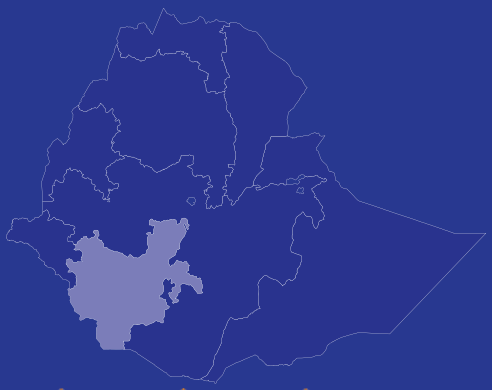
REGIONAL BRIEF



HSFR/HFG End of Project Achievement Highlights - SNNP

The USAID-funded HSFR/HFG project provides technical assistance to the Government of Ethiopia to implement and scale-up health care financing reforms across the country. The goal is to increase access to and utilization of health services through improved quality of health care and reduced financial barriers.

Project objectives are to:

- *Improve the quality of health services*
- *Improve access to health services*
- *Improve governance of health insurance and health services*
- *Improve program learning*

June 2018

THE REGIONAL CONTEXT

Southern Nations, Nationalities and People's (SNNP) region is one of nine regions in Ethiopia. It is located in the southwestern part of the country. It is divided into 15 administrative zones, 164 woredas (133 rural and 27 urban), four of which are special woredas. According to Ethiopian Central Statistical Agency projections, SNNP has a population of almost 20 million people, the majority of whom are farmers.

In 1998, the Federal Democratic Republic Government of Ethiopia approved a health care and financing strategy that calls for increasing financial resources available for the health sector. Following the strategy and the prototype Health Service Delivery and Administration (HSDA) proclamation developed by the federal government, the SNNP regional government put in place several legal frameworks, including: the SNNP Regional State Proclamation No. 84/2004, Regulation No. 46/2005, and the HSDA Directive, August 2010. These edicts provide clear operating procedures for health service delivery and administration. In addition, implementation guidelines were issued in 2006 and updated in 2007 to further elaborate the implementation procedures enumerated in the legal frameworks.

The regional proclamation and HSDA directive provided an opportunity to launch health care financing reforms and allowed for the establishment of health insurance with a specific focus on community-based health insurance (CBHI) at the woreda level.

ORGANIZATION OF THE REGIONAL HEALTH SYSTEM

In line with the national policy of devolving decision making to the local level, the Federal Ministry of Health and regional health bureaus (RHBs) focus mainly on policy, strategy, and technical support, while woreda health offices (WorHOs) manage and coordinate operations of the woreda health system under their jurisdiction.

With regard to health service delivery, the SNNP RHB introduced a three-tier health system adapted from that of the FMOH. Level one is the woreda health system, which comprises a primary hospital (for 60,000–100,000 people), health centers (for 15,000–25,000 population), and their satellite health posts (for 3,000–5,000 population). These facilities form a primary health care unit linked by a referral system. Level two is a general hospital serving 1–1.5 million people and level three is a specialized hospital with a catchment area population of 3.5–5 million people.

The SNNP regional government has given priority to the expansion of health facilities, especially those for primary health care. The region currently has 58 functional hospitals and an additional 27 are under construction. The number of health centers has reached 716. Through the accelerated expansion of health facilities and the overall transformation of the health system, potential access to primary health care has reached more than 95 percent.

Health System and Financing Challenges in the Region

As in other regions of the country, the health care system in SNNP has faced many challenges related to financing, including:

Poor facility governance: Prior to the introduction of health care finance reforms, health facilities were not able to make strategic decisions that have meaningful impact on their performance, because decisions were made higher up at the RHB and WorHO levels.

Low quality of services and low utilization rate: Due primarily to underfunding of the health sector, facilities were not able to provide good-quality services because they did not have the drugs, medical supplies, and diagnostic equipment required to provide such care. As a result, the health utilization rate in the region was very low.

Low financial management capacity: Because health facility workers were not properly trained in public financial management, facilities were not able to properly plan and budget, or effectively utilize their resources in line with public finance procedures. This also resulted in a weak auditing system, loose financial transaction record keeping, and delays in preparing financial reports.

Low-resourced health system: Before the introduction of health financing reforms, health was extremely underfunded, and there was significant reliance on government and donor funding. There was also no clear strategy to identify alternative forms of financing such as prepayment arrangements.

