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Resource Mobilisation and Allocation for Primary Health Care: Lessons from the Ethiopian Health System

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Lancet Global Health Commission on Financing Primary Health Care

The Lancet Global Health Commission on Financing Primary Health Care (2020 – 2022) is committed to drawing on robust, evidence-based knowledge to generate useful findings and actionable recommendations to inform decisions made by governments and partners that shape the effective financing of primary health care. Our work is focused on enhancing, protecting and enabling the appropriate resourcing of primary health care as a critical engine for the achievement of universal health coverage.

Country case studies

The Commission organised 10 case studies. Each country lead consultant and team undertook a scoping review to identify 'hot topics' in the financing of PHC in the respective countries. The teams then chose a 'deep dive' topic on which to undertake primary research. The 10 case studies were undertaken in: Brazil, Chile, China, Estonia, Ethiopia, Finland, Ghana, India, New Zealand and the Philippines.

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Acronyms

ANC	Antenatal care
BoFED	Bureau of Finance and Economic Development
CBHI	Community-Based Health Insurance
EHSP	Essential Health Services Package
FGB	Facility governing Board
GF	Global Fund
HC	Health Centre
HCF	Health Care Financing (strategy)
HDA	Health Development Army
HDT	Health Development Team
HEP	Health Extension Programme
HEW	Health Extension Workers
HHM	Health Harmonization Manual
HSTP	Health Sector Transformation Plan
IMR	Infant Mortality Rate
JSC	Joint Steering Committee
LSHTM	London School of Hygiene and Tropical Medicine
OOP	Out of pocket
MBB	Marginal Budgeting for Bottleneck
MDGPF	MDG performance/pool fund
MoFEC	Ministry of Finance and Economic Cooperation
MoFED	Ministry of Finance and Economic Development
MOH	Ministry of Health
MDG	Millennium Development Goals
MMR	Maternal Mortality Ratio
NGO	Non-Governmental Organisation
PCD	Partnership and Cooperation Directorate
PHEM	Public Health Emergency Management
PHC	Primary Health Care
PHCU	Primary Health Care Unit
PFM	Public Financial Management
RBoFEC	Regional Finance and Economic Cooperation Office
RHB	Regional Health Bureau
SDGPF	Sustainable Development Goal performance/pool fund
SHI	Social Health Insurance
UHC	Universal Health Coverage
WoFED	Woreda office of Economic Development
WrHO	Woreda Health Office

Executive summary

Background

The primary health care (PHC) system in Ethiopia is frequently cited as one of most successful health systems owing to its rapid expansion of essential health services to the village level. The institutionalization of health extension workers (HEWs), and mobilization of millions of community health volunteers to support their work are remarkable undertakings in this health system. The health system has achieved both national and global health targets including reducing the maternal mortality ratio (MMR) and infant mortality rate (IMR) to meet the Millennium Development Goals (MDGs). However, little has been said in the literature to understand the approaches and mechanisms used to mobilize and allocate finances in the PHC system with so much success. Hence, the aim of this assessment was to explore the approaches for mobilization and allocation of resources for PHC in Ethiopia and to draw lessons for similar settings and beyond.

Methods

An extensive review of existing policy documents, guidelines, evaluation reports, and published articles was conducted, as well as key informant interviews with policy makers, health financing experts, and health managers at national and subnational levels. We also interviewed experts from development partners actively engaged in the health financing landscape. Interviews were tape recorded, transcribed verbatim, and thematically analysed.

Findings

Priority for PHC in Ethiopia: The Health Sector Development Plans (HSDP 1995-2015) and the Health Sector Transformation Plans (HSTP 2015 to present) emphasize the organization and delivery of PHC services to the population at the kebele (village) level. A remarkable change to the community health system in Ethiopia happened during the implementation of the HSDP III (2005/6-2009/10). This 5-year plan had two significant strategies that aimed to improve access to essential health services at the village level - the health extension program (HEP) and the accelerated expansion of PHC coverage. Both initiatives required huge financial commitment for realization. The accelerated PHC expansion document indicated that additional 4,486 health posts and 1,141 health centres were to be built and equipped; 1,055 health stations to be upgraded and equipped to become health centres in less than 5 years. Since 2004, more than 30,000 HEWs have been trained and deployed and more than 3,000 health centres and 15,000 village health posts have been built.

Overview of health financing: Health expenditure in Ethiopia has increased over the last twenty years. For example, per capita health spending increased from US$7.7 in 1999/00 to US$34 in 2016/17 despite the high rate of population growth. However, Ethiopia's health system is dependent on external funding and out-of-pocket (OOP) expenditure for about two-thirds of the total resources spent on health.

