# Agreement for Performance of Work

Support services to enable country level collaboration for improved institutional frameworks in the area of health financing systems

## ETHIOPIA Summary

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*by*

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### 1. BACKGROUND DOCUMENTS:

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## 2. ANALYSIS:

### (i) Political/Governance challenges:

● Ethiopia has done great improvements regarding its health system in recent years and in 2015, the Ethiopian government introduced its second 20-years strategy towards Universal Health Coverage (UHC) through strengthening of primary health care[1]. Implementation of the primary health-care approach in Ethiopia has been possible through policies, strategies and programmes that were aligned with country priorities. There has been a holistic approach to disease control programmes along with health systems strengthening, community empowerment and multisectoral action. These strategies have enabled the country to increase health services coverage and improve the population's health status.

● Keys components of these improvements are the community-based health insurance (CBHI) initiatives that the Ethiopian government has been piloting and scaling-up for the informal sector since 2010[2]. The Government is still preparing to launch Social Health Insurance (SHI) for civil servants and formal sector workers[3]. Both CBHI and SHI are developed as a means of achieving UHC. Indeed, CBHI and SHI are two potential strategies to address the poor health care financing in the country. CBHI is an alternative to user fees to improve equity in access to medical care particularly to those rural communities and the informal sector[4]. SHI is a form of

[1] The first strategy was the 1998 Health Care and Financing Strategy, which emphasized the goals of increasing the financial resources for health through a pluralistic approach involving government, external, and private domestic contributions; increasing efficient use of resources linked to decentralized planning; strengthening sustainability of health financing; and improving service coverage and quality.

[2] The implementation of CBHI schemes has been piloted in 13 woredas based on a feasibility study and is moving from piloting to scaling up phase.

[3] The proposed SHI scheme requires all employees and employers to pay contributions of three per cent of workers' salaries.

[4] It has the potential to increase utilization, better protect people against catastrophic health expenses and address issues of equity.

mandatory health insurance for formal sector employees, including retirees and pensioners[5].

● Ethiopia's CBHI scheme was established with the objectives of enhancing access to health care, reducing Out-of-pocket (OOP) expenditure, mobilizing financial resources and enhancing the quality of health care. Previous analyses have shown that the scheme has enhanced health care access[6] and led to reductions in OOP[7].

● In the Ethiopian model, the management and operation of CBHI schemes is not left to the community alone but is integrated into the existing Government structure at the *woreda* and *kebele* levels[8]. This has facilitated informational campaigns, registration of members, collection of contributions, and monitoring of health service providers. The schemes remain community based as the higher governance structures (General Assembly and Board of Directors) are a community and government partnership.

● CBHI is a promising pathway to UHC since it provides financial risk protection, increases health services utilization and availability of finance in health facilities[9]. Besides, CBHI has a high coverage rate (CBHI covers 11 million people making it one of the largest health insurance schemes in Africa)[10] and is inclusive and pro-poor (almost one-fifth - 19.1% - of CBHI members are poor)[11].

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[5] It is meant to improve access to health services by removing catastrophic health expenditure at the point of service delivery.

[6] CBHI-affiliated facilities experience a 111% increase in annual outpatient visits and annual revenues increase by 47%. In 2018, CBHI members pay a 240 birr (US$8.40 at December 2018 exchange rates) annual premium per household, with additional payments for adult children. This premium includes a 25% federal government subsidy. Regional and woreda governments cover premiums for a small proportion of "indigent" households deemed unable to pay.

[7] OOP payment is not pooled and has a negative impact on access and equity.

[8] Districts of Ethiopia, also called *woredas*, are the third-level of the administrative division of Ethiopia - after zones and the regional states. These districts are further subdivided into a number of wards called *kebele* or Ganda neighbourhood associations, which are the smallest unit of local government in Ethiopia.

[9] Increased revenues are used to ameliorate drug shortages. These increases have translated into enhanced patient satisfaction. Patient satisfaction increased by 11 percentage points.

[10] CBHI is being expanded in the four regions + Benshangul-Gumuz and Addis Ababa and scaled-up to 350 additional districts. 80% of districts and 80% of households were targeted under HSTP-I by 2020.

[11] Ethiopia's CBHI, along with Rwanda's *Mutuelles de Santé*, provide a sharp contrast with the CBHI schemes that have little potential to contribute to UHC. While past CBHI schemes have been local initiatives based on voluntary membership and community involvement in scheme management, the

● However, the financial sustainability of CBHI schemes is still questionable in the mid to long term. While a higher utilization rate of outpatient services per enrolled household is strongly associated with the CBHI scheme having a net negative balance, the number of outpatient visits per enrolled member is still very low by global standards, and below the level desired to optimize health outcomes. More revenue is needed for CBHI schemes to be financially sustainable. In particular, there is a need to mobilize a minimum threshold of money to attain a reasonable probability of financial solvency.

● From 1998-2014, Ethiopia achieved a substantial increase in total per capita health expenditures. With rapid GDP growth, all sources of health spending increased substantially in nominal terms[12]. OOP spending decreased notably as a share of the total, accounting from 53% in the first to 34% in the most recent National Health Accounts - NHA (from 1995/96 to 2010/11), although also increasing in nominal terms. The most significant increase has been in external sources of financing from development partners. There has been a dramatic scale-up in external financing from the mid-2000s[13]. Being the largest recipient of official development assistance in the African region, donors play a significant role in Ethiopia's health system[14] and the health sector is heavily dependent on external sources.

● In Ethiopia, health service delivery is ensured throughout a three-tier health system - primary, secondary and tertiary -. The primary health care infrastructure has expand enormously, with potential coverage reaching more than 90% in 2019[15]. In the second and third tier facilities, implementation of strategic initiatives and reforms

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Ethiopian and Rwandan Governments play a central role in CBHI encouraging, even compelling, individuals to enrol. In Rwanda, the Government has sought to implement a legal mandate requiring all residents to purchase health insurance, punishing those who do not comply. Consequently, Rwanda achieved unprecedented 75% enrolment. In Ethiopia, while there is not yet a health insurance mandate, the Government has strongly promoted CBHI expansion, with the scheme now covering 11 million people, some 16 per cent of the informal sector.

[12] The government health budget financed with general revenue increased by 376% over this period (in nominal birr) but has been flat or declining throughout as a share of total government budget.

[13] This now makes up 50% of total health spending and an even larger share of about 55% of primary care expenditure.

[14] Ethiopia received the highest share of total development assistance for health amounting to US$ 828.3 million in 2015, with United States being the largest health donor. Donor financing, which has mostly focused on primary health care has been the main driver of improved health outcomes in Ethiopia.

[15] The Health Extension Program continues to make significant contributions towards improved health indicators in the country.

has strengthened pre-hospital and hospital clinical care. Overall, outpatient attendance rate increased from 0.27 to 0.9 per capita per year between 2000 and 2019. In 2005, the first essential health services package (EHSP) was defined. It included a set of health promotion, disease prevention, curative, and rehabilitative services. This was revised in 2019 to include 1.019 interventions that are now included in the EHSP. Emphasis is put on service availability, accessibility, acceptability, and affordability[16].

● Several interventions have been implemented to enhance financial risk protection in accessing essential health services and to address equity. These include provision of high-impact interventions free of charge through an exemption program, subsidization of more than 80% of the cost of care in public health facilities and full subsidization of the very poor through fee waivers[17] for both health services and CBHI premiums. The poor now get free access to both the EHSP and the high-cost services[18] through the fee waiver system[19].

● Despite the revision of the Ethiopia's EHSP, it should be noted that the Government is now seeking other ways to provide financial protection against catastrophic household OOP spending on health, which often arise from use of

[16] Seven prioritization criteria were employed: disease burden, cost effectiveness, equity, financial risk protection, budget impact, public acceptability and political acceptability. In the first phase, 1.749 interventions were identified, including existing and new interventions, which were regrouped and reorganized to identify 1.442 interventions as relevant. The second phase removed interventions that did not match the burden of disease or were not relevant in the Ethiopian setting, reducing the number of interventions to 1.018. These were evaluated further and ranked by the other criteria. Finally, 594 interventions were classified as high priority (58%), 213 as medium priorities (21%) and 211 as low priority interventions (21%). The current policy is to provide 570 interventions (56%) free of charge while guaranteeing the availability of the remaining services with cost-sharing (38%) and cost-recovery (6%) mechanisms in place. The revision of Ethiopia's EHSP followed a participatory, inclusive and evidence-based prioritization process.