Adare Hospital used retained revenue to purchase medical equipment

MAJOR ACHIEVEMENTS

Revenue retention and utilization

This reform allows hospitals and health centers to collect and retain the revenue generated at the facility rather than remitting it to the government treasury, and to use this revenue to make improvements in the provision of quality health services. Revenue sources include consultation fees, sales of drugs and medical supplies, fees for diagnostics and impatient services, sale of used materials, cash and in-kind donations and revenue from research and training services.

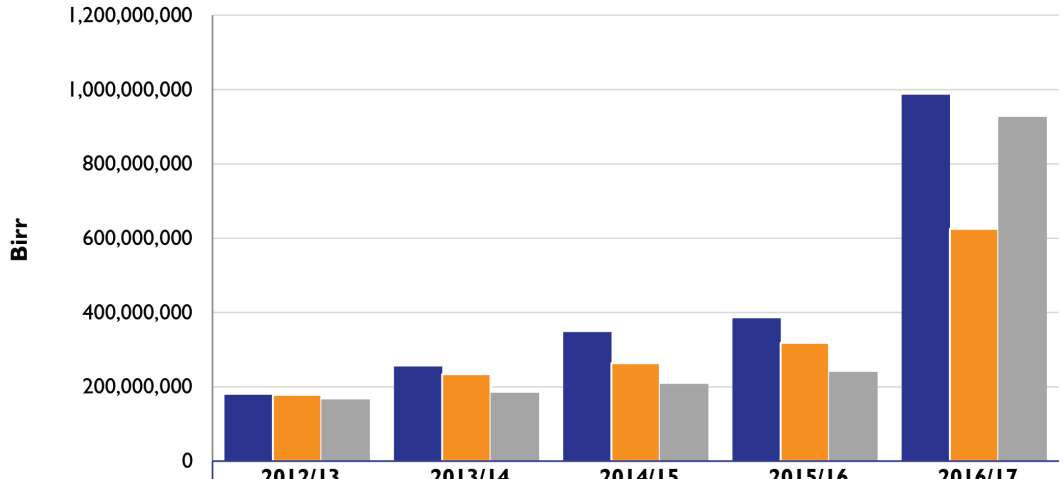
The technical support that the Health Sector Finance Reform/Health Finance and Governance (HSFR/HFG) project gave to local stakeholders in implementing this reform included: adaptation of the revenue retention and utilization (RRU) financial management manual to the regional context and training of key finance staff on the contents of the manual; technical assistance to health facilities and WorHOs in the RRU planning and budgeting process; and on-site technical support during supportive supervision visits. The number of health facilities implementing RRU increased from 676 at the beginning of HSFR/HFG in 2013 to 774 at project end in 2018. All health facilities in SNNP are now implementing this reform although there are differences in the magnitude of resources mobilized (retained) and in their utilization.

Figure 1 shows the total amount of birr retained allocated, and utilized by health facilities in SNNP over the last five years. The trend has been increasing amounts across all three of these RRU variables, particularly in 2016/17, when the amount of birr retained more than doubled and the amount utilized more than tripled. Although further research is required to know for sure, the revenue jump in 2016/17 might be because the number of hospitals increased in 2015/16, and new hospitals received medical equipment such as ultrasounds, x-rays, and chemistry machines, which increased the volume of services provided and therefore increased the revenue pool of each hospital. Health facilities have used retained revenue to improve the availability of drugs, medical supplies, and medical equipment; to maintain clean and safe compounds; and to improve health education and outreach services.

Health Facility Governance

The Ministry of Health's health facility governance reform allows for increased health facility autonomy through the establishment of governing bodies at health facilities to contribute to the proper and timely use of facility resources and respond to client needs. Called "governing boards" at hospitals and "management committees" at health centers, these governing bodies are mandated and authorized to ensure that facilities are fully implementing health care financing reforms, are offering the best patient care possible, and are functioning efficiently and effectively. This reform is

Figure 1. Revenue Retained, Allocated, and Utilized by Health Facilities in SNNP (birr)



	2012/13	2013/14	2014/15	2015/16	2016/17
Revenue Retained	178,419,077	254,496,087	346,951,300	384,119,594	985,963,755
RR budget allocated	178,389,077	234,014,425	263,482,151	318,408,229	624,983,453
RR budget utilized	165,972,770	183,911,338	207,825,321	240,076,540	926,195,384

RR=retained revenue

considered critical because its implementation impacts the proper implementation of the other reforms, including the retention and use of revenue collected at health facilities, which is intended to improve quality of services.