Share of PHC financing: Ethiopia's domestically funded government spending on health in 2007/08 was US$ 267 million, which amounted to a per capita spending of US$ 3.4. The decision to recruit HEWs and construct new health centres and health

posts has resulted in substantial recurrent costs. As of 2016, HEW's compensation expenses were US$ 31.7 million annually, 21% of the government's recurrent health expenditure. At the woreda (district) level, out of total woreda government spending (including channel 1 donor support), the share allocated to health grew from 7% in 2005/06 to about 10% in 2011/12. This proportion is 8%-10% at regional level. The share of government spending on health at the woreda level (which is essentially PHC service delivery) was as high as 15%, rising to 21% in some regions.

Sources, channels, and governance of PHC finance: The main sources of health finance in Ethiopia are government revenue, donor funds, revenue collected from user fees, and insurance schemes (mainly community-based health insurance, CBHI). User fees are retained and used by the PHC facilities (health centres and primary hospitals). Health facilities receive reimbursement for the health services they provide to the CBHI beneficiaries from the agency which manages the scheme. The health finance coming from government revenue and donor funds use three different channels.

In terms of governance, the allocation and monitoring of health financing is done through the One Plan, One Budget, and One Report system. This is a donor coordination mechanism aimed at enhancing aid effectiveness put in place since 2007. The system is guided by an evidence-based planning approach which follows four key actions: (i) prioritizing high-impact interventions related to achieving progress toward targets; (ii) introducing, facilitating, and institutionalizing the use of evidence for planning at the woreda, regional, and national levels; (iii) aligning and harmonizing health priorities, plans, activities and budgets within the government and between the government and development partners; (iv) increasing funding for health.

Facilitators and barriers to resource mobilization and allocation: A major contributor to the successful expansion of PHC infrastructure and services during the last three decades is the political willingness and commitment at all levels of government. Since the ruling party was committed to "delivering tangible, broad-based socioeconomic progress and ethnic-self-determination through ... ethnic federalism" any departure from attaining this goal would threaten local officials' stay in office. Furthermore, sectors such as education, health, and agriculture have always been priorities for the ruling party, which largely draws its popularity and support from the rural peasantry at the kebele level. Second, Ethiopia received a significant amount of official development aid for health during the last two decades which enhanced the government's capacity to implement health plans. This was compounded by the fact that the share of health budget from the overall government budget has been progressively increasing both at regional and woreda levels.

There are also some critical challenges identified. First, although the government has been successful in mobilizing a significant amount of external funds, little attention was paid to improving domestic sources of health financing. Second, although government financing for health is increasing at lower levels of the health system, budgeting for health facilities does not fully cover operational costs. Finally, insufficient facility funding is exacerbated by the lack of adequate and timely reimbursement of health facilities for the exempted and waiver services they provide.

Conclusions and recommendations

The findings in this study provide several lessons for other countries:

- The political system in Ethiopia is devolved, with regional states and woredas having the ultimate authority of decision making for planning and implementation of health services. However, the political arrangements allow the centre to consistently influence the health system to its lowest level.
- The combined bottom up and top-down planning and the ability to align and harmonize different channels of finances, have significant influence on the successful use of external and domestic resources for PHC expansion.
- The health system continues to retain revenues from user fees as a means of mobilizing local resources to help run health facilities. This is coupled with extensive waiver and exemption mechanisms to protect those who are unable to pay and enhance uptake of essential health services.
- In addition to the financial risk protection, equity is considered in budget allocation for the different regions. Both the federal and regional governments allocate funds using transparent criteria.

There are, however, critical areas of concern demanding the attention of the Ethiopian government:

- Since donor funds are clearly being reduced, there is a need for targeted mobilization of domestic resources for funding the PHC system.
- The declining allocation of budgets to cover non-salary operational costs for PHC health facilities has impacted how the internal revenues of the facilities are used. Hence, due attention should be given to improve the situation so that health facilities could use their internal revenue to improve quality of health services.
- Exempted services (e.g., antenatal care (ANC), delivery, and neonatal care services) mostly fall under the PHC level and the woredas rarely have the capacity to reimburse health facilities for providing these services. Similarly, delayed or inadequate reimbursement to health facilities for providing services to the poor under the fee-waiver scheme compromises the quality and volume of services delivered at the PHC facilities. Hence, regional and woreda governments should make sure adequate finances are allocated to cover the expenses of health facilities.