[17] This is a right conferred to an individual that entitles him or her to obtain health services at no direct charge or at a reduced price based on the inability to pay.

[18] High-cost services are services outside the EHSP domain, which are provided on a high-cost recovery basis.

[19] The ultimate goal of any health care financing strategy should be to ensure equity by making quality health service to all regardless of individual financial status. The health care financing strategy 2017 - 2025 recognized that health care should be financed through multiple financing mechanisms to ensure long-range sustainability. The reforms introduced include implementing revenue retention and use at health facility level, systematizing a fee-waiver system for the poor, standardizing exemption services, setting and revising user fees, introducing a health facility autonomy through the introduction of a governance system.

tertiary services that are beyond the reach of the EHSP. As a result, the EHSP has become less relevant[20].

● Ethiopia has accomplished the second growth and transformation plan (GTP-II, June 2015 – June 2020). If positive results and achievements have been attained, however, this period was also characterised by internal conflicts, resulting in large displacement of populations and creating additional burden to the health system[21].

● The second Health Sector Transformation Plan (HSTP-II) is the next five-year national health sector strategic plan, which covers the period between 2013–2017 Ethiopian fiscal years (July 2020 - June 2025). During this strategic period, the sector envisions building on the successes and consolidating the gains of HSTP-I to build a resilient, sustainable, high-quality, equity-based health system[22]. The overall objective of HSTP-II is to improve the health status of the population by accelerating progress towards UHC, protecting populations during health emergencies, transforming woredas, and improving the health system's responsiveness[23].

● An effective leadership and governance system is needed to further strengthen the legal and regulatory framework for the implementation of HSTP-II. This implies mainly to enhance public accountability on resource management as well as optimal health service provision. It also requires designing and implementing sound regulation mechanisms, building effective teams, and institutionalizing appropriate implementation mechanisms and platforms. Incorporating the views of minorities, minimizing corruption, and including the voices of the vulnerable in decision-making and implementation of decisions is also needed.

● The COVID-19 pandemic posed a clear threat to ongoing reforms and relatively strong economic growth. Actually, like most others in Sub-Saharan Africa

[20] Essential packages of health services play an important role in early stages of health system development. However, as governments develop health benefit plans to reduce household out-of-pocket spending for an ever-expanding package of services, the importance of the essential package of health services as a priority-setting instrument is less clear. Governments are increasingly under domestic and international pressure to use resources to protect their citizens from catastrophic health spending, which often comes from use of secondary and tertiary services.

[21] Evaluations mention 1.7 million internally displaced persons (IDPs) during this period.

[22] HSTP-II aims to build on the successes of the HSTP-I period, incorporating the lessons from its implementation.

[23] The transformation plan has identified four interrelated agendas: (i) quality and equity of health care; (ii) district transformation; (iii) compassionate, respectful and caring health professionals; and (iv) information revolution.

(SSA) and in Least Developed Countries (LDCs), Ethiopia's health system was not ready for a large-scale crisis such as the COVID-19 pandemic. Diversion of resource to combat COVID-19 has impacted other essential services such as antenatal care (ANC) and sexual and reproductive health (SRH) services for women and girls. Polio and immunisation campaign for up to 17 million children under 5 was postponed. Excess morbidity and mortality appeared to be a result of the limited availability and utilisation of both preventive and curatives services.

● Poor health care financing remains a major challenge for the health system of Ethiopia[24]. Important barriers to improved health care financing include: low Government spending on the health sector; strong reliance on OOP expenditure; inefficient and inequitable utilization of resources; poorly harmonized and unpredictable donor funding; inadequate political commitment to support health sector in some regions and Woredas.

● To resolve gaps in the health system, Ethiopia needs to improve its domestic financing for health and targets disadvantaged locations and populations through an innovative public health approach.

● Attaining UHC by 2035 is the direction for Ethiopia's health sector development through guaranteeing access to all the essential services, for everyone in need, while providing protection against financial risk[25].

[24] Other key challenges include inadequate coverage of services, inequity of access, slow health-systems transition to provide services for non-communicable diseases and inadequate quality of care.

[25] Nationally, the overall Ethiopian UHC service coverage for the year 2015 was 34.3%, ranging from 52.2% in the Addis Ababa city administration to 10% in the Afar region. The coverage for non-communicable diseases, reproductive, maternal, neonatal and child health and infectious diseases were 35%, 37.5% and 52.8%, respectively. The national UHC service capacity and access coverage was only 20% with large variations across regions, ranging from 3.7% in the Somali region to 41.1% in the Harari region. Conclusion The 2015 overall UHC service coverage for Ethiopia was low compared with most of the other countries in the region. Also, there was a substantial variation among regions. Therefore, Ethiopia should rapidly scale up promotive, preventive and curative health services through increasing investment in primary healthcare if Ethiopia aims to reach the UHC service coverage goals. Also, policymakers at the regional and federal levels should take corrective measures to narrow the gap across regions, such as redistribution of the health workforce, increase resources allocated to health and provide focused technical and financial support to low-performing regions.

**(ii) Socio-economic Challenges:**

● The Ethiopian Government aspires to reach a middle-income status by 2035[26]. The economic system has seen a substantial growth over the past decades[27]. While about 55% of Ethiopians lived in extreme poverty in 2000, this figure had been reduced to about 34% in 2011, as measured based on the international poverty line of less than US$ 1.90 per day. Ethiopia has a wide socio-economic development gap between the rural and urban areas in terms of access to education, health and other social services. Nevertheless, the substantial expansion of the economic system is gradually narrowing this gap and is bringing positive trends in terms of poverty reduction in both urban and rural regions.

● Despite national initiatives to address financial barriers (fee waiver system for the poorest of the poor, fee exemption for selected essential Primary Health Care (PHC) services, and CBHI with premium subsidy for indigents), socio-economic disparities in health service utilization are very wide, even for services that do not require user fees, including Reproductive, Maternal, Newborn and Child Health (RMNCH) services.

● To address the social and environmental determinants of health, the Government of Ethiopia has taken steps to strengthen engagement with key local and international sectors and stakeholders, for example in the nutrition and WASH programs[28]. Despite its significant economic growth, the country remains one of the world's poorest.

● The contribution of the health sector towards national socio-economic development is critical since it is a means to ensuring social justice and sustainable economic development. However, use of health services is low, especially among

[26] Ethiopia is engaged in rapid, comprehensive development activities to transition from poverty to sustainable, reliable growth and prosperity. Since 1991, the country has implemented several macroeconomic policies, including a market-based and agriculture-led industrialization. The government has introduced initiatives to ensure successful transformation from an agrarian to industry-led economy. The country has registered commendable achievements on Millennium Development Goals (MDGs) mainly in reducing poverty head count, achieving universal primary education, narrowing gender disparities in primary education, reducing child and neonatal mortality, and combating HIV, TB, and malaria.

[27] Expansion of the services and agricultural sectors accounts for most of this growth, while the performance of the manufacturing sector was relatively modest.

[28] There have been multi-sectoral collaborative activities and interventions to improve the status of food security and nutrition, including the high-level government commitment platform, for instance the "Seqota" Declaration to end child under-nutrition by 2030.

rural dwellers and socio-economically deprived groups such as pastoralist communities, and those without formal education. Diverse socio-cultural beliefs and practices greatly influences decisions regarding use of health facilities. Facility-related factors such as poor client satisfaction and disrespectful treatment, low trust in the health service provided, poor geographical accessibility, stock outs of medical supplies and equipment, lack of cleanliness at facilities, and long waiting times limit use of health services[29].

● The periodic occurrence of regular outbreaks such as measles, yellow fever, and cholera poses a challenge to the health system, and the global COVID-19 pandemic has further tested the health system's resilience. In 2020, an estimated 8.4 million needed humanitarian assistance[30]. Of these, women and children are disproportionately affected. For the health sector specifically, 5.9 million people are estimated to have humanitarian needs, including 1.2 million women and girls needing family planning and maternal health services. Internally displaced persons (IDPs) put additional pressure on local health systems, in particular on the health care work force and stocks of medicines and other essential supplies[31].

**(iii) Financial challenges:**

● Ethiopia's institutional and governance environment for health financing is complex with multiple levels and actors. The health sector is financed through three sources: Government budget (including on-budget donor support), off-budget donor assistance[32], and private OOP expenditures. Specifically, there are three distinct channels of financing at the national level[33]. Each of these channels has several

[29] General low health system literacy, where a community is not fully aware of available services at different system levels, also contributes to the low demand and utilization of health services.

[30] UNOCHA, 2020.

