Resource Mobilisation and Allocation for Primary Health Care

Lessons from the Ethiopian Health System

The Lancet Global Health Commission on Financing Primary Health Care

SYNOPSIS

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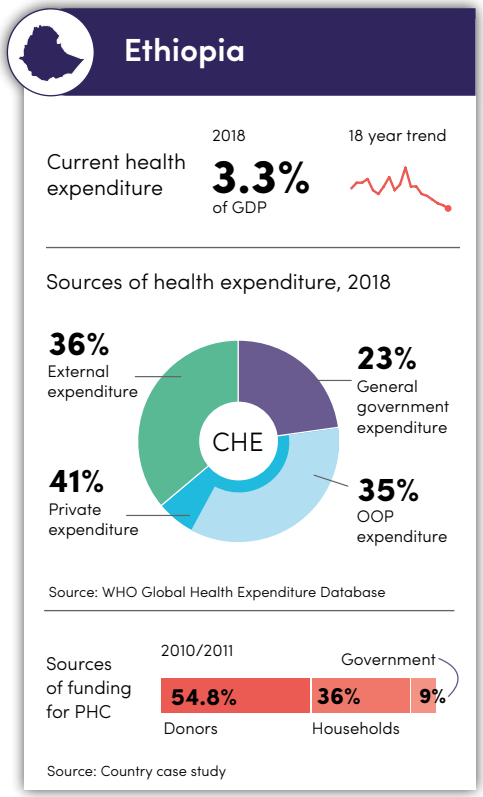
The health sector in Ethiopia has made significant progress in recent years, achieving the health Millennium Development Goal targets for reducing maternal and infant mortality. Much of this success can be attributed to the central government's focus on primary health care (PHC) and the rapid expansion of essential health services to communities through its health extension programme (HEP). However, the programme and health sector in general are heavily dependent on funds from external donors. With several sources of funding and channels for allocating funds from the central, regional and woreda (district) levels, Ethiopia's PHC financing system is complex, involving multiple actors and organisations with ensuing challenges in ensuring effective planning and governance.

This paper provides an overview of the approaches used to mobilise and allocate resources for PHC in Ethiopia, explaining how these have evolved over time, the governance structures that underpin resource allocation decisions, and factors affecting the efficient and equitable use of resources.



PRIORITY FOR PHC IN ETHIOPIA

Since 1995, Ethiopia's development and health plans have emphasised the organisation and delivery of PHC services at the kebele (village) level, and the sector has received significant budget support from the government and donors to achieve this. Between 1999/2000 and 2016/17, per capita spending on health increased from US$7.7 to US$34, and in 2016 more than 20% of the central government's health budget was spent on the HEP alone. The focus on PHC at the centre has ensured that it was also prioritized at regional and woreda levels, and between 2005/06 and 2011/12 the share of woreda government spending on (primary) health care increased from 7% to 10%.

ALLOCATION OF FUNDING FOR PHC

The Ethiopian PHC system has multiple sources of funding, the largest being donors (54.8%), followed by households (36%) and the government (9%). Government and donor funds are allocated to PHC through three main channels: (i) block grants allocated to regional then woreda levels from the Ministry of Finance and Economic Cooperation (MOFEC), which are then passed on to PHC facilities via Woreda Finance and Economic Cooperation Offices; (ii) funding for health allocated by the Ministry of Health (MOH) in line with the 5-year strategic health plan, which reaches facilities via Woreda Health Offices; (iii) funding from donors directly to local or international NGO health service providers. The funding streams from the MOFEC and the MOH include both unearmarked and earmarked funds, which are allocated to specific health programs, with funding often dependant on performance. Unearmarked funds are pooled and allocated under the government's 'One Plan, One Budget, One Report' system that aims to bring together and align multiple sources of funding.

Households pay health facilities directly through user fees for routine health services and medicines. This important source of facility revenue is allocated by the woreda cabinets with spending decisions made by facility management teams/ governing boards. Communities in rural areas also make in-kind or cash contributions towards, for example, purchasing ambulances. Finally, facilities receive funding from community-based health insurance (CBHI) schemes which have scaled up significantly in recent years, now covering approximately 30 million people.

The government employs a bottom-up/top-down approach to planning and allocating resources, whereby plans are developed and refined through a process of engagement across all levels and with development partners, and

efforts are made to harmonize woreda health plans with those from the centre. However, despite the decentralised structure of the health system, the planning process remains dominated by top-down negotiations and target setting, limiting the opportunity for local-level decision-making.

EFFICIENT AND EQUITABLE USE OF RESOURCES

Several factors across different levels of government and the PHC system have limited the efficient allocation and use of resources. At the woreda level, government officials lack awareness of health care financing reform and the technical capacity for effective financial management, such as the ability to audit resource use by health facilities. Inadequate supervision of facility staff has prevented them from collecting, planning, and using internal revenue effectively, exacerbated in some instances by a lack of motivation and poor attitudes of some staff.

The government has sought to improve equity in resource allocation across regions by using a formula to calculate levels of resources for general purposes, with weighting given to the country's least developed regions. A fee waiver programme also exists to subsidise the medical costs of the poorest populations, whereby health centres treat families for free and seek reimbursements for fees from the woreda administration offices. However, evidence suggests that coverage of this programme is low and there is insufficient funding to cover the whole population living below the poverty line. Further, health facilities often face delayed or inadequate reimbursements from woreda governments, compromising the quality and volume of PHC services that they deliver.

Ethiopia's experience shows that it is possible to expand PHC infrastructure and access to essential services with long-term political commitment and a clear strategy for achieving PHC. The effective and equitable allocation of resources is limited by a lack of capacity and insufficient funding for health facilities, a challenge that is likely to grow as donor funding reduces. Several lessons can be learned from Ethiopia's experience.

LESSONS LEARNED

1. **Political will and commitment are essential in securing funding for primary health care.** The successful scale up of PHC in Ethiopia is due to long-term prioritisation of the sector across all three levels of government and support from donor funding.
2. **Increase domestic funding for health.** Whilst the government has been successful in mobilising a significant amount of external funds for health, this source of revenue is unstable and declining. There is a need to mobilise domestic resources for health to ensure sufficient and stable funding going forwards.
3. **Harmonizing health plans and budgets is essential with multiple sources of funding**. Ethiopia's One Plan, One Budget, One Report approach has had some success in mobilising and aligning resources towards PHC, away from disease specific programmes.
4. **Ensure there is sufficient opportunity for local actors to meaningfully contribute to planning and resource allocation decisions**. This will allow health services to be better tailored and responsive to local needs.
5. **Ensure adequate and timely reimbursement of funds to health facilities.** It is important that government provides reimbursements to health facilities for fee-exempt and waiver services so not to compromise the quality and quantity of PHC services.

This synopsis is based on one of 10 country case-studies written for the Lancet Global Health Commission on Financing Primary Health Care:

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