1. Background

1.1 Context of the study

Ethiopia is the second most populous African country next to Nigeria. The majority (80%) live in rural areas with subsistence farming as a means of livelihood. The country has a federalized administration with authority and responsibility of most public welfare activities devolved to the regional states. There are 10 regional states and two city administrations with their own geographical jurisdictions.[1]

In the health sector, the Ministry of Health (MOH) develops national guidelines and policies and coordinates the planning and implementation of national priorities. The Regional Health Bureaus (RHBs) are responsible for the planning, implementation and monitoring of all health-related activities in their respective regional states. Bigger regions, such as Oromia and Amhara, also have Zonal Health Departments to assist the RHBs in coordinating health activities in several of the woreds (districts) within their jurisdictions. The lowest level where authority for decision making is devolved is the wored. Health activities at the woreda level are planned and implemented by the Woreda Health Office (WrHO).[2]

In terms of service delivery, types of health PHC facilities range from health posts to primary hospitals. At primary hospitals, clients can get primary curative, preventive, and rehabilitative services either through referral from health centres or directly. A primary hospital provides inpatient and ambulatory services to a population of 60,000 to 100,000. The service mixes at this level include emergency surgical services, including caesarean sections and blood transfusion services. Next to the primary hospitals are health centres. These units are supposed to provide services for approximately 25,000 people. Basic curative, preventive and rehabilitative services are delivered in the health centres. The nearest service point to the community are health posts. Health posts provide mostly preventive and promotive services as well as some basic curative care home to home, outreach and at facilities. On average a health post provides services to 5,000 people. Health posts are typically staffed with a minimum of two health extension workers (HEWs).[3]

Critical issues in the successful expansion of PHC facilities during the early days of the HEP were the determination of the essential health services package and setting the norms and standards for accessible health facilities. The government of Ethiopia demonstrated its commitment to ensuring a minimum package of promotive, preventive, curative and rehabilitative interventions defined as Essential Health Services Package (EHSP).[4] The presence of these norms and standards, coupled with the determination of the government to use those as an investment plan, fuelled PHC expansion efforts.

There is a referral and administrative linkage between the three facility types. The health centre is a referral point for health posts. Similarly, primary hospitals are referral centres for health centres. A single PHCU is comprised of five health posts and a referral health centre. The health centre directors serve as a director to the PHCU.

Health posts get technical support and supportive supervision from health centres while health centres get supportive supervision and technical support form primary hospitals.[3]

Health care issues that can't be managed at primary hospitals are referred to general hospitals at the secondary level of care. This referral linkage continues to tertiary level hospitals. There is demand among communities for linkages between the formal health system, especially the PHC system and community-level systems. This has been guaranteed through the introduction of health development armies (HDAs). Organizing a functional HDA requires the establishment of health development teams (HDTs) that comprise up to 30 households residing in the same neighbourhood. The HDT is further divided into smaller groups of six members (households), commonly referred to as "one-to-five" networks. Since HDA implementation started in 2011, considerable progress has been made in the organization and formation of a network of HDAs. In Ethiopia there are about 442,773 HDTs, within which are 2,289,741 one-to-five networks. The HDA network enables community mobilization through participatory learning and action meetings.[5] The participation of these community members in their own and their neighbours' health affairs is totally voluntary and there are no formal payments. The role of the HDA network has slightly faded after the recent political change of 2018.

2. Study objectives

The main aim of the study was to explore the evolution of the mobilization and allocation of resources for PHC in Ethiopia.

Specific objectives are:

- To assess mechanisms for resource mobilization and allocation
- To identify the different sources of financing and their channels of flow
- To understand the relationship between the different levels of the health system in the allocation of finances
- To understand the role of policies, guidelines, standards and criteria in shaping the mobilization and allocation of resources
- To understand the role of political, economic, social and equity considerations in the process of resources mobilization and allocation
- To identify barriers and facilitators affecting the resource mobilization and allocation processes

3. Methods

3.1 Study participants

Key informants were identified at national and sub-national levels. From the MOH, 2 key informants were included from two relevant directorates: Partnership and Cooperation Directorate (PCD) and HEP and PHC Directorate. We also interviewed representatives from Ministry of Finance and Economic Cooperation (MoFEC) and key donors of PHC in Ethiopia. At sub-national levels relevant managers in RHB, WrHO, Woreda Administration Office, and Regional Finance and Economic Cooperation Office (RBoFEC) were interviewed. To capture features in all settings of the country we interviewed health and finance managers from each of the three geographical setups (agrarian, pastoralist, urban). At the sub-national levels, we included Oromia (agrarian), Somali (pastoralist) and Dire Dawa (urban).

3.2 Data collection methods and tools

We conducted a review of guidelines, policy documents and project reports relevant to the research questions. We also conducted in-depth interviews with key informants at national and sub-national levels in three contexts: agrarian, pastoral and urban. The in-depth interviews were guided by semi-structured interview guides with appropriate probes and follow up questions.

Due to the current Covid-19 pandemic, interviews were conducted virtually (e.g., Skype, Zoom or phone) by the local investigators using a semi-structured interview format. The interviews lasted between 60-90 minutes and were recorded. The interviews were conducted either in English or Amharic language. Participants were advised to conduct their interview from a private location to ensure confidentiality.