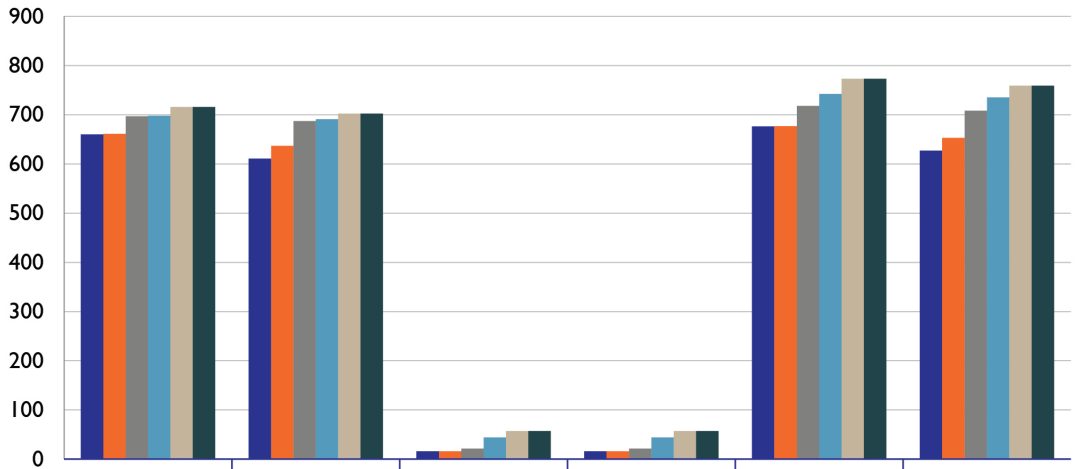
HSFR/HFG supported regional government efforts to implement governance reform. This included advocating to all relevant stakeholders on the importance of governing bodies, and providing training on the objectives, implementation procedures, and monitoring and review mechanisms of the reform in order to strengthen governing body capacity.

Since HSFR/HFG began, the number of health facilities with functional governing bodies has increased from 16 to 57 boards in hospitals and 611 to 702 management committees in health centers (Figure 2). Equally important, their capacity to govern and oversee health care financing reform implementation has improved. Through HSFR/HFG support, health facilities now have functional governing bodies in place that are capable of making informed decisions about mobilizing and allocating resources at their facilities, as well as developing and administering facility budgets.

Despite an inevitable difference in the performance of governing bodies across the various zones of SNNP, almost all health facilities in the region have established them. Members of these governing bodies include zonal leaders, district administrators, representatives of select sector offices, and community representatives. Since members come from different backgrounds and in order for them to best discharge their leadership and governance roles, HSFR/HFG provided health facility governance training to 693 (321 hospitals and 372 health center) governing body members over the last five years.

As a result of the decisions made by facility governing bodies, some health facilities have shown noteworthy progress in health service provision. For example, the board of Adare General Hospital decided to use the hospital's retained revenue to purchase medical equipment such as a chemistry analyzer, hormone analyzer, hematology machine, and electrolyte analyzer, which significantly improved diagnostic and treatment services at the hospital. Regular board oversight enabled the hospital to launch the Auditable Pharmacy Transactions and Services (APTS) system, a government requirement for pharmacies, and to open a

Figure 2. Number of Health Facilities in SNNP with Functional Boards and Management Committees



	Total # of health centers	# of health centers with functional management committees	Total # of hospitals	# of hospitals with functional governing boards	Total # of health facilities	Total # of functional boards and management committees
2012/13	660	611	16	16	676	627
2013/14	661	637	16	16	677	653
2014/15	697	687	21	21	718	708
2015/16	698	691	44	44	742	735
2016/17	716	702	57	57	773	759
2017/18	716	702	57	57	773	759

public pharmacy in Hawassa city, thereby making drugs more available to patients. In addition, the hospital board played an important role in the hospital acquiring land on which to build hospital rooms to expand service provision. As a result of the expansion and improved quality of services, patient flow has increased significantly.

