsibly. RRU is the HCF reform that allows health facilities to keep the fees they collect from patients, rather than remitting them to the Treasury, and use that revenue to improve the quality of services.

The HSFR/HFG project team provided technical support to facilities in defining key financial management positions, advocated for and facilitated filling these positions, and trained 2,696 health facility finance staff on HCF reforms, financial management, and development of RRU utilization plans and budgets. The team also supported regional governments in developing financial management manuals that harmonize with government financial management requirements and the HCF reforms. This capacity building has resulted in improved facility management and use of the government budget as well as in using retained revenue to provide quality health care services. Nearly 91% of health centers and 95% of hospitals across the country – 3,417 facilities – are successfully implementing the RRU reform. On average, the amount of internal revenue health facilities have collected has doubled for health centers and tripled for hospitals between 2011 and 2016. Retained revenue accounts for almost 28% of total health facility budgets in health centers and 30% in hospitals. This has allowed for improvements in infrastructure such as renovation and expansion of facilities; procurement of medical equipment, supplies, and medicine; made utilities available (electricity, water supply, and telephone services); and enhanced availability of specialist care on part-time or contract basis. It is also enhancing delivery of quality clinical services and health service utilization. To establish and institutionalize financial management systems, the HSFR/HFG team supported woreda health offices to recruit key finance and procurement personnel for health facilities and provided training on financial management in collaboration with RHBs and regional bureaus of finance and economic development. The project and government counterparts also conduct follow-up visits and mentoring to ensure application of what trainees learned.



Health facility staff in Benishangul-Gumuz participate in a financial management training session. HSFR/HFG has trained 2,696 facility finance staff on health care financing reforms, financial management, and the development of revenue retention and utilization plans and budgets. These efforts improve the quality of care and efficient management at Ethiopian hospitals and health centers.

Established governing boards at the facility level to increase capacity for decentralized decision-making. Allowing health facility autonomy through the introduction of health facility governance is a GoE reform area that contributes to proper and timely use of resources to improve the quality of care at health facilities in a more transparent and accountable manner. The HSFR/HFG project contributed to strengthening Ethiopian health facility governance structures by supporting the establishment of facility governing boards. The team provided training in HCF reform for health facility governance board members and health facility management committees. Of all functioning health facilities in Ethiopia, 3,223 health centers (92%) and 234 hospitals (95%) now have boards actively involved in providing overall direction and oversight of health facilities. By strengthening governing boards, the HSFR/HFG team fostered greater autonomy and decentralization of facility-level planning, management, and decision-making, resulting in more local input and control over resources. It also ensured that health centers and hospitals used budget allocations and retained revenue to respond to client needs to provide the best patient care possible in accordance with standards and guidelines.

Institutionalized health insurance in Ethiopia. The HSFR/HFG project provided technical support to the GoE to establish and strengthen capacity of EHIA, thereby institutionalizing health insurance in Ethiopia. The project team provided assistance in designing the agency structure and functions and in developing legislation and operational frameworks to establish EHIA. The HSFR/HFG project team strengthened EHIA's institutional systems and capabilities to administer insurance programs, including providing assistance with developing job descriptions for EHIA staff, and in recruiting, hiring, and training EHIA staff in topics such as provider payment mechanisms and insurance scheme management so staff can carry out their roles and responsibilities. HSFR/HFG seconded five technical experts to EHIA headquarters and branch offices to address technical gaps in health insurance planning, programming, and communications. The project team also provided technical support to develop and refine insurance-related operational manuals and guides, and to conduct regular performance review meetings. With HSFR/HFG assistance, EHIA is assuming full responsibility for leading and operationalizing community-based health insurance (CBHI) and social health insurance (SHI).



Butajira Hospital in SNNPR and Debre Birhan Hospital in Amhara have used retained revenue to purchase maternal and newborn care equipment. The new sonogram machine at Butajira Hospital and the incubator purchased at Debre Birhan Hospital enable these facilities to better address maternal and newborn health care needs.