3.3 Data analysis

The recorded interviews were transcribed verbatim. We did thematic analysis of the interview data guided by the study questions, which were used to do manual coding on an excel spread sheet. The findings from the key informant interviews were supplemented with a review of documents relevant to resource mobilization and allocation processes in Ethiopia.

3.4 Ethical considerations

The overall study protocol for all country case studies was reviewed and approved by the research ethics committee at the London School of Hygiene and Tropical Medicine (LSHTM). The Ethiopia case study protocol was submitted to the Institutional Review Board (IRB) of the Institute of Health, Jimma University. Approval of the research protocol was obtained on December 21, 2020 with reference number of IHRPG/1042/20. The study participants were informed about the objectives of the study, and audios were recorded upon obtaining permission. The recorded interviews are stored securely, accessible only to the research team. The interviewer transcribed the interviews verbatim using MS word and saved these transcription files in the

secure folders. Anonymised versions of transcriptions, where all identifying information of the individual and their associated institutions has been removed or replaced with generic identifiers, were used for collaborative analysis. Saved recordings and non-anonymised transcripts were permanently deleted from the servers at the end of the project and anonymised transcripts will be kept for seven years following the project end.

3.5 Structure of report

This report provides a bird's-eye view of the health financing landscape in general and PHC system in particular in Ethiopia, including a historical background. This is followed by a detailed discussion on the governance of PHC financing and the mechanisms used to harmonize resource mobilization and allocation. Next, discussion on the mechanisms and sources of resource mobilization and allocation for PHC are presented. This section provides details of the different sources of funding for PHC, and how they are channelled to health facilities. Subsequent sections explore major challenges and facilitators for PHC financing including equity and efficiency and monitoring and control mechanisms in PHC financing in Ethiopia. We conclude with a section that outlines key lessons that could be emulated by other low- and middle-income countries from the Ethiopian PHC system.

4. Financing of PHC in Ethiopia: historical background

4.1 Priority given to PHC in the country over the past decades

The government of Ethiopia has demonstrated its commitment to ensuring a minimum package of promotive, preventive, curative and rehabilitative interventions defined as Essential Health Services Package (EHSP). Among the main criteria to include an intervention in the ESHP are burden of disease, cost-effectiveness, equity, financial risk protection, and budget impact. The EHSP document also outlines the main objectives for determining a minimum package of health services, which include protecting "the population against catastrophic health expenditures and provide financial risk protection." It is also indicated that the EHSP will increase health system efficiency. The list of interventions in the ESHP is, however, very long and risks ending up as a wish list. For instance, "337 essential promotive, preventive, curative and rehabilitative sexual and reproductive health, maternal health, neonatal health, child health and adolescent health services" are included as part of EHSP. It is important to note that most of the 337 services are provided at the primary health care level.[4]

A remarkable change to the community health system in Ethiopia happened during the implementation of the health sector development plan (HSDP) III (2005/6-2009/10).[6] This 5-year plan had two significant strategies to improve access to essential health services at the village level: the HEP and the accelerated expansion of PHC coverage.[7] Both of these initiatives required huge financial commitment for realization. The accelerated PHC expansion document indicated that an additional

4,486 health posts and 1,141 health centres were to be built and equipped; 1,055 health stations to be upgraded and equipped to become health centres in less than 5 years. The strategic document also indicated that training and deployment of 8,972 paid HEWs to manage the newly constructed health posts was to happen. These seemed unrealistic to many at the time. However, although equipping the health posts remained a challenge (with 75.6% of the target of equipping 16,253 health posts met), the number of health posts increased from the baseline 6,191 in 2004/05 to 14,416 in 2009/10. The number of health centres increased from the baseline 519 to 2,689 during the same period. In addition, more than 33,000 HEWs were trained and deployed. There was also a program of accelerated training of health officers (health cadres of BSc level for local need) aiming to simultaneously fill the clinical and health administration gap at the district level during the same period. With this initiative, nurses and other health professionals were trained to fill the human resource gap of the health system.[8] Training was provided at public universities in Ethiopia and financed by the Ethiopian government in collaboration with development partners.