Outsourcing of Non-clinical Services

Outsourcing of non-clinical services is the health care financing reform that allows hospital management and clinical staff to focus on their core business of delivering health care, while contracting out auxiliary services such as laundry, security, and catering to outside vendors. In SNNP, about 13 hospitals are outsourcing some services and have realized encouraging efficiency gains in doing so. For example, Adare General Hospital outsourced cleaning and cafeteria services for staff in 2015/16, which resulted in a 59 percent cost savings (Table 1). Over the same period, Gebre-Tsadik Shawo Memorial General Hospital used an outside vendor to supply food for hospital patients and saved 19 percent in costs. These two examples illustrate the potential the outsourcing reform has if successfully implemented in all hospitals. That said, this reform requires hospitals to have strong contract administration capacity to maximize the potential savings.

Community-Based Health Insurance

To address high out-of-pocket spending for health services, a major financial barrier to care seeking, and to generate more resources for the health sector in the long term, the Ethiopian government piloted and scaled up CBHI for citizens in the agricultural and informal sectors.

HSFR/HFG supported the regional government in developing and adapting the CBHI directive, manuals and bylaws. It also provided training to RHB, woreda administration, WorHO, CBHI scheme staff, and to woreda and kebele cabinet members on: the concepts and principles of CBHI, the design parameters of CBHI, implementation procedures and practices, CBHI financial management, and program monitoring, review and reporting requirements.
Further, the project supported the RHB in organizing high-level conferences that were important for advocating for CBHI to key stakeholders in the region. Project engagement with regional media and community mobilization initiatives helped explain and build membership in CBHI.

COVERAGE

The implementation of CBHI started in 2011 in the three pilot woredas of Damboya, Damot Woyde, and Yirgalem town. Based on the findings of the pilot evaluation conducted by HSFR/HFG, the project supported the regional government's scale-up of CBHI to 98 woredas (rural and urban), 60 percent of the total 160 woredas in the SNNP region (Figure 3). The Ethiopian government's Health Sector Transformation Plan sets forth a target of covering 80 percent of the woredas by 2020. With 60 percent of rural woredas currently covered, the region seems to be on the right track to achieve this target.

Table 1. Illustrative Cost Savings from Hospital Outsourcing of Non-clinical Services (birr)

Name of hospital	Outsourced service	Cost of service before outsourcing (birr)	Cost of service after outsourcing (birr)	Cost savings (birr)
Adare General Hospital	Cleaning and cafeteria services	2,019,864	823,200	1,196,664
Gebre-Tsadik Shawo Memorial General Hospital	Food supply for patients	822,932	666,480	156,452
Total		2,842,796	1,489,680	1,353,116

In terms of uptake of CBHI by the community, the population coverage ratio in 2017/18 was about 21 percent of the total SNNP population (Figure 3). In woredas that have established CBHI schemes, the enrollment ratio reached about 36 percent of the eligible households in 2017/18. With this enrollment ratio, it will be a challenge to meet the target of enrolling 80 percent of the population by 2020. Nevertheless, based on the current enrollment ratio, over 864 thousand households (4 million beneficiaries) have access to health services through CBHI.

RESOURCE MOBILIZATION

The major sources of revenue for the CBHI schemes as outlined in the regional directive include contribution from households, the targeted subsidy from the woreda administration for poor households, and the general subsidy from the federal government for the CBHI schemes. The magnitude of resources mobilized through CBHI schemes has increased significantly with more woredas implementing the program and an increasing number of households enrolling in schemes. In the five years since 2013/14, CBHI schemes in SNNP region have mobilized close to 245.8 million birr in contributions from enrolled households. Despite a slight decline in 2014/15, the amount of resources mobilized from enrollee paid contributions and government subsidies has increasing substantially over the past three years. This is the result of vigorous effort made by the regional government to mobilize members to join the schemes. During the same period, CBHI schemes mobilized close to 22.2 million birr in targeted subsidy and 12.1 million birr in general subsidy, except in 2017/18, when there was no transfer from the federal government. The total amount of resources mobilized from the three sources of revenue over the five years was about 280.1 million birr. Table 2 shows the amount and trend of contribution mobilized from the community and the general and targeted subsidies transferred from government.