[31] Among internally displaced people (IDPs), unmet need for health services for pre-existing and new disease conditions, physical and mental trauma, and sexual and gender-based violence (GBV) remains high.

[32] There are two modes of external aid flow in Ethiopia: off-budget and on-budget. While on-budget aid is channelled through the MOFED or the FMOH budget processes, off-budget aid goes directly to specific programs or projects.

[33] The three funding channels in Ethiopia are the following: (i) Channel 1A (un-earmarked) is through the Ministry of Finance (MOFED): Funds are provided to Treasury. This is the disbursement channel used by Government itself and by donors providing General Budget Support (GBS). Channel 1B (earmarked) also uses Government financial management system as in Channel 1A, except that these funds are earmarked to specific outcomes. Various projects and programs financed by the UN to regions are transferred through this channel; (ii) Channel 2A (un-earmarked) is through the Federal

subsidiary mechanisms and different sources of financing which include general government revenue, block transfers from Development Partners (DPs), and project financing from development partners both on and off budget[34].

● Major financial challenges include low government budget allocation to health, inefficient resource utilization, lack of a strategic purchasing and performance-based financing mechanism, ineffective processes for the selection and financing of the poor, absent SHI, and low coverage of the informal sector through the ongoing CBHI scheme.

● Main financial risks for the health sector are the inadequacy of financial resources and the low predictability of external funding. Several mitigating measures have already been identified such as the need to focus more on domestic financing to fill the financial gap required during the HSTP-II period. This may imply to implement innovative domestic financing strategies to mobilize adequate finance domestically, to strengthen the implementation of CBHI, to initiate the effective implementation of SHI as an internal mechanism to increase financing to the health sector[35], and to strengthen public-private partnerships (PPPs).

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Ministry of Health (FMOH) This is mainly the MDG Performance Fund (MDG/PF) where FMOH spends the funds, based on the Government procedures. It is the FMOH‟s preferred funding modality. Resources are allocated as per agreed work plan in the woreda based planning process. Channel 2B (earmarked) deals with other Funds that are provided to the health sector. The funds are managed and reported by the FMOH but the accounting and reporting mainly follows donors procedures. Examples are The Global Fund, GAVI, UN Agencies funding, and other Development Partners (DPs) channelling resources through FMOH. Allocation follows agreed project/program agreements; (iii) Channel 3 is outside the oversight of Government: the donors or their implementing agencies under a project type of support manage Funds. While the donor agency may report on the use of funds (in the resource mapping), the day-to-day financial management and procurement are in the hands of the donor. Examples are the Health Pooled Fund (HPF), where UNICEF on behalf of the FMOH procures Technical Assistance (TA), the Protection of Basic Services (PBS), where funds are provided for the procurement of commodities, but financial management is done by the World Bank and other bilateral Partners (DPs and NGOs) that fund various activities directly.

[34] Positive movement of funds to more on-budget and accountable mechanisms has been achieved, but off-budget funding is still significant. Some channels of financing work through devolved mechanisms of allocation and responsibilities at region and woreda level, while others are more centralized and provide funds or in-kind inputs to the health care delivery system.

[35] The social protection review shows that Ethiopia spends an equivalent of three percent of GDP on social protection, in form of safety nets, indirect subsidies (wheat, electricity and kerosene), labour market interventions and social insurance. Social safety net programs are largely financed by donors, while the government mainly finances subsidies and social insurance for public servants.

● Ethiopia's spending on health expenditure has increased in recent years but is still among the lowest in the region. In the 7th round of NHA (2016/17), Ethiopia's total health expenditure was estimated at 72 billion ETB ($3.1 billion)[36]. At 7.8%, Ethiopia's government health spending is low. Average health expenditure per capita is $33, as compared to a regional average of $38[37]. Although the government allocates 60-70% of total budget to pro-poor sectors, allocations to health fall well short of the Abuja Declaration target (15%) or WHO's recommended $86 per capita spent to deliver UHC[38]. And OOP spending on health remains high at 31% of Total Health Expenditure (THE), with a significant proportion of households (4.2%) facing catastrophic health expenses[39].

● Reforming public financial management and health financing to improve efficiency and accountability, while pursuing the agenda of sustainable domestic resource mobilization for health, is now the main challenge for the Ethiopian Government.

● Strategic objectives for health financing are: to decrease expenditure as a share of total health expenditure; to increase general government health expenditure (GGHE) as a share of general government expenditure (GGE); to increase total health expenditure per capita; to decrease incidence of catastrophic health spending; to increase proportion of eligible households enrolled in CBHI; and to increase proportion of eligible civil servant/employees covered by SHI[40].

[36] Public expenditure is allocated through two harmonized financing arrangements: the MDG Performance Fund (MDG-PF) channelled through the FMOH; and the block grants provided by MOFED to regional states. The block grants mainly cover recurrent costs, especially salary and operational costs at health facilities, including salaries for health extension workers; the MDG-PF supports procurement of equipment and commodities for facilities, construction of health facilities, capacity building of health extension workers, and establishment of CBHI.

[37] World Bank, 2016.

[38] For HSTP-II, 12% of general Government spending is estimated to be allocated to health by 2024/25, with an annual proportional growth rate.

[39] It should be pointed however that the share of OOP spending in health financing has continued to decline, but not enough to protect households from catastrophic and impoverishing spending (source: Ministry of Health of Ethiopia, 2019).

[40] Health financing through insurance is considered as earmarked domestic resource to health. Promoting and extending insurances (CBHI and SHI) as percent of Total Health Expenditure (THE) is thus a key challenge regarding domestic resources mobilization. Insurance's contribution to health financing proportionally go with the level of reduction in OOP.

- **Revenue raising[41]:**

● The Government needs to increase its level of spending in order to finance its primary health care system and slowdown or decline its dependence on external resources. The future sustainability of primary care services without increasing contributions from households will depend largely on significant economic growth and more government funding for primary care.

● Ensuring a transition to more sustainable financing for health through gradual replacement of resources from external to domestic sources is a key challenge. The Ethiopian Government has already shown a strong commitment to increasing public health spending and has coordinated the use of program-based strategies, such as pooled funding, to mitigate the effect of fragmented aid in the sector.

● The fiscal space[42] analysis primarily focuses on domestic resources with specific attention to potential expansion from the improved use and performance of public resources[43]. Ethiopia can realistically increase funding through economic growth and efficiency gains, along with some reallocation of the general budget going to health.

● Some Interventions can be introduced to increase health sector resources, such as establishing an excise tax on alcohol, tobacco, sugar, and used cars. However, given Ethiopia's low income and limited tax-paying population, new dedicated taxes are unlikely to offer much advantage. Removing the subsidy for fossil fuels and redirecting the funds to health care and introducing levies on financial transactions are other measures.

[41] Revenue raising includes the following issues: sources of funds, structure of payments or contribution methods for funding health services and collection arrangements.

[42] The fiscal space can be predicted using assumptions for economic growth, Government resource allocations to health, external aid for health, the magnitude of OOP expenditure, and other private health expenditures as critical factors affecting available resources devoted to health.

[43] A Government can increase fiscal space for health in five ways without jeopardizing its fiscal position or other priority sectors. This can be done through (i) sufficient and sustained economic growth allowing greater revenue generation and low levels of debt; (ii) increasing the share of health spending within the overall government budget; (iii) raising new revenue earmarked for the health sector; (iv) improving efficient use of health expenditures; and (v) increasing development assistance for health.

● The financial resources required to implement the Ethiopian EHSP from 2020 to 2030 and expand the EHSP service provision in the public sector have been assessed using the OneHealth Tool (OHT). To implement the EHSP, 13.0 billion USD (per capita: 94 USD) would be required in 2030[44]. Allocating gains from economic growth to increase the total government health expenditure could partly address the estimated gap.

● Strengthening health facility revenue generation and effective utilization is a priority. This would imply to recover full cost of services from either patients or an entity that pays on their behalf, to establish pre-negotiated rates for all of user fee exempted services, and to introduce user fee to cover curative health services at Health Post (HP) level[45].

● Improving private sector engagement in health can also be one means to substantially increase available resources for health in Ethiopia via domestic and foreign direct investment[46].

- **Pooling[47]:**

● Countries use different strategies for implementing risk-pooling mechanism[48]. Some countries have used top-down public financing (tax-based) and social health insurance (SHI) without CBHI, while others have used CBHI as the main model of reaching the informal sector[49]. In Ethiopia, there is a strong need to strengthen pre-payment and risk pooling mechanisms to reduce OOPs. The

[44] The largest (50 - 70%) share of estimated costs is for medicines, commodities, and supplies, followed by human resources costs (10 - 17%).