In 2019, there was a national evaluation of the HEP commissioned by the HEP and PHC Directorate of MOH with a funding from the Bill and Melinda Gates Foundation. The evaluation concluded that there is "a mismatch between the current capacity of HEWs and the skills required to effectively deliver expanded HEP packages." It also indicated that the skillsets of the HEWs has led to "sub-optimal quality of care." The evaluation further implied that there were inadequate resources for upgrading the skills of the HEWs, which aggravated the problem related to quality of care. As a consequence, the MOH and stakeholders came together to craft a roadmap for the HEP for the next 15 years (2020–2035) proposing several changes to this flagship program of the Ethiopian health system.[3,9]

According to the proposal in the roadmap, kebeles (villages) with limited or remote access to a health centre will have health posts providing "comprehensive HEP services". Kebeles having a health centre close by will have health posts with just a "basic package", with referral connection to a health centre for more comprehensive care. While currently all kebeles including those with a health centre have a health post, which is sometimes located in the same compound as the health centre, the road map suggests merging the two to avoid duplication of efforts. Another proposal worth noting is that HEP services will not be limited to health posts but will also be provided in health centres and at primary hospitals.[3]

To improve the poor quality of care at the health posts, it is proposed to "increase the accountability and responsiveness of HEP to community needs." The staffing pattern in the health posts will also be changed over time to become multidisciplinary, where both male and female health officers, nurses/midwives, environmental health professionals, and HEWs will be included. There is a plan to address concerns related with infrastructure, basic amenities and medical supplies as deemed necessary.[3] The proposed changes in the roadmap, if realized, will reaffirm that PHC remains a priority to the Ethiopian government for the years to come.

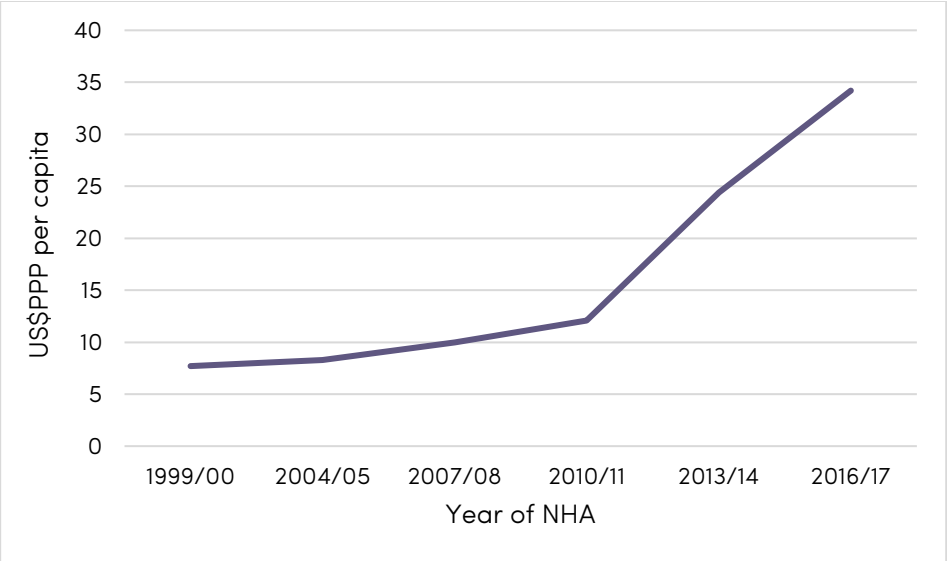
4.2 Overview of health expenditure

The Ethiopian health system has various sources of funding. According to the most recent national health accounts, the country spent ETB 72.05 billion on healthcare in 2016/17 fiscal year. From the total amount, the contribution of donors, government and households was 35.2%, 32%, and 30.6%, respectively. The remaining 2.1% was contributed from private employers, NGOs and other sources of finance.[10]

Total and per capita health expenditure in Ethiopia has been increasing over the last twenty years. For example, per capita health spending increased from US$7.7 in 1999/00 to US$34 in 2016/17 despite the high rate of population growth (Fig. 1). However, Ethiopia's health system is dependent on either external funds or out-of-pocket (OOP) expenditure for about two-third of the total resources spent on health. According to the seven consecutive health accounts, there is a slightly decreasing trend of expenditure on health as a percentage of Gross Domestic Product (GDP). For instance, the share of health as a proportion of GDP decreased from 4.7% to 4.2% in the recent four-year period (Fig. 2). However, the government's share out of total health expenditure is increasing as can be seen from various indicators. For example, general government expenditure on health as percentage of GDP has increased from 0.9 to 1.4 over a period of ten years. Similarly, during this period both general government expenditure on health as a percentage of general government expenditure and as a percentage of total health expenditure increased from 4.8 to 8.07 and 22.3 to 32.0, respectively. The per capita government expenditure on health also doubled three times between 2007/08 and 2016/17.[10–13]