Figure 3. CBHI Geographic and Population Coverage

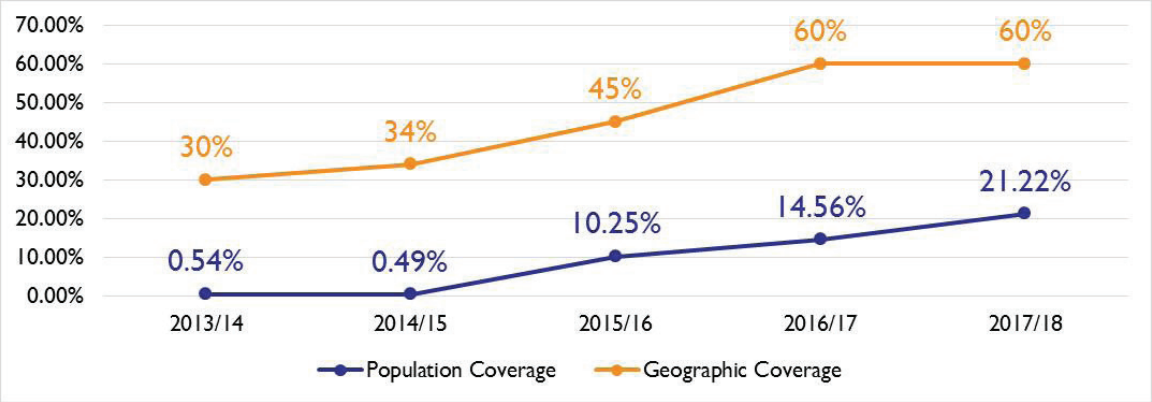
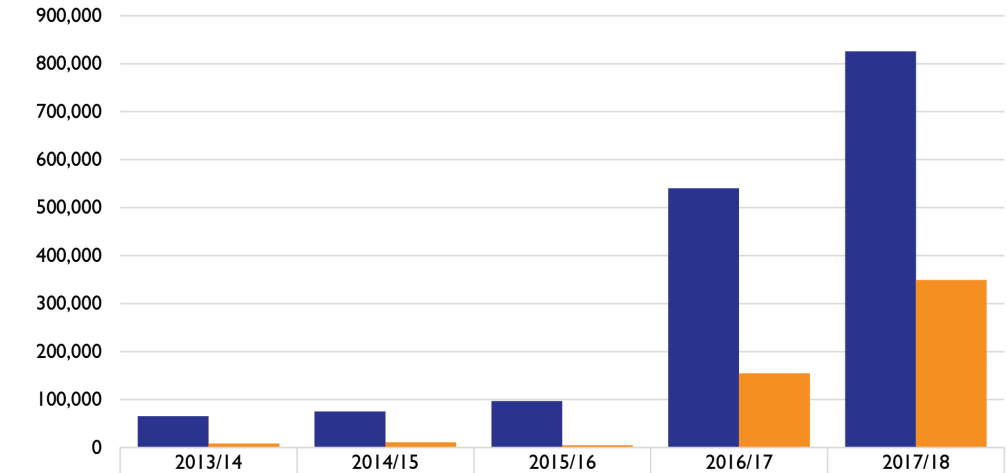


Table 2. Resources Mobilized through CBHI Contributions and Subsidies (birr)

	2013/14	2014/15	2015/16	2016/17	2017/18
Payee contribution	1,026,925	1,002,854	39,958,783	63,877,783	139,951,802
Targeted subsidy	178,000	213,030	219,030	8,694,950	12,887,826
General subsidy	830,340	344,954	4,608,903	6,343,338	0
Total	2,035,265	1,560,830	44,786,716	78,916,071	152,839,628

Figure 4. CBHI Outpatient and Inpatient Beneficiary Visits by Type of Health Facility