[45] The primary level of care includes primary hospitals, health centres (HCs) and health posts (HPs).

[46] Private sector engagement can also facilitate technology transfer, improve quality, and redirect resources from other sectors.

[47] The arrangements for accumulating prepaid revenues for health on behalf of some or all of the population and whether these are combined in one or more fund pools.

[48] There are usually four main financing mechanisms used to pool health risks, promote prepayment, raise revenues, and purchase services: state-funded systems through ministries of health or national health services; social health insurance; voluntary or private health insurance; and community-based health insurance.

[49] Successful CBHI models show that there are important conditions for CBHI to grow and develop, including: (i) existence of a minimal level of (perceived) quality of care and gradual improvement of quality at the supply side; (ii) instituting adequate organizational practice and design including responsiveness to people's needs; (iii) Government commitment to subsidize and finance the premium for the poorest in society; and (iv) the need for CBHI schemes to harmonize themselves to expand risk pooling and ensure financial sustainability.

commitment from the Ethiopian Government to support CBHI will help reduce the role and proportion of OOP spending in overall financing of the health sector. It also means that the Government remains the critical body in pooling and managing resources coming to the health sector.

● Resources are pooled and invested through Government transfer mechanisms. The Government at federal and regional levels collect funds from a variety of sources on behalf of the citizens and uses those funds to pay for public provision of designated health care services. Financial resources are transferred from federal government to regional governments in the form of both general-purpose grant[50] and specific purpose grant[51]. At the regional level, transfers are made to woredas in the form of general-purpose grant.

● Some regions have also started supporting pilots of CBHI, which pools Government contributions with household contributions at woreda levels. So far, SHI is at the design and preparatory phase and private health insurance is very limited.

● With regard to pooling of resources throughout CBHI, several features are unique to Ethiopia. Enrollment in a CBHI scheme is decided collectively at the kebele/tabia[52] level as opposed to the household level[53]. Scheme management is integrated and works within the woreda administration office. A general subsidy from the federal government is provided for all scheme members and a targeted subsidy from the regional and woreda governments is provided for the very poor who cannot afford to pay the contribution. The federal government also provides resources to health facilities contracted to provide services to CBHI members, so that the providers maintain an acceptable quality of care[54].

● Scaling up CBHI schemes will have a beneficial pay-off by reducing the incident and severity of poverty for CBHI members. However, the effectiveness and continued relevance of CBHI scheme as one of the paths to UHC depends on CBHI

[50] e.g. block grants-channel 1a.

[51] e.g. channel 1b.

[52] The tabia (known as kebele elsewhere in Ethiopia) is the lowest administrative authority in the regional government structure in the Tigray Region.

[53] Associated kebeles/tabias form a larger woreda-wide scheme.

[54] Although there is overall guidance from the federal level, scheme parameters are decided at the regional level based on the regional CBHI directives; as a result, there are minor variations in schemes in different regions in terms of registration and enrollment rates, and service provider contracting.

collecting a reasonable share from the community[55]. Over the last few years, Ethiopia has seen remarkable achievement in CBHI enrolment and resource pooling. However, the 2016/17 NHA reported that about 1% of total heath expenditure was pooled into the Government system through CBHI, while private employers and insurance companies contributed 3% of total health expenditure in 2016/17. Establishing higher-level pooling has thus recently emerged as a key challenge for the Government.

● The establishment of the MDG Performance Fund (MDG-PF) that pools the resources of DPs[56] to finance programme areas in the primary health-care system was a great improvement. The MDG-PF is now continuing to grow in numbers of contributors and funds managed[57]. A Joint Financing Arrangement (JFA) was also established to manage the MDG-PF, to give operational oversight and to monitor the implementation of the MDG-PF[58].

● Established in 2005 and managed by UNICEF on behalf of the FMOH, the Health Pooled Fund (HPF) is an important instrument for providing technical assistance. It is intended to complement other donor investments.

● Both pooled Funds have mobilized significant funding from the DPs. The success of the PHC approach in service delivery and especially the health extension program was used as evidence of value for money to pull additional funding from external resources.

● Additional funds to respond to emergencies are needed. A contingency fund could be established to provide for additional resources in case of pandemic situations or health emergencies.

[55] The way of life in pastoralist communities differs from that of urban and rural contexts. The service delivery mechanism remains weak and the FMOH is working to strengthen these systems. So far, CBHI has been piloted only in rural and to a limited context in urban settings. Its relevance to the pastoralist context should be explored during the scale-up.

[56] Includes the World Bank and the European Union.

[57] The MDG-PF is a pooled funding mechanism managed by the FMOH, using the Government of Ethiopia procedures. It provides flexible resources, consistent with the “one plan, one budget and one report" concept, to secure additional finance to the Health Sector Development Program (HSDP). It is one of the three Government’s preferred modalities for scaling up DPs assistance in support of HSDP.

[58] The JCCC reviews quarterly financial and activity plans, and reports and facilitates the allocation or reprogramming of pooled funds.

- **Purchasing[59]:**

● Key challenge is designing and implementing strategies for efficient utilization of existing resources and capacity. This requires investing on high-impact, and cost-effective interventions, strengthening financial resource tracking systems and conducting regular financial audits. Improving efficiency and effectiveness, in particular to ensure that funds are used in the most efficient and equitable way, supposes to introduce performance-based financing and results-based financing.

● Strategic objectives are the following: harmonizing and aligning procurement/supply systems, phasing out parallel systems, and focusing on best value for money.

● Pharmaceutical Fund and Supply Agency (PFSA) plans and conducts the main part of the national health procurement using global procurement mechanism i.e. international competitive bidding. Aside from PFSA, procurement pertaining to health is also done through the centralized and globalized system by UNICEF/UNOPS.

● Payment and purchasing arrangements can be important determinants of better resource allocation and efficiency. Guidance for the development and updating of payment and purchasing arrangements will be more pressing in the future. The annual evidence-based planning process, which seeks to plan for improvements in service coverage and quality, could be a precious tool in this regard. It uses a methodology based on the marginal budgeting for bottlenecks (MBB) approach[60].

● For primary health care systems, the supply-side interventions include strengthening the supply chain management system to ensure an adequate and uninterrupted supply of pharmaceuticals at the point of service delivery. An internal quality assurance mechanism would help ensure effective implementation of performance monitoring and quality improvement standards and tools at all levels of the health system. Standards applied by accrediting entities continue to draw on the

[59] The means used to allocate the prepaid resources from the pool to the providers for service benefits.

[60] The marginal budgeting for bottlenecks tool (MBB) is an analytical costing and budgeting tool that helps countries develop their health plans by taking into account the most effective interventions, cost and budget marginal allocations of their implementation to health services and assess their potential impact on health coverage, Health related Millennium Development Goals (MDGs) and health outcomes of the poor.

expertise of provider organizations, health professionals, purchasers, health planners, and consumers, Through regulatory processes, overseeing provider organizations and facilities should continue to monitor providers, ensure feedback and accountability, and strengthen patient safety and quality improvement

● In 2010, with the establishment of the Ethiopian Health Insurance Agency (EHIA)[61], the Government has looked into innovative systems like provider payment mechanisms and financial sustainability. There is space today for EHIA to better establish itself as the purchaser and play a greater role by leveraging financing mechanisms to influence service delivery and oversee quality of care. This would require a clear provider-purchaser split at the national level, and improved integration of EHIA at the regional level.

**(iv) Collaborative challenges:**

● HSTP-II is a holistic and multi-sectoral plan designed to address all the determinants of health, e.g. personal, social, environmental, economic, and political, through multi-sectoral collaboration.

● As such, HSTP-II's management and ownership: (i) Involves entities beyond the health sector: Government bodies, non-government and community organizations, DPs, civil society organizations (CSOs) and professional associations. Key stakeholders in Ethiopia engage public sector, private sector, non-government agencies, civil services and community-level organizations; (ii) Requires action outside the health sector in interrelated fields: education, environment, agriculture, housing and infrastructure, finance and economic.

● Community engagement has been at the core of the national strategy to implement HSTP-I. The Government used the Women Development Army (WDA) to serve as a primary community engagement platform at local level, in particular in agrarian settings[62] and, to a lower extent, in urban settings. However, low capacity and acceptability among WDA leaders and low acceptance by community members have recently resulted in under-utilization of other community resources, including those of men, religious leaders, and traditional leaders.

[61] EHIA has about 500 employees at the federal and regional level offices.
[62] In pastoralist settings, social mobilization committees serve as community engagement platforms.