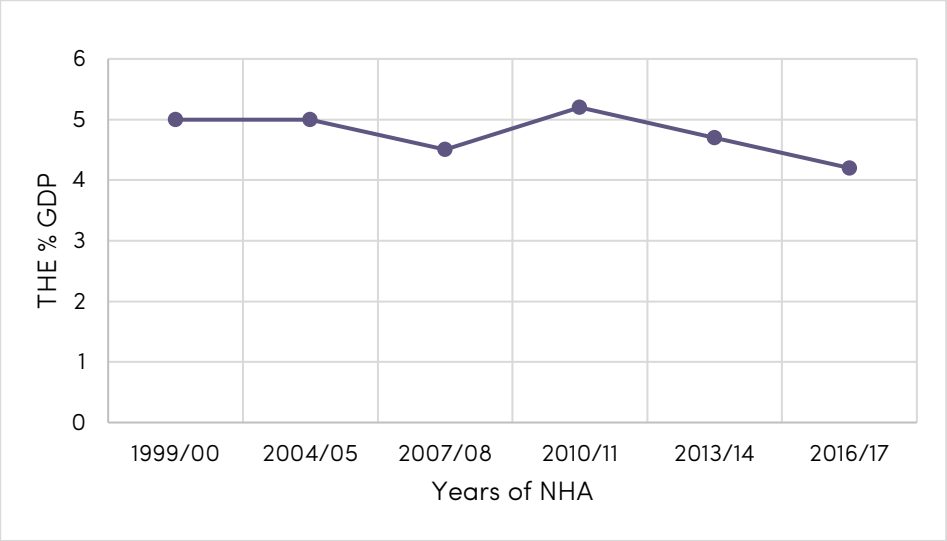
On the contrary, recent figures show that the share of external funding for health and out of pocket health expenditure are decreasing over time, albeit slowly. The external resources for health as a percentage of total health expenditure decreased by 14.7% between 2010/11 and 2016/17. Similarly, out-of-pocket expenditure as a percentage of total expenditure on health has showed a decreasing trend starting from 2007/08.[10–13]

Figure 1: Health expenditure in US$PPP per capita in Ethiopia



Source: The Ethiopian National Health Accounts.[10–13]

Figure 2: Health expenditure as a share (%) of GDP in Ethiopia



Source: The Ethiopian National Health Accounts.[10–13]

4.3 Expenditure for primary health care

For PHC, analysis based on data from the MOH annual woreda-based planning exercise provided estimates of annual spending in PHCUs for 808 woredas in 2011. This analysis projected the share of different sources of funding for primary health care. Accordingly, rest of the world (54.8%), households (36%), government (9%), and other sources such as private and not-for-profit organizations (0.2%) contributed to the PHC expenses (Fig 3).[14]

Specific focus on the HEP reveals that the program was exclusively government financed when it was established. Communities were mobilized to voluntarily contribute in-kind contributions of building materials and labour for the construction of health posts. Later, the HEP started to attract significant funding from external sources. The national HEP evaluation reported that, during the period 2010/11 to 2016/17, HEP spending increased from 70 million to 148 million US$. An average of 86% of this spending went towards recurrent costs (24% for human resource and 62% for drugs and other medical supplies) with the remaining 14% was spent on capital expenditure.[3,9]

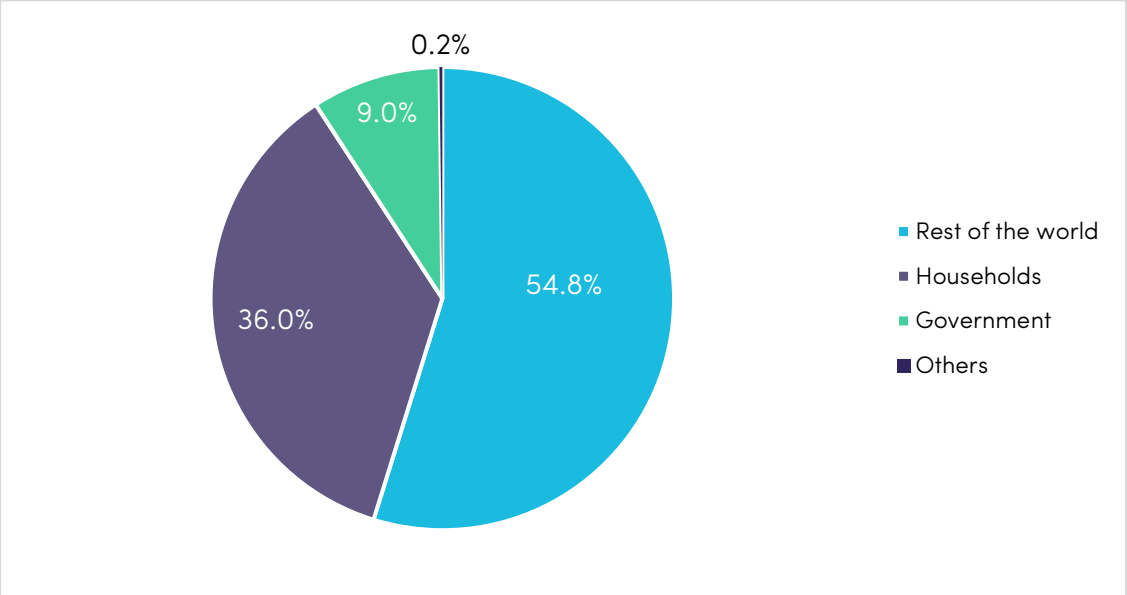
According to the evaluation, the percentage of government spending on HEP expenditure increased from 20.8% in 2010/11 to 40.4% in 2013/14. Similarly, the government contributed 40.3% of HEP spending in the period 2016/17. The contribution of external aid was high at 59.7% in 2016/17. Relative to total PHCU level spending and total health expenditure (THE), financing for HEP has declined. The proportion of HEP expenditure out of THE and total PHCU level spending dropped from 8.9% to 7.1% and from 25% to 22%, respectively, during the period 2010/11 to 2016/17.[3]