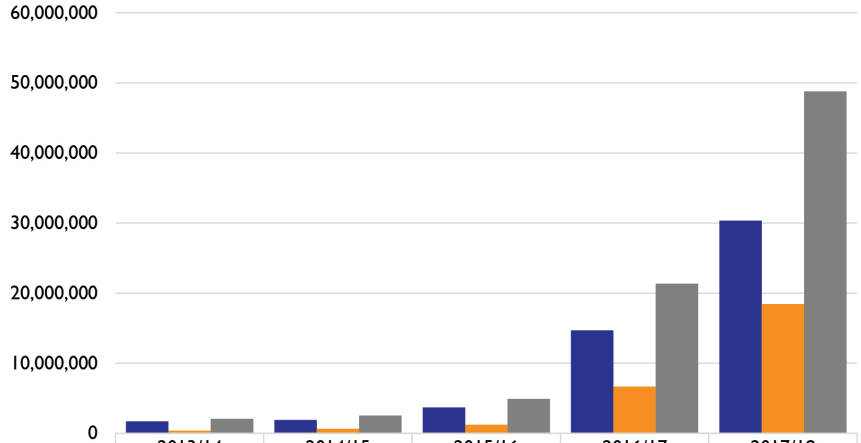
	2013/14	2014/15	2015/16	2016/17	2017/18
HC visit	65,167	75,065	96,656	539,967	825,438
Hosp. visit	8,293	10,748	5,009	154,379	349,096

HEALTH SERVICE UTILIZATION

A primary goal of CBHI is to increase people's utilization of health services. To facilitate this, CBHI schemes enter into contractual agreements with public hospitals and health centers. Over the past five years, CBHI beneficiaries in SNNP have sought care in 285 contracted health facilities (252 health centers and 33 hospitals). The majority of visits (75 percent) were made to health centers, which is in line with Ethiopia's prevention-focused health policy that requires all first-time visits be at the primary healthcare level.

With respect to the CBHI goal of increasing utilization, the trend in total number of visits has been positive, with a huge initial hike in visits in 2016/17. As Figure 4 shows, the number of facility visits made by CBHI beneficiaries increased from 65,167 in health centers and 8,293 in hospitals in 2013/14 to 825,438 and 349,096 visits, respectively, in 2017/18. The sharp increases in 2016/17 and 2017/18 are mainly due to the increased number of households enrolled in CBHI and improvements in the quality and range of health services offered at health facilities. In addition, reimbursement to health facilities jumped from 2 million in 2013/14 to 48.8 million in 2017/18, reflecting the jump in enrollment and utilization of services by CBHI beneficiaries (Figure 5).

Figure 5. CBHI Reimbursement by Type of Health Facility



	2013/14	2014/15	2015/16	2016/17	2017/18
HC reimbursement	1,695,839	1,885,880	3,678,486	14,688,289	30,339,328
Hosp. reimbursement	360,947	648,902	1,225,579	6,661,165	18,455,929
Total reimbursement	2,056,786	2,534,782	4,904,065	21,349,454	48,795,257

Ato Dessie Dalke, SNNP President, awards a trophy to a best-performing CBHI woreda

NETWORKING AND COMMITMENT

The main challenge to implementing the CBHI program has been having the full support and commitment of government leadership at all levels of the governance structure. To address this, HSFR/HFG in collaboration with the RHB and EHIA organized a regional CBHI conference in 2017, which included high-level federal and regional officials. As a result, regional, zonal, and woreda-level leadership understands that CBHI is a core element of the woreda health transformation agenda, and woredas and kebeles are striving to achieve the targets set out in the Ethiopian government's Health Sector Transformation Plan.

The RHB used the conference as a platform for disseminating best practices to schemes and woreda officials. Schemes shared their successes and challenges, and best-performing schemes were publicly recognized, which motivated other woredas/schemes to improve their performance. The conference was particularly important since it sent a strong message to all stakeholders of the regional government's full and strong support for the successful implementation of the CBHI program.

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KEY LESSONS LEARNED

Key lessons learned from the implementation of health care financing reforms in SNNP are as follows:

- Health care financing reforms require strong government support and political commitment. Butajira town administration in the Guraghe zone and Salamago woreda in South Omo zone provide a good example of the difference committed leadership can have on the success of reform implementation. Butajira, with strong local government support, is among the best-performing schemes, whereas Salamago, which needs stronger government support, is among the poor-performing ones.
- Close partnerships between government and development partners results in improved CBHI implementation capacity of local actors, uptake of the program, and enhanced accountability of implementers and consequently trust in the program by the community.
- Continuous technical support to build the capacity of all health care financing reform implementers is important, because there are capacity problems in areas such as health insurance implementation and in planning, budgeting, and overall financial management, particularly at the woreda and health facility levels.
- Establishing the requisite institutional arrangements (organizational structure, systems and human resources), particularly for CBHI, in order to institutionalize reforms, is critical for their sustainability.
- Strong and committed facility governing boards and management committees lead to better performance in implementing health care financing reforms.

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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