● To accelerate progress towards UHC and improve health financing, multi-sectoral coordination mechanisms, at national and local levels, need to be strengthened among Government ministries, competent authorities, non-governmental organizations, and non-state actors.

● While stakeholder engagement and partnership with the health sector has already be strengthened through platforms such as the Joint Steering Committee meetings with Regional Health Bureaus, the Executive Committee Meetings with agencies and the regular meetings of the JCF, JCCC, the health, population and nutrition (HPN) partners group, the health financing technical working group (HF TWG), a lot remains to be done.

● Examples of opportunities to strengthen collaborations at country level are the following:

(i) Supporting coordination in a context of strained Government and partners relationships. In many countries, ongoing conflicts or other political and social sensitive issues have led to strained relationships between Government and other stakeholders, negatively impacting efforts and work on health financing issues, social protection and donor alignment. Many countries are dealing with social unrest, triggered by longstanding issues, which has led to conflict, the loss of lives and property and, often, internally displaced persons (IDPs). In Ethiopia, in a more stable and serene political environment, DPs, in particular WHO and the World Bank, should now act as honest brokers to help safeguarding or developing existing collaborations for health financing.

(ii) Strengthening collaboration at the sub-national level: Efforts to strengthen and support collaborations are often focused on the national level. However, there is also a need for this type of support at the sub-national level, in particular in Ethiopia where there is a high degree of decentralization, with large regional differences. Leveraging DPs' sub-national presence and ongoing support is today a key challenge.

(iii) Strengthening information exchange between DPs: it is often unclear when and what information should be shared between DPs. In addition, among DPs, positions are not always aligned between headquarters and country offices. Lack of functional coordination mechanism and absence of a systematic/institutional management of knowledge assets limit the ability to create value and meet the strategic requirements for health financing. In this context, formulating lessons from

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existing successful multi-sectoral initiatives such as the One WASH program, the Seqota Declaration to end child under-nutrition by 2030, and multi-sectorial woreda transformation[63] could be of great help.

**(v) Health workforce challenges:**

● Ensuring equitable distribution and availability of health workers is a key priority[64]. Ethiopia is actually facing two main challenges: (i) Lack of quality of health professionals: In addition to the low ratio of health professionals to population, the general lack of quality and competency among health professionals has drawn the attention of federal and regional health officials, as well as the communities being served. It is of the utmost importance to conduct quality and competency assessments for both the educational curriculum and the employees in service; Inequitable distribution of health professionals: The health workforce is inequitably distributed across urban and rural areas. If there are few disaggregated data on the number of professionals working in rural and urban areas, emphasis could be laid on the fact that high-level specialized doctors and master's holders live and serve almost exclusively in urban areas.

● Another problem is that professional distribution depends on the regional government budget allocation for HR in health facilities of the region[65]. In 2009, the FMOH introduced the Human Resources Information System (HRIS) to facilitate routine data collection and management. However, the system has not been fully functional at various levels and has failed to produce comprehensive national HR information[66].

● The HSTP-II aims at building and sustaining a competent, motivated, and compassionate health workforce, with adequate number and skill mix. To motivate

[63] Utilizing multi-sectoral woreda transformation platform to enhance planning, budgeting, execution, and monitoring and evaluation of multi-sectoral development interventions in pilot woredas to bring about the four L's, e.g. Livelihood, Lifestyle, Literacy and Longevity could be very useful.

[64] In 2018, health worker density was estimated at 1.0 per 1,000 population (considerably lower than 4.5 per 1000 population standard proposed by WHO to achieve UHC). The inadequate skill mix of health professionals is another issue; there is a relatively high number of nurses but a shortage of medical doctors, midwives, anaesthetists, pharmacists, and medical laboratory technologists.

[65] Sometimes the deployed professionals are sent back to FMOH because of a shortage in budgetary allocation.

[66] During the HSTP-I period, the MOH took actions to strengthen the HRIS. High staff turnover has been a persistent challenge for the health sector.

and retain health staff, the FMOH needs to develop a new incentive package for health workers that is allocated based on pre-identified exposure level of risk. Focus should be on scaling up the training of community-level and mid-level health professionals[67].

● CBHI schemes are run by a structure that was developed to guide the pilot implementation. As schemes grow larger, staff members are today insufficient to carry out the duties necessary to run CBHI schemes. Furthermore, with the scale-up of the program, health facility staff are serving more beneficiaries now than before. Recruiting and retaining CBHI staff is a priority, which supposes to clarify the structure of the team, to revise the salary scale, to define the career structure, and to create an enabling working environment by allocating an adequate operational budget. Introducing incentive mechanisms so that staff will be motivated to give quality health services to CBHI beneficiaries[68] is core to this strategy.

**(vi) Health information challenges:**

● The Ethiopian Government has made significant progress regarding health information challenges. With regard to data quality for example, report completeness improved from 72% in 2015 to 89% in 2019[69]. Data consistency also improved, leading to reduced discrepancy between the data from routine information system and data in surveys. Various platforms were put in place to strengthen key decision-making, including performance monitoring teams (PMTs), review meetings, a Joint Steering Committee (JSC), and planning forums. Likewise, improvements have been done toward institutionalizing health accounts throughout the establishment of the Health Economics and Finance Analysis (HEFA) unit within the FMOH.

● However, despite interventions to strengthen health information systems (HIS), there are persisted gaps, including limited human resources HIS, inadequate functionality of PMTs at all levels, poor documentation, inadequate implementation of data quality assurance, and limited coverage of VPN-Health Net, LAN, electricity,

[67] With regard to community-level professionals, a total of 31 831 health workers have been trained and deployed to meet the HRH requirements of the Health Extension Programme. Similarly, the Accelerated Health Officer Training Programme was launched in 2005 in five universities and 20 hospitals to address the clinical service and public health sector management needs at district level.

[68] It has been reported that staff at facilities view CBHI members as burdensome, as CBHI members seek more health care services than non-members and have a preference for patients that pay user fees directly.

[69] Source: FMOH, 2019.

and computers.

● The Ethiopian Government is still facing huge challenges with regard with health information. In particular, it is today important to maximize the utility of health accounts data, which implies to conduct health accounts exercises regularly. In recent years, the FMOH has collaborated with the Ethiopian Central Statistical Agency (ECSA) to capture health spending by households through regular household surveys. Further institutionalizing the regular production of health accounts is a strategic objective to improve the quality and relevance of information for health financing.

● Streamlining the data collection process is another key challenge. The very purpose is to reduce the cost of conducting health accounts exercises. Developing innovative mechanisms is needed. For example, the FMOH could work with the Ministry of Finance and Economic Development (MOFED) and the National Bank to create a mechanism by which the FMOH could obtain regular information on health spending by DPs and insurance companies.

● The disease surveillance system has improved. A national database center was created at the Ethiopian Public Health Institute (EPHI) to handle the Public Health Emergency Management (PHEM) information system. Vital events and civil registration systems are operational, but the coverage is still low[70]. Vital event registration needs improvement, especially at health-facility and community levels.

● "Information Revolution" is a strategic objective for HSTP-II: Improving methods and practices for collecting, analysing, presenting, using, and disseminating information that can influence decisions has been pointed out[71].

## 3. WHAT IS NEEDED?

### (i) Strengthening policy frameworks by:

- **Adopting conducive policies and strategic plans:**

[70] So far, 23 reportable diseases, including maternal and perinatal death surveillance and response, are reported.

[71] During HSTP-I, the indicators selected to monitor progress did not align with the burden of disease and had an unbalanced mix. Most performance indicators were not measured, due to lack of appropriate data source and inability to conduct the required surveys and assessments.

- Adequate, fair and updated policies would allow for Ethiopia to match levels of spending at least comparable to others lower middle-income countries (LMICs) in the SSA. This would result in much more resources devoted to primary care in Ethiopia, which would likely significantly improve the health conditions of its people and advance its efforts to achieve UHC based on a primary care approach.

- Enhancing Health in All Policies (HIAP) and strategies is a key priority[72]. By promoting healthy practices across all sectors, HIAP fosters inclusive, sustainable development and helps address the social determinants of health, reduce multi-sectoral risk factors, and promote health and well-being.

- Conducive policies and strategic plans have already been adopted in recent years by the Ethiopian Government to strengthen the health system. The development of the first ESHP in 2005, which defined appropriate priority health services to improve the health status of the Ethiopian population, and its revision in 2019, goes along with this rationale[73]. Ensuring sustainable health financing and a clear and viable payment mechanism for EHSP is now crucial.

