BRIEF

April 2019

Key Advocacy Priorities to Improve Sustainable Financing of Ethiopia's Health Sector

Background

Ethiopia's health sector has, historically, been heavily reliant on external sources of financing. However, external resources declined as a share of total health expenditure from 50% to 36% from fiscal year 2010/11 to 2013/14. Over the same period, government resources nearly doubled as a share of total health expenditure from 16% to 30% and nearly tripled in current U.S. dollars from $258 million to $752 million. However, Ethiopia is still a long way from achieving the targets for health expenditure outlined in its Health Sector Transformation Plan, 2015/16–2019/20 (HSTP), international targets to provide "a minimum level of key health services in low-income countries," or the Sustainable Development Goals (SDGs) by 2020 (McIntyre and Meheus, 2014; Stenberg et al., 2017).

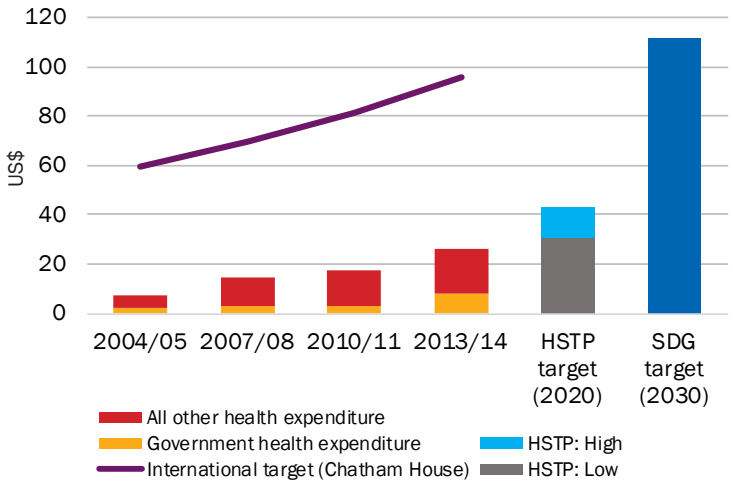
Achieving both national and global targets for health expenditure will require substantial increases in the Government of Ethiopia's allocation of domestically generated revenue to health. Achieving the SDG targets would likely require increasing the health budget, in nominal Ethiopian birr (ETB) terms, by roughly 25% annually through 2030. To put itself on track to meet this target, Ethiopia should commit ETB 64 billion (approximately US$2.1 billion) to health for 2020.

Advocacy Priorities to Improve Sustainable Financing for Health

To put Ethiopia on track to achieving the necessary levels of health expenditure, while ensuring that this expenditure is efficient and targets the areas of greatest need, four priorities should be pursued. These priorities were identified by Palladium through a Global Fund-supported analysis (Fagan et al., 2019).

1. Commit a greater share of domestically generated resources to health
2. Focus new health budget allocations on commodity procurement and exempted services
3. Clearly articulate areas and targeted interventions for efficiency improvements

Per Capita Health Expenditure, Historical and Targets



Sources: McIntyre and Meheus, 2014; MOH, 2014 and 2016a

4. Promote the integration of user fee-exempted health care services into social health insurance and community-based health insurance

In the following tables, each priority area is defined along with current challenges and a set of focused advocacy actions, based on a three-step process to:

A. Articulate the problem and generate evidence as to why it must be addressed

B. Elevate the issue to decisionmakers and identify policy options for addressing the issue

C. Build political momentum and capacity to act in accordance with recommendations

By following this process, advocates and decisionmakers can work to ensure more sustainable financing for health, including priority disease areas, in Ethiopia.

PRIORITY 1

The Government of Ethiopia must commit a greater share of its domestically generated resources to health. Given current macro-fiscal trends, domestic government health expenditure is projected to grow at approximately 19% annually (nominal, ETB) with health remaining constant as a share of the general budget at 6.9% (FMOH, 2017; IMF, 2018). In contrast, a commitment of ETB 64 billion in 2020 would account for about 12% of all domestically generated resources (including loans). Therefore, there is a need to achieve greater prioritization of health. To do so, the Federal Ministry of Health (FMOH) and its partners will need to make an effective investment case for health, demonstrating how investments in health pay off both in terms of future savings (e.g., in averted health and social protection costs) and economic gains (i.e., increased productivity).