Community representatives in South Achefer woreda, Amhara region, perform a skit to raise awareness about CBHI. HSFR/HFG educates communities at the grassroots level about the CBHI program which helps encourage enrollment.

Expanded health insurance coverage through CBHI.

The GoE initiated CBHI to benefit Ethiopian citizens engaged in the informal sector. Under the HSFR bilateral project, the project provided technical support to the GoE in piloting CBHI in 13 woredas in Amhara, Oromia, SNNP, and Tigray from 2011-2013. The project evaluated the CBHI pilot program to assess the extent to which pilot schemes were achieving desired results in relation to enrollment, increased utilization of health services, improved quality of health services, better financial protection of households from catastrophic out-of-pocket expenses, and enhanced financial sustainability of schemes. Evaluation findings showed that health services utilization improved among CBHI enrolled members to almost double the national average, and CBHI members were 26% more likely to seek care at time of sickness compared to non-members. At 15% threshold of non-food expenditure, CBHI members were less likely to be impoverished due to health expenditure, 7% compared to 19% for non-members.

- ◆ Grounded in lessons learned during the pilot, the HSFR/HFG project team supported GoE efforts to design and implement a national CBHI program scale-up strategy targeting 80% of Ethiopia's population in the informal sector.
- ◆ CBHI program scale-up has used a phased approach – first in the aforementioned pilot woredas in Amhara, Oromia, SNNP, and Tigray regions, later expanded throughout those regions and more recently to Benishangul-Gumuz and Harari regions and Addis Ababa and Dire Dawa city administrations. HFG project technical assistance helped expand CBHI from 13 woredas to an additional 161 and later to 176 (350 woredas). Of these 350 woredas, 227 have established CBHI schemes and the remaining 123 are undertaking preparatory activities and are set to establish schemes in 2017.

As of December 2016, 11.3 million people have insurance coverage through CBHI. CBHI schemes have collected 388,902,114 birr (nearly US\$18 million) from contributions. The GoE has contributed an additional 186,469,026 birr (\$8.1 million) in the form of general and targeted subsidies.

- ◆ As part of its support of the CBHI program, the HSFR/HFG project team built the capacity of key stakeholders at all levels – federal, regional, woreda, health facility, and community – for successful implementation. HSFR/HFG trained 3,301 health facility staff on the CBHI directive, scheme contractual agreements, audits, reimbursement mechanisms, and provider payment mechanisms, and 15,564 federal, regional, zonal, and woreda officials on the CBHI program. HSFR/HFG also supported regional and zone-level CBHI review meetings at which performance such as enrollment, contribution collection, health service utilization, reimbursement of health facilities, indigent selection, and experience sharing takes place.

Provided supportive supervision on HCF reform and CBHI implementation. To monitor and support project implementation, HSFR/HFG conducted supportive supervision visits to over 2,071 health facilities (176 hospitals and 1,895 health centers) in eight regions and two city administrations. The HSFR/HFG project conducted most supportive supervision visits with the participation of government counterparts from different levels. Visits are aimed at providing on-the-spot technical support, collecting data on the overall progress and performance in implementing CBHI and HCF reforms, and identifying best practices and implementation challenges. Supportive supervision findings have been used to provide feedback at different levels and as input for periodic review of the health sector at different levels. It has also been serving as the main monitoring tool for HCF implementation. The HSFR/HFG project produces an annual synthesis report that consolidates supportive supervision data and includes key findings and recommendations. The FMOH and regional and woreda authorities use these reports regularly as data sources and to guide HCF reform implementation strategies and corrective actions. The HSFR/HFG project also participated in FMOH/RHB integrated supportive supervision visits in several regions, including Addis Ababa and federal hospitals, as part of an RHB-HSFR/HFG collaboration. The team visited zonal health departments, woreda health offices, hospitals, and health centers, and assessed the status of HCF reform implementation, identified strengths and bottlenecks, and recommended feasible solutions. The team also assessed government budget allocation and utilization, RRU, fee waiver and exempted health services, health facility governance structure, and financial management.