- The launch of SHI is a key challenge. Preparation is at an advanced stage and the EHIA has already established offices at national and regional level. SHI will initially cover Government employees and their families as well as formal sector workers through a combination of employer and employee contributions.

- Development and implementation of clear and consistent policies and procedures for fee retention and use by health facilities has been successful in incentivizing facility managers to collect and make good use of these resources. Other priorities include: To advocate for the inclusion of health and health-related perspectives in all relevant sectorial policies and regulation; To scan existing policies and strategies from all sectors and identify priority collaborative areas for multi-sectoral engagement; To introduce policies to

[72] HIAP is a systematic approach for considering the health implications of decisions of public policies across all sectors.

[73] The values and guiding principles of Ethiopia's EHSP draw from the values reflected in the national health policy and other strategic plans. These include value for money, priority to the poorest, enhanced equity, financial risk protection, poverty reduction, creation of a resilient health system, achievement of UHC, cost-effectiveness, affordability, improved quality, building institutional capacity and sustainability of health interventions.

strengthen the financing of Government hospitals and provide positive incentives to retain specialist physicians in Government facilities[74]; and to mobilize domestic resources for HIV in a way that promotes the sustainability of the response and the transparent, efficient, and cost-effective use of resources for priority interventions[75].

- **Elaborating costing frameworks:**

- Conducting a costing exercise for the entire EHSP[76] and per health intervention was an important step to improve health financing. The costing and fiscal space analysis included scenario analysis to provide information for the final decision of the package[77].

- The overall costing for HSTP-II implementation was computed using OneHealth Tool (OHT)[78]. Accordingly, U.S. dollars $21.88 billion and $ 27.55 billion at base and high-case scenario respectively is required for the five years to be covered in the plan, while the available financial resources during that period are projected at $18.7 billion, $19.7 billion, and $21.9 billion for low-, medium-, and high-case scenarios, respectively. Where there are financial limitations, the tool facilitates a process of prioritization and/or scenarios with more realistic levels of ambition for developing the plan. The biggest cost difference between base and high case scenarios is observed in infrastructure and pharmaceutical supply.

[74] Such as establishing private wings in a number of government hospitals.

[75] The Federal HIV/AIDS Prevention and Control Office (FHAPCO) and the FMOH recently developed the HIV Domestic Resource Mobilization and Sustainability Strategy to coordinate and govern all domestic resource mobilization efforts.

[76] The interventions that should be included in the EHSP were revised/updated based on the cost estimation and fiscal space analysis.

[77] A fiscal space analysis for the years 2020–2030 for the EHSP was conducted to predict the expected available resources. In the fiscal space, all potential sources of resources for health were explored by comparing the estimated resource needs with projections of the resources available. The fiscal space analysis was performed based on the current proposed reforms to the health financing structure and discussions on innovative funding options/sources with the Ministry of Finance and Economics Cooperation (MOFEC).

[78] OHT is a tool based on the WHO's six health system building blocks framework.

### ● Promoting equity in health system financing[79]:

- Inequitable distribution of health outcomes and health services continues across different segments of the population. Health indicators vary significantly by region, place of residence, gender, disability status, education, and socioeconomic status[80]. Recognizing these challenges, the Government has given special attention to addressing equity by designing and implementing initiatives that provide special support to relatively disadvantaged regions.

- The regional block grants from the MOFED to regional states, through which the Health Extension Program (HEP) is financed, are calculated based on an equity formula.

- However, matters of concern still persist. CBHIs are piloted at woreda level, with population and enrollment rate varying a lot. As a consequence, the actual risk pools vary by size. In addition, there is no redistribution between households based on income level in such a way that smaller households are subsidizing larger households. Another issue of concern is that the per capita public subsidy for Government employees covered under the SHI program will be much higher than that for CBHI enrollees, which may exacerbate inequities in Government budget allocations.

- Fee-exempt services minimize the burden of user fees on households for key health services[81], and the fee waiver program also benefits the poor. But fee waiver schemes still may not reach a sizable population in need[82].

- Monitoring equity has become a priority: it is now critical to measure performance by disaggregation (equity measures) in order to determine the equity of health service use.

[79] It is generally accepted that the burden of health financing should be distributed according to an individual's ability to pay, that is, the burden should increase as household income increases.

[80] In general, urban residents, literates, and wealthier segments of society enjoy better health outcomes compared to others.

[81] Fees for non-exempt services still pose a significant barrier to access to health care for the poor who are not covered by fee waiver.

[82] 1.4 million people nationally are reported as eligible with the appropriate certification as compared to the close to 24 million people who live below poverty line.

**● Ensuring financial sustainability and enhancing the efficient use of resources:**

- Improving the health financing efficiency is one of the priorities in HSTP-II and one of the strategic objectives of the Health Care Financing Strategy. Loss of resources due to inefficiencies is a global concern. UHC cannot be achieved by raising resources alone. Resources will have to be used more efficiently. Experts claim that 20-40% of all health resources are wasted due to inefficiencies and the costs saved from addressing these reported health sector inefficiencies is estimated between $37 and $90 million per year.

- Introducing Performance-Based Financing (PBF) is strongly needed. The FMOH and DPs are currently in the process of designing a PBF mechanism which would incentivize sub-national levels to allocate more resources to the health sector and would improve efficient and effective delivery of results by linking disbursement of funds with achievement of set outcome indicators.

- Ethiopia has already made improvements regarding expenditure efficiency. The prioritization of high impact intervention at the primary care level and attempts to improve allocative efficiency through the One-Plan, One-Budget, One-Report system allowed for improved planning, budgeting and reporting.

- With regard to budget, using line-item budgeting allows for activities to be inputs-focused but is not effective for getting value for money since resources used are not linked to service outputs or outcomes. There is also room for potential efficiency gains through harmonizing fragmented off-budget donor financing. In addition, better planning and coordination may promote efficiency given that recurrent cost and capital cost are managed by regional governments and the FMOH separately.

- SHI and CBHI should increase value for money since they intend to increase risk pooling and reduce OOP spending. It is of the utmost importance for the Government to calibrate benefit package design, provider payment mechanisms, and cross subsidization within and between the two programs. The financial sustainability of some of the pilot CBHI schemes is not ensured. There is a need to increase enrollment for better risk pooling at the scheme level. Premium collection mechanisms should be strengthened, and premium levels made consistent with benefit packages and service utilization. There is also a need to establish larger risk pools to have reinsurance and risk pooling

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among schemes. Establishing CBHI risk pools with clear resource contribution and expenditure assignment criteria at zone and region levels should be prioritized.

- With regard to supply side interventions, efforts need to be focused on more open and accountable budgeting, planning and coordination, procurement and human resource management to respond more effectively to health care needs.

- **Improving data availability to inform policy and decision making:**

- HSTP-II identified evidence-based decision-making as one of the strategic directions to transform use of information in decision-making in the sector, including the M&E system[83].

- The introduction and scale-up of the health management information system (HMIS), and community health information system (CHIS) at health post level, allows health facilities to keep track of health coverage and outcome data. This is routinely used in the annual woreda based core plans as well as to measure performance.

- Despite efforts to conduct resource mapping, there are still huge difficulties to get data on external assistance coming through channel 2 and channel 3. Likewise, collecting expenditure data from lower administrative levels is still a challenging and time-consuming process. DPs' continuing requirements for data on indicators that are not collected in the HMIS remain an issue.

- The Ethiopian eHealth Architecture will be implemented in the upcoming years with the aim of improving data quality and use, interoperability between and across eHealth applications, performance monitoring, and sharing of information. Data quality-assurance techniques will be implemented holistically at each level of the health system. As part of external verification

[83] The common data sources used to measure and inform HSTP-II include: (i) Routine health information sources such as HMIS, the regulatory information system, the health commodity management information system, the human resource information system, civil registration and vital statistics, the health insurance information system, the integrated financial management information system, and administrative reports; (ii) And non-routine data sources such as population and housing census surveys, Demographic and Heath Surveys, and burden of disease studies.

process, and to enhance reliability and credibility, data quality audit (DQAs) will be conducted every two years by the EPHI. A data access and sharing protocol will be developed and implemented to institutionalize a proactive approach for releasing data to stakeholders and to the public.

**(ii) Strengthening legal and regulatory frameworks by:**

- **Adopting robust legislations:**

- During HSTP-I, health care facility standards have been developed and routine inspection of public and private health care facilities took place. A number of proclamations, regulations, and legal frameworks have been developed and implemented during the HSTP-I period, including a tobacco control proclamation, directives on national medicine use, food and pharmaceutical sampling, food registration, and alcohol advertisement. The main challenge today consists in harmonizing and strengthening the enforcement of all the regulatory frameworks.