ADVOCACY OUTCOME: INCREASE SHARE OF GENERAL GOVERNMENT BUDGET ALLOCATED TO HEALTH	
Key stakeholders	• Partnership and Cooperation Directorate, FMOH • Ministry of Finance (MOF) Budget Office • Council of Ministers • Regional health bureaus
Challenges	• The MOF does not see health as a productive sector and believes that current resources are both sufficient and inefficiently used • The FMOH does not have a regular, institutionalized line of communication with the MOF • Regional Health Bureau and Bureau of Finance staff are not aware of the latest financing trends, particularly from development partners
Advocacy goal	**Advocacy activity**
Articulate the problem and generate evidence	• Generate evidence—including briefs, dashboards, and presentations—summarizing current financing trends, contrasted against projected funding requirements • Support the FMOH Partnership and Cooperation Directorate to regularly update and share resource mapping to clearly articulate the current external financing situation and changes
Elevate issue to decisionmakers and identify policy options	• Conduct national and regional workshops to develop the capacity of the FMOH, regional health bureaus, and partners to use data and understand opportunities to influence budget processes • Leverage and support dissemination and advocacy around the policy dialogue document currently being developed by the World Bank to elevate health within the national policy agenda • Conduct national and regional workshops to sensitize key decisionmakers on recent financing trends • Identify parliamentarians to serve as champions for the health sector and increased financing for the sector
Build political momentum and capacity to act	• Assign a budget officer in the MOF to serve as a liaison to the FMOH, Federal HIV/AIDS Prevention and Control Office, and other health sector institutions • Improve engagement and coordination between the FMOH Partnership and Cooperation Directorate and the Policy and Planning Directorate to better link targets and results reporting to resource allocations

PRIORITY 2

Increased allocations to health should target commodity procurement, particularly for exempted health services. The Government of Ethiopia has fully absorbed health care workers and infrastructure previously supported by donors and has invested significant additional resources in expanding their reach through its Health Extension Program. However, external resources remain the major or sole financing source for many key commodities, particularly those for HIV, tuberculosis, malaria, and family planning. As demand for these commodities continues to grow, the FMOH and MOF must begin to supplement these funds with domestically generated resources, both to achieve targets and to mitigate the vulnerability of these key programs to sudden reductions in external financing.

ADVOCACY OUTCOME: INCREASE ALLOCATION OF DOMESTICALLY GENERATED RESOURCES TO COMMODITY PROCUREMENT	
Key stakeholders	• Disease Prevention and Control Directorate and disease units (HIV, tuberculosis, malaria), FMOH • Partnership and Cooperation Directorate, FMOH • Maternal and Child Health Directorate and Family Planning Unit, FMOH • Regional health bureaus and woreda health offices • Pharmaceutical Fund Supply Agency
Challenges	• Commodities for priority health care programs and services, such as HIV, tuberculosis, malaria, and family planning, are exempted from user fees, do not participate in the Pharmaceutical Fund Supply Agency's revolving drug fund, and have no consistent source of domestic financing • The greatest opportunity for increased resource mobilization for commodities is at the central level (FMOH), while responsibility for commodity financing within government currently lies at the woreda level, where there is limited fiscal space for health

Advocacy goal	Advocacy activity
Articulate the problem and generate evidence	• Generate evidence on current and forthcoming commodity financing gaps for dissemination • Identify potential commodity gaps at the regional or local level
Elevate issue to decisionmakers and identify policy options	• Conduct workshops with key stakeholders from the FMOH, the Pharmaceutical Fund Supply Agency, and regional health bureaus to review the current commodity financing situation and discuss sustainability strategies • Conduct workshops and training with FMOH staff to analyze procurement funding data and identify emerging gaps
Build political momentum and capacity to act	• Engage regional health bureaus and woreda health offices to make procurement commitments • Facilitate negotiation between woreda health offices (and regional health bureaus) and the FMOH to transfer formal responsibility for commodity procurement to the federal level for exempted health services • Secure commitment for an increase in health resources (above the previous year) that can be allocated to commodity procurement

PRIORITY 3

Increased efficiency in the use of funds for health must be articulated and achieved.

Improving efficiency can play a dual role in meeting the current funding gap for the health sector—it lessens costs and associated budgetary needs and demonstrates why increasing budgetary allocations to the health sector are a productive investment. The FMOH should focus on identifying clear and specific areas and efforts to improve efficiency, including absenteeism (estimated at 10%; Feysia et al., 2012) within the health workforce, reducing leakages in patient referrals and retention, and improved targeting and prioritization of high-impact interventions, such as for HIV. The efficiency improvements identified should clearly link costs to outcomes. The FMOH should demonstrate how it can free up additional resources to match, at least in part, additional allocations from the MOF.