◆◆◆◆ A woman with a CBHI insurance card in hand seeks services at a health center. The government of Ethiopia is scaling up CBHI with support from the HSFR/HFG project. Technical assistance has helped expand CBHI from 13 to 350 woredas. Approximately 11.3 million people across the country have insurance coverage through CBHI.

Assisted with preparations to launch SHI. The HSFR/HFG project supported EHIA with preparations to launch its payroll-based SHI program for Ethiopian citizens working in the formal sector. The project provided assistance to develop the system for administering SHI, and implement a communication strategy to orient both employers and employees about procedures and benefits of SHI. Awareness-raising meetings with regional cabinet members and senior management of various sector offices to discuss the SHI legal framework and implementation steps were also conducted.

Raised health insurance awareness through media.

The HSFR/HFG project team held workshops on the concept and benefits of health insurance for journalists and other members of the media so that they had the knowledge and information needed to produce effective health insurance promotion programs. HSFR/HFG worked with EHIA on media campaigns to raise community and stakeholder awareness about health insurance programs. This led to the production and nationwide broadcasting of 13 television and 227 radio public service announcements with targeted messages that explained the CBHI and SHI initiatives and encouraged CBHI enrollment and membership renewal.

Establishing private wings in public hospitals.

Ethiopia's private wing HCF reform focuses on establishing private wings in public hospitals to improve retention of key clinical service providers in the public system, provide alternative choices for users of private hospital services, and generate additional revenue for hospitals. Fifty-four hospitals across all regions of the country have established private wings or rooms, and are generating revenue from patients who are willing to pay higher rates for health services with shorter waiting times than in the regular public wards. HSFR/HFG provided technical assistance to establish and implement the private wing reform. This included training hospital management and RHBs on concepts of and rationale for private wings, roles and responsibilities of different bodies (RHB, hospital board, and hospital management), preconditions needed to establish private wings (e.g., availability of rooms, willingness of hospital staff, and having a hospital governing board), and expected benefits and implementation challenges. Hospitals implementing this initiative have been able to increase revenues from patients who are willing and able to pay, and to retain physicians who are paid a percentage of the generated fees. To address some practical challenges related to staff assignments and the sharing of revenue between staff and health facilities as well as among different cadres of health professionals, with the technical support from HSFR/HFG and other key partners, the FMOH developed standard guidelines that are expected to be adapted and endorsed by regions.



Bishoftu Hospital used retained revenue for several facility improvements, including the construction of a new 80-bed wing. The expansion doubles the hospital's admission capacity, improves patient flow, and increases service utilization.

Outsourcing non-clinical services at public hospitals.

Outsourcing of non-clinical services allows hospital management and clinical staff to focus on their core business of delivering quality health care, while auxiliary services such as laundry, security, and catering are outsourced to specialized organizations. The HSFR/HFG project team developed protocols and detailed guidelines for outsourcing and provided technical assistance through regular supportive supervision. Seventy-one hospitals now use this contracting-out mechanism. Outsourcing has resulted in efficiency gains and resource saving, as hospital management can now focus more time and resources on the provision of clinical care and allow companies with a comparative advantage to manage select non-clinical services.

Supported generation and use of evidence in health financing decision-making through Health Accounts.

Health Accounts is a globally recognized health expenditure tracking framework used to measure the amount of health expenditures and resource flows in the health systems. Health Accounts findings provide evidence to gauge health sector performance, and provide information that can support accelerating investment in health and redirecting resources to priority health areas. The HSFR/HFG team provided technical support for Ethiopia's fifth and sixth round of Health Accounts. This included a household health expenditure survey and a survey of people living with HIV/AIDS to obtain evidence on where people go for their health care, why, and how much they spend. Health accounts findings have consistently been used to stimulate budget negotiation that enabled increase flow of resources to the health sector. Data from successive Health Accounts on the percentage of household expenditures going to health also provided the FMOH with solid evidence to support the design and introduction of both CBHI and SHI.

Institutionalized Health Accounts within the FMOH.