- There is a need to provide a legal basis for CBHI scale-up, which requires either the development of a CBHI legislative framework or revisiting the health insurance proclamation. This legislative framework should clearly define the CBHI scale-up roles and the respective mandates of the FMOH and the EHIA vis-a-vis regional health bureaus and woreda administrations and/or health offices. This strengthened legislative framework should also provide a legal basis for creating larger risk pools in order to enhance reinsurance and future integration of CBHI into SHI as a vehicle for UHC Last but not least, CBHI bylaws and the CBHI Financial and Administrative Management System (FAMS) need to be reviewed and modified.

- Lack of legal frameworks and of standardized PPP[84] operating procedures is a major limitation in the implementation of PPPs in Ethiopia. PPPs need to be guided in a systematic and organized way for design, management,

[84] Public-private partnerships can make useful contributions to access, quality, and equity when designed and managed well. There are many examples of different approaches such as: Contracting (government procurement of services from non-government actors through formal legal agreements), both to strengthen the functioning of government facilities (sometimes called "contracting in") as well as to augment government service delivery capacity or in some cases substitute for it (sometimes called "contracting out"); Transactional arrangements to enable private financing and management of health services such as "build, operate, transfer" agreements; and Demand-side financing of non-government providers through mechanisms like vouchers.



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monitoring and evaluation of contractual agreements. The absence of legal and regulatory foundations and technical capabilities in Government agencies jeopardizes the possibility of designing contracts, negotiating agreements, and monitoring processes and results.

- In addition, partnerships between Government and private-for-profit facilities on specific programs, particularly HIV/ART and tuberculosis (TB), need to be structured and fully led by Government for sustained impact. Building strong structures from federal to woreda levels, and establishing a unit dedicated to PPP at national, regional and possibly at woreda levels is a key challenge.

- The Ethiopian Government has recently committed itself to strengthen its legislative framework in order to promote health activities in the country and health financing. On 17 March 2020, the Excise Tax Proclamation n°1186/2020 has been adopted by the President of the federal democratic republic of Ethiopia. The very purpose was to review the type of goods on which excise tax has been collected and impose the tax on goods and services that are believed to be luxury and hazardous to health. As a result of the legislation, Ethiopia has now introduced a mixed-excise system on cigarettes in line with the recommendations of the WHO.

- **Adopting implementing/regulatory measures:**

- During HSTP-I, efforts were undertaken to strengthen the regulatory system for food, medicine, traditional medicines, equipment and supplies, health professional, and health and health-related facilities. The regulatory system needs today to be further strengthened.

- Despite the finalization of the legal framework, the SHI has not been rolled out. Delayed Government decision to implement SHI is a matter of concern. Similarly, CBHI, which is expected to cover the vast majority of the population, is still in pilot phase in such a way that it cannot produce any measurable contribution towards financial risk reduction. Adopting implementing measures has become a priority[85].

- There is divergence between health care financing proclamations, regulations

[85] Regions are responsible to establish a mechanism to develop the legal framework for implementation. Most often, a committee established from relevant regional bureaus (health, finance, regional cabinet) steer this process.

and guidelines and actual implementation of the health care financing strategy. Actually, the exempted services provided currently not only differ from the list provided in the laws but also have significant equity issues as some woredas benefit from such services from donor funded services while other do not. Aligning implementing measures to legal basis is a recurring challenge.

- Overall, accountability for health financing supposes to standardize and institutionalize grievance handling and monitoring mechanisms at all levels.

**● Enhancing leadership and governance mechanisms:**

- A key challenge is enhancing leadership and governance mechanisms at all levels of the health system to drive attainment of the national strategic objectives. Enhancing leadership and governance will foster the translation of plans into results and will allow for alignment and harmonization.

- A priority issue in HSDP-II is reforming public financial management and health financing to improve efficiency and accountability, while pursuing the agenda of sustainable domestic resource mobilization for health. From this point of view, leadership is supposed to play a pivotal role in policy and strategy development, to create and strengthen transparency and accountability in the health system, and to promote coordination and inter-sectoral collaboration and overall guidance of the health system.

- In a very significant way, HSDP-II includes a “quality of health services” component. This component encompasses supply-side interventions, demand-side interventions and regulatory measures. The supply-side interventions include providing adequate numbers of skilled and motivated professionals and strengthening the supply chain management system to ensure an adequate and uninterrupted supply of pharmaceuticals at the point of service delivery. An internal quality assurance mechanism will help ensure effective implementation of performance monitoring and quality improvement standards and tools at all levels of the health system. Other measures include placement of community members on health facility governance boards, development of a patients’ rights charter and conducting regular surveys on client satisfaction. Focus should be on provider organizations and facilities to ensure feedback and accountability and strengthen patient safety and quality improvement.

- For CBHI, institutionalizing formal mechanisms and procedures to gather and address complaints from beneficiaries seemed to positively influence enrollment ratios. Dedicated units for management of inputs and feedback from beneficiaries are likely to contribute to accountability and responsiveness of CBHI schemes, which will in turn encourage increased and sustained enrollment.

**(iii) Strengthening institutional frameworks by:**

- **Creating supportive environments:**

- The Ethiopian Government committed itself to create an enabling environment for CSOs and the private sector so that they can participate more efficiently in health promotion, disease prevention, curative, rehabilitative, and palliative care. To attain this objective, financial support should be channelled through CSOs[86] and regular policy dialogue with the Government established regarding ways to improve PPPs[87]. Likewise, the relations between the private sector and DPs should be further strengthened. This could be done by encouraging the private sector to participate more actively in the implementation programs.

- Revitalizing the implementation arrangements will strengthen the institutional framework for health financing:

(i) The Joint Consultation Forum (JCF) is the highest governance body[88]. It decides, guides, oversees, and facilitates the implementation of HSTP-II. It is also a forum for dialogue and consultations on the overall policy direction, reform, and institutional concerns about the health sector between the Government, DPs, and other stakeholders. The JCF plays a leading role in expanding the involvement of the private sector and CSOs in health service delivery. Its functions needs to be revitalized through processes for

[86] For example through CSOs such as Marie Stops International Ethiopia (MSIE), FGAE (Family Guidance Association of Ethiopia) and DKT Ethiopia - DKT is a non-profit organization founded in 1990 that employs social marketing to promote the adoption of family planning, HIV prevention, and maternal and child health products and services.

[87] There is also a need to revitalize the unit overlooking the private sector within the FMOH.

[88] The JCF is chaired by the Minister of Health, co-chaired by Health, Population and Nutrition (HPN) chair, and the Secretariat will be the Policy, Plan, Monitoring and Evaluation Directorate (PPMED). The membership of JCF consists of high-level representatives of the appropriate federal government bodies, representatives of the Health Population and Nutrition (HPN) development partner groups (multilateral and bilateral DPs), NGOs, the private sector, and health professional associations.

collaborative agenda setting and close follow-up of planned actions.

(II) The Joint Core Coordinating Committee (JCCC)[89] serves as the technical arm of the JCF and assists and works closely with the FMOH in following up the implementation of the decisions of the JCF and the recommendations of the review missions[90]. With the ongoing revision and full implementation of the HDSP Harmonizing Manual (HHM)[91], the functioning of the JCCC has to be revitalized by revising its composition and by developing performance accountability measures among federal and regional government levels.

- Arrangements between donors, the federal government, and the FMOH should also be further developed to avoid the duplication, fragmentation, and mismanagement of external aid flow.

- Last but not least, to accelerate progress toward UHC, CBHI requires strong and functional institutional arrangements. This requires re-examining the structure of the EHIA and its branch offices, as well as regional and woreda government structures and their relationship in CBHI implementation. It is also necessary to review and establish kebele/tabia-level structures for CBHI, in particular to ensure that kebele/tabia executives will play a significant role in CBHI enrollment, and collection and depositing of premiums.

**● Advocating for new investments:**

- Investment in health can reduce poverty and catalyse wider cycle of economic growth. HSTP-II plan focuses on strengthening health investment areas such as medicines, information health workforce, health infrastructure, digital health and innovations in health. Continued investments are planned to expand the scope and improve the quality of the health care system over the next 20 years[92].

[89] The JCCC is composed of Policy, Planning and Monitoring & Evaluation Directorate (PPMED) staff, and senior members from the Health Population and Nutrition (HPN) Group. It is chaired by the Director of PPMED.