Interestingly, the 6th NHA provides a monetary value of the contribution of community volunteers. The NHA report estimated that community contribution through WDA and malaria control programs was at a nominal value of US$ 99 million in 2016/17.[10]

The growth of PHC in Ethiopia over the last 16 years has been celebrated as a model in sub-Saharan Africa, especially the extent of social movement it achieved to improve PHC. Since 2004, more than 30,000 HEW have been trained and deployed in the country and more than 3,000 health centres and 15,000 village health posts have been built. In contrast, Ethiopia's domestically funded government spending on health in 2007/08 was US$ 267 million, which amounted to a per capita spending of US$ 3.4. Ethiopia's decision to recruit HEWs and construct new health centres and health posts has resulted in substantial recurrent costs. As of 2016, HEW's compensation expenses were US$ 31.7 million annually - 21% of the governments recurrent health expenditure.[15] Ethiopia faced financial difficulties with regards to its involvement in PHC: the PHC investment initiative (including the HEP) required an estimated US$ 1.2 billion in start-up costs over 5 years.[16]

According to a study by Kelly R. et al., there is a low public health spending in Ethiopia, but health outcomes are favourable. Ethiopia allocates about 7.8% of its national annual budget on health which is far below the Abuja target of 15%, but relatively generous external support has enabled the country to finance and achieve significant health improvements over the last two decades.[17] The significant health improvements with low spending are mainly due to a large amount of donor support, which at one point exceeded half of the national health expenditure, as well as well-coordinated and targeted spending by government.

Figure 3: Percentage of total expenditure on primary health care according to source of revenue, latest available year



Source: Financing Ethiopia's Primary Care to 2035: A Model Projecting Resource Mobilization and Costs.[18]

5. Financing for the PHC system: Governance

5.1 Governance of PHC financing

The health care budget is decided by the Ministry of Finance and Economic Development (MoFED), Bureau of Finance and Economic Development (BoFED), and Woreda Office of Economic Development (WoFED) at the federal, regional, and woreda levels, respectively. MoFED first collects budget requests from all sectors. The ministry then analyzes their requests and allocates funds accordingly. At the regional level, BoFED and WoFED manage all the government resources and others included in channel 1 (described later). Expenditure management and reporting of channel 1 funding is mainly executed by WoFED/BoFED with limited involvement of the MoFED in the management of health care financing (HCF) at the regional level and below. The WoFED/BoFED are expected to "play a significant role in resource generation, allocation and utilization."[19]

WoFED is also commissioned with the task of providing oversight of health centres retaining and using internal revenues. A review of the 1998 HCF strategy found, however, that the WoFED is not discharging this responsibility, probably because of "limited capacity to undertake this function (e.g., auditing health facility utilization of resources)." The review reported that the Oromia region BoFED and WoFED were exceptions to this as they were fully engaged and supported the health finance reform at the facility level, including undertaking annual audit reviews at the regional and woreda levels.[19]

At the top of the health system, the MOH-RHBs Joint Steering Committee (JSC) meets every 2 months to facilitate the effective implementation of priority interventions set out in the health sector's strategic plan (HSTP). This is a committee chaired by the Minister of Health with very good functionality. This platform is "critical for program prioritization, resource allocation, and sharing of best practices, as well as initiation and pursuit of new health initiatives, including health financing."[19]