ADVOCACY OUTCOME: ARTICULATE AREAS AND TARGETED INTERVENTIONS FOR EFFICIENCY IMPROVEMENTS		
Key stakeholders	• Partnership and Cooperation Directorate, FMOH • Ministry of Finance (MOF) Budget Office	• Council of Ministers • Regional health bureaus
Challenges	• The MOF views the health sector's current use of resources as inefficient, limiting willingness to allocate additional resources • A lack of adequate targeting and prioritization of health interventions (such as for HIV) reduces program impacts • Poor incentive structures do not link health worker compensation to outputs or patient outcomes	
Advocacy goal	**Advocacy activity**	
Articulate the problem and generate evidence	• Generate evidence on prevalence and causes of health worker absenteeism and identify high absenteeism cadres and regions • Identify primary contributing factors for patients that are lost or discontinue treatment/services for priority public disease areas such as HIV, tuberculosis, and family planning • Establish clear performance indicators for efficiency, including for absenteeism, case identification, treatment success/failure, loss to follow-up, and targeting of key populations (e.g., for HIV prevention)	
Elevate issue to decisionmakers and identify policy options	• Strengthen dialogue with the MOF through a proposed MOF health sector focal point to identify evidence needs and areas for efficiency improvements • Design appropriate monitoring reporting mechanisms to provide regular updates to the MOF on performance indicators • Increase the use of cost-effectiveness analyses to determine programs and interventions that have the greatest impact; align budgets accordingly, clearly demonstrating this rationale to the MOF	
Build political momentum and capacity to act	• Engage regional health bureaus and woreda health offices to make procurement commitments • Facilitate negotiation between woreda health offices (and regional health bureaus) and the FMOH to transfer formal responsibility for commodity procurement to the federal level for exempted health services • Secure commitment for an increase in health resources (above the previous year) that can be allocated to commodity procurement	

PRIORITY 4

User fee-exempted health services must not be left behind in the drive toward insurance-based health care. With community-based health insurance being rapidly scaled up and social health insurance pending implementation, Ethiopia has quickly embraced insurance expansion as the primary pathway to achieve sufficient, sustainable financing for health. Both schemes are central to the objectives of the draft health care financing strategy, which aims to achieve a combined 40% national coverage under both schemes by 2020 (FMOH, 2017). However, the exclusion of services that are currently exempt from user fees presents a significant limitation to the ability of social and community-based health insurance to ensure sustainable health financing.

ADVOCACY OUTCOME: INTEGRATE PRIORITY USER FEE-EXEMPTED HEALTH SERVICES INTO PUBLIC HEALTH INSURANCE IN A MANNER THAT ENSURES EQUITY AND SUSTAINABILITY

Key stakeholders	• Ethiopia Health Insurance Agency (EHIA) • EHIA bureau offices and woreda health offices • FMOH
Challenges	• User fee exemptions for priority health areas are seen by the government and development partners who finance them as key to providing equity in access, although these exemptions do not necessarily target government subsidies for clients who most need them

Advocacy goal	Advocacy activity
Articulate the problem and generate evidence	• Identify impact of underfinancing priority health areas, particularly on poor and marginalized populations (i.e., those without the ability to pay) • Generate and update unit costs for exempted health services for both public and private facilities, considering current public subsidies, to be used as reimbursement rates
Elevate issue to decisionmakers and identify policy options	• Engage the EHIA in conversations and decisionmaking around domestic resource mobilization broadly to define the role of social and community-based health insurance in financing for exempted services • Conduct sustainability and actuarial analyses of the integration of exempted services into social and community-based health insurance, considering demographic and health characteristics and utilization rates; develop scenario based-options for integrating multiple packages of exempted services (e.g., packages that exclude more costly commodities) • Develop a clear roadmap for integration, considering a staged process that prioritizes equity and sustainability
Build political momentum and capacity to act	• Engage patients and community groups at the local level to understand benefits package preferences and willingness to pay for inclusion of exempted services • Revise social and community-based health insurance benefits package(s) to reflect inclusion of priority health services

REFERENCES

Fagan, T., E. Lang, and B. Lee. 2019. *Achieving Sustainable Health Financing in Ethiopia: Prospects and Advocacy Opportunities for Domestic Resource Mobilization.* Washington, DC: Palladium.

Federal Ministry of Health (FMOH). 2006–2017. *Ethiopia National Health Accounts for 2004/05, 2007/2008, 2010/2011, and 2013/2014.*

Federal Ministry of Health (FMOH). 2015. *Health Sector Transformation Plan, 2015/16–2019/20.* Addis Ababa: FMOH.

Federal Ministry of Health (FMOH). 2017. *Health Care Financing Strategy 2017–2025.* Addis Ababa: FMOH.

Feysia, B., C.H. Herbst, W. Lemma, and A. Soucat. 2012. *The Health Workforce in Ethiopia: Addressing the Remaining Challenges.* Washington, DC: World Bank.

International Monetary Fund (IMF). 2018. *2018 Article IV Consultation-Press Release; Staff Report; and Statement by the Executive Director for The Federal Democratic Republic of Ethiopia.* Washington, DC: IMF.

McIntyre, D. and F. Meheus. 2014. *Fiscal Space for Domestic Health Funding and Other Social Services. Working Group on Financing Paper 5.* London: Chatham House.

Stenberg, K., O. Hanssen, T. Edejer, M. Bertram, C. Brindley, et al. 2017. "Financing Transformative Health Systems towards Achievement of the Health Sustainable Development Goals: A Model for Projected Resource Needs in 67 Low-Income and Middle-Income Countries." *Lancet Global Health* 5(9): E875–E887.

Cover photo credit: Willow Gerber, courtesy of Photoshare

The Global Fund

Palladium
MAKE IT POSSIBLE