[90] Mid-term and annual review meetings, and final evaluation.

[91] Published in 2007 by the FMOH for use by Ethiopian health officials at all levels, as well as foreign stakeholders in the Ethiopian health care system.

[92] Costing and target setting was developed by linking strategic objectives and targets of health programs to the required investments in health systems.

- Improving private sector engagement in health can be one means to substantially increase available resources for health in Ethiopia via domestic and foreign direct investment. Furthermore, private sector engagement can also facilitate technology transfer, improve quality, and redirect resources from other sectors.

- As part of a larger systems-level response to strengthen the institutional sustainability of the CBHI scheme, priority should be placed on advocating for increased investment and resources to improve services provided at health facilities[93]. Mobilizing resources to address these issues needs increased focus and commitment from both regional and federal governments in order to ensure the sustainability of the CBHI program. Exploring the potential of alternative sources of financing for CBHI, including member contributions, and subsidies from federal, regional and woreda government is thus crucial.

**● Establishing close monitoring and accountability for results:**

- The Ministry has developed a scorecard system to improve the accountability of the health system by enabling communities to measure the performance of health facilities and provide feedback. Currently, the scorecard system is in use in more than 600 woredas. Despite these initiatives, there is a recognized need to further strengthen accountability framework at each level during HSTP-II period.

- An annual "resource mapping" process is also in place. It tracks flow of fund and other resource from DPs. Coverage and timeliness of reporting has improved over time, but gaps still remain[94].

**● Improving coordination between all stakeholders:**

- Domestic efforts should be focused on better aid coordination and effective use of development assistance and technical expertise to strengthen country health systems and institutions.

[93] Health facility readiness, quality of care, and availability of drugs are highlighted as the main factors that constrain enrollment into CBHI schemes.

[94] Despite the emphasis on woreda-level planning, according to the many Joint Review Mission (JRM) and the Midterm Review (MTR) reports, local authorities may not have the full and timely information about externally financed resource flows that they need to incorporate into their planning.

- As a coordination platform with regional health bureaus, the FMOH holds regular Joint Steering Committee (JSC) meetings every two months, and Executive Committee Meetings take place with agencies every two weeks. These platforms support the health sector by regularly reviewing and monitoring the performance against set targets.

- JCF and JCCC meetings are held regularly between FMOH and donors to address technical and operational issues. The FMOH is now working closely with private organizations and professional associations to ensure their engagement in planning, review meetings, supportive supervision, and other health activities.

- To engage effectively with other sectors, the FMOH has initiated the concept of multi-Sectoral Woreda Transformation[95]. The very purpose is to strengthen and transform district health systems through improving key health system investments. High-impact health interventions will be implemented, mainly at household and primary health care levels. The health specific Woreda transformation focuses on creating model households, model kebeles and high performing primary health units through a meaningful community engagement and a transformed Woreda leadership[96].

**● Enhancing data collection and analysis:**

- While data for financial protection indicators are being collected in household income, consumption, and expenditure surveys, these data are not analysed or reported to cast light on the level of financial protection available in the country. As such, they are also not relevant for annual planning and programming. Timely generation and use of evidence on what works and what doesn't is critical for good scheme management and for policy decision making.

[95] A pilot implementation took place at Gimbichu Woreda, but there needs to be further action.

[96] It also focus on implementation of Woreda management standards, reforms and implementation of health-financing strategies to reduce financial risks to the community. The health specific Woreda transformation will be measured on indicators that includes the following key attributes: Creation of model households and model kebeles; Creation of high performing primary health care units; Implementation and high coverage of health insurance mechanisms such as CBHI; Creation of a resilient Woreda management; and Enhanced community participation and engagement in health.

- There is a need to review and strengthen the CBHI monitoring and evaluation (M&E) and management information system. This may imply the following actions: (i) to define key data analysis; to clarify responsibilities at the federal, regional, zonal, and woreda levels; to strengthen record keeping at scheme and kebele/tabia levels; and to institutionalise periodic reporting and performance reviews. There is also a need to improve the information system to ensure that data on health service utilization by CBHI beneficiaries are properly documented and shared with the schemes. The routine M&E system should include regular supportive supervision by government authorities at all levels.

**● Aligning overall health system and health financing reforms:**

- Under the leadership of FMOH and regional health bureaus, and in line with the country's GTP II, the HSTP-I was developed with the aim of transforming the health system and ensure equitable, quality, resilient, sustainable health services to all segments of the population. Annual woreda-based health sector plans (WBHSP) were developed, based upon the principles of "one plan, one budget, and one report". The WBHSPs have contributed to the alignment and harmonization of systems for planning, budgeting, resource allocation, prioritization, tracking, and reporting.

- In recent years, Ethiopia's Joint Consultative Forum has promoted harmonization and alignment of programme activities, mobilization of resources, and implementation and monitoring. In addition, both strategies and annual plans are the result of consultation entailing top-down and bottom-up processes. The top-down process ensures alignment of national priorities and targets with those of the regions and woredas and also helps to create consistency between health sector plans and the national prosperity plan.

- However, matters of concern remain. In particular, the ESHP, CBHI, and SHI are still not explicitly aligned[97]. In addition, weak resource mapping, misalignment of the timing with the Government budget ratification schedule, and poor utilization of plans for budget negotiations at sub-national level, still result in disproportionate budgeting for health.

[97] The SHI appears to be even less aligned with the EHSP given that it covers a broad package of services, including tertiary care services that would likely be unaffordable for the Government to cover for the entire population.

- Developing a comprehensive vision for the future development of health care financing in Ethiopia, aligned with broader development plans, with clear roles and directions for Government, non-government, and DPs, is thus a priority.

- **Transferring powers and resources to local authorities (decentralization):**

- Ethiopia has one of the most ambitious decentralization programs in Africa[98]. Powers and mandates are devolved first to regional states, and then to woreda authorities and kebele (village) authorities. The decentralized levels receive block grants from the MOFED based on mutually agreed resource allocation criteria[99].

- Decisions for priority setting are made at the national, regional, district, and service delivery levels. The nine regional health bureaus and two city administrations are responsible for plans and programs in their areas to deliver health services based on the national health policy and health service delivery capacities within the region[100]. The woreda health offices[101] manage and coordinate the primary health care units and are responsible for planning, financing, and monitoring the health progress and service delivery within the woredas.

- So far, the reforms have increasingly decentralized management of the primary health-care system and created opportunities for governance at local levels to improve the effectiveness, efficiency, equity and sustainability of health services. Besides, the bottom-up process ensures that the priorities

[98] Ethiopia practices fiscal decentralization, where different tiers of Government are assigned with defined expenditure discretion (expenditure assignment), revenue-raising powers (revenue assignment), and defined intergovernmental transfer and borrowing functions, as provided by Federal and Regional States Constitutions.

[99] If the expenditure assignment on health is more at the lower levels (woredas and regions) than the national level, however, resources are pooled and invested through government transfer mechanisms. So far, financial resources are transferred from federal government to regional governments in the form of both general-purpose grant (block grants-channel 1a) and specific purpose grant (channel 1b); and at the regional level, transfers are made to woredas in the form of general-purpose grant.

[100] They are also responsible for licensing of health facilities and ensuring adequate supply of safe and affordable medicines and supplies.

[101] The woreda health offices fall under the administrative control of woreda councils.

and targets within regions and districts take local challenges and capacity into account[102].

- However, some issues at the decentralized level have still to be dealt with. For example, coverage with fee waivers is still low in many regions and implementation is uneven. Many woredas are actually reluctant to apply fee waivers to the full extent due to the implications for limited woreda budgets.

**● Developing Public-Private Partnerships (PPPs) and "contractual arrangements":**

- If the private sector has strong presence in the health sector in Ethiopia, enhancing its engagement is still a key challenge[103]. In particular, through proper regulation, the private sector should provide and finance more curative services and some preventive care and increase its engagement in a comprehensive range of health-related activities, from service delivery to supply forecasting. This direction includes the engagement of both private for-profit and private non-profit institutions. So far, however, limited incentive mechanism for private sector investment in health services and products is a recurring obstacle.

- The political will and full involvement of the Ethiopian Government is today crucial to subsidize or facilitate the development of an insurance system capable to deal with private curative services without incurring catastrophic costs. The Government should also facilitate the private sector's engagement to expand health infrastructure, local production of pharmaceuticals, and medical devices.

[102] Each decentralized entity and programs will have its own strategic plan that emanates from the broader HSTP-II.

[103] Though, it is largely limited to major urban centers.