To support the GoE to institutionalize Health Accounts within the FMOH, the HSFR/HFG team worked with the FMOH to involve its technical staff in Health Accounts data collection, analysis, and report writing. HSFR/HFG engaged in dialogue and consultations with the FMOH, which led to the establishment of the Health Economics and Financing Analysis (HEFA) Unit under the FMOH Resource Mobilization Directorate, the latter tasked with Health Accounts, health resources tracking, and health financing analysis for policy use. The HEFA team is currently leading and coordinating the sixth round Health Accounts.

Increased financial risk protection for the poor by supporting fee waiver implementation.

A major goal of Ethiopia's HCF reforms has been to enhance the availability of basic services and ensure that financial barriers to access are minimized for the poor. This includes ensuring that the poorest of the poor have access to the full range of services offered through the public system. HSFR/HFG supported RHBs and woreda administrations to implement the fee waiver program with technical assistance, training, mentoring, and supportive supervision. In regions where standardization of the fee waiver system has been successfully accomplished (most notably, Amhara) access to health care services by the poor has substantially improved. With HSFR/HFG project support, more than 1.5 million households (representing approximately 7 million beneficiaries) have been certified to be fee waiver beneficiary households in the non-CBHI implementing woredas. Communities and kebele administrations identified beneficiary households as the neediest, and woreda authorities gave approval. Beneficiaries are entitled to access the entire package of preventive and curative services free of charge. Woreda administrations are setting aside resources to reimburse health facilities, based on the user fee rates, for providing services to fee waiver beneficiaries. Enabling kebele councils to identify and enroll poor households annually has helped to mitigate bias and favoritism in allocation of fee waiver benefits, and allowed those most in need to receive services when they seek care.

About HFG

A flagship project of USAID's Office of Health Systems, the Health Finance and Governance (HFG) Project supports its partners in low- and middle-income countries to strengthen the health finance and governance functions of their health systems, expanding access to life-saving health services. The HFG project is a six-year (2012-2018), \$209 million global health project. The project builds on the achievements of the Health Systems 20/20 project. To learn more, please visit www.hfgproject.org.

The HFG project is led by Abt Associates in collaboration with Avenir Health, Broad Branch Associates, Development Alternatives Inc., Johns Hopkins Bloomberg School of Public Health, Results for Development Institute, RTI International, and Training Resources Group, Inc.

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HSFR/HFG supports the Government of Ethiopia in implementing a range of health care financing reforms that are helping to increase access to quality health services across the country.



Standardized the package of exempted services. The GoE HCF strategy calls for regions to standardize a package of critical public health services provided free of charge to the entire population, including maternal services (ante- and postnatal care, delivery, etc.), immunization including children under-5, treatment of tuberculosis patients, and HIV/AIDS diagnosis and treatment services. Prior to the strategy, there was variation among facilities, leaving consumers unaware of what they would be charged for services, which often deterred care seeking. The HSFR/HFG project team assisted the GoE to standardize the package of exempted services, which has helped to enhance equity in access. When citizens are sure which services require payment and which are provided free of charge, they are more likely to use them. Health facilities are required to provide clear information on exempted services including posting the list in appropriate locations in health facilities. However, health facilities have expressed concern that exempted services are unfunded mandates. The HSFR/HFG project has generated evidence on the magnitude and the financial burden of providing exempted services, and facilitated dialogue between health facilities and government officials to increase the budget allocation for exempted services. Evidence generated with project support is also being used for standardization of the exempted services; that has allowed regions and woredas to plan and budget more accurately for service provision and hold facilities accountable for achieving coverage targets. Some regional governments are also reimbursing for drugs and other supplies consumed in the provision of exempted services.

Revised user fees. Ethiopian public health facilities have been collecting user fees for certain curative services for over half a century. However, like the package of exempted services, application of user fees was not standardized or transparent, nor did it reflect the actual costs of providing these services. HSFR/HFG facilitated user fee revision studies to inform regional-level discussions on setting of standard user fees; and costing exercises were conducted. An important aspect of this activity was the mandate that these fees be clearly posted in each facility to inform users of the financial liabilities associated with each service.