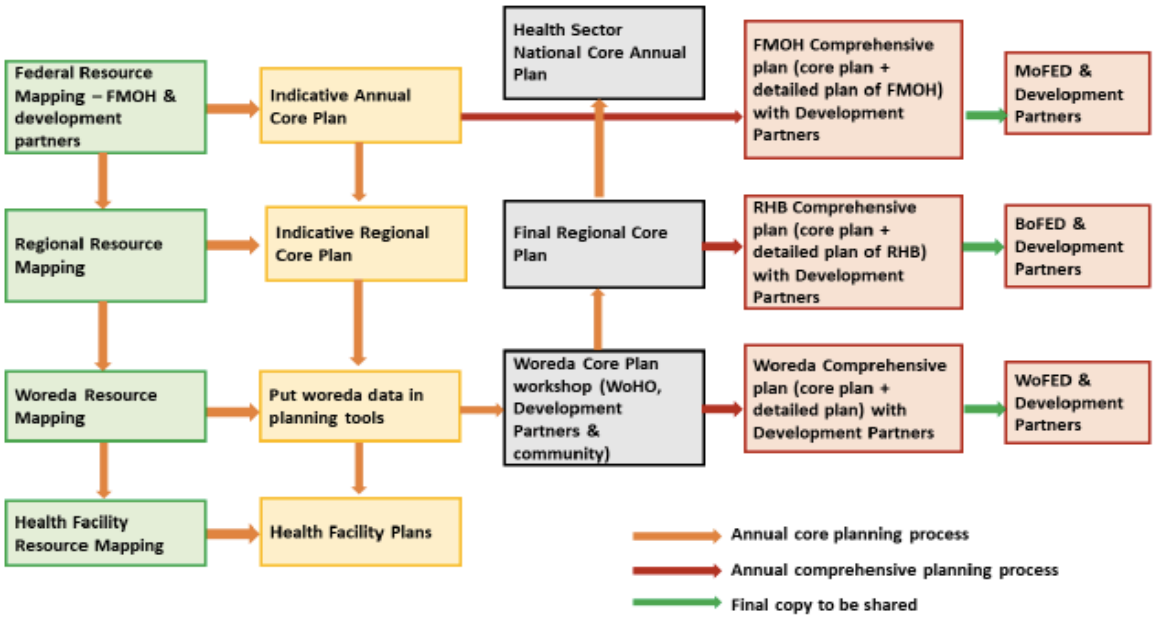
At subnational level, regions are expected to establish mechanisms for implementation of the HCF strategy through committees with representatives from relevant sectors (health, finance, and regional cabinet). There are focal persons at regional and zonal health offices (one each) to coordinate health care financing issues. The health centres and hospitals, however, are required to have 8 and 10 staff for administration and finance. Some of the positions in the facilities for this purpose include accountant, cashier, procurement, and property administration.[20]

An evaluation conducted in 2012 reported that the evidence-based bottom-up/top-down planning process was highly engaging for the lower levels. The WrHOs, WoFED, and the health centres were actively engaging in the planning process. On the other hand, the participation of the Woreda council and administrations of the NGOs was very low. This is a very critical procedure since it involves resource mapping where the MOH, RHBs, and WrHOs identify all sources of funding for activities and projects.[21]

5.2 Harmonized health planning

Allocation of finances and accountability of use in the Ethiopian health system is guided through the One Plan, One Budget, and One Report approach. This has been adopted since 2007 as a donor coordination mechanism to enhance aid effectiveness. "One Plan" in this case refers to the 5-year health sector strategic plan (HSDP) and its associated annual plans. The health plans are developed through extensive engagement of all stakeholders including development partners.[22] A further refinement to this was the inclusion of the woreda-based health sector plan during the period 2010/11-2014/15, which created an opportunity for joint planning by all stakeholders at all levels of the health system. The harmonization of health plans between different levels of the health system happens through a two-staged process at federal, regional and woreda levels. First, each level prepares a core plan including the minimum targets set by the higher level government core plan and health activities to be implemented by development partners in the region/zone/woreda.[17] Second, the resulting comprehensive plan is submitted to the government finance office at each level and to the partners implementing health activities at this same level. Figure 4 below maps how the health planning process is managed in the Ethiopian health system.

Figure 4: The process of planning in the Ethiopian health system



Source: The HSDP Harmonization Manual, First Edition (p. 29). 2007: FMOH.[21,23]

"One Budget" is created through the pooling of health funds from all the different sources (government, donor, and NGOs) and is used to fund "One Plan." This is mainly the result of agreement between donors and the government to undertake an annual resource mapping exercise to ensure that the flexible basket, initially known as the MDG performance/pool fund (MDGPF) and now as the SGD performance/pool fund (SDGPF), prioritizes funding gaps after reviewing the finances from other channels. This is channelled through the MOH with a significant degree of flexibility and power for the Ministry to allocate funds based on national health priorities.[23,24]

"One report" demands a unified way of integrated supervision, performance review, and quality assurance and inspection mechanism to complement health sector M&E, which should inform strategic health planning. A set of indicators are identified to track the implementation of the HSTP through a standard reporting system without duplication in reporting.[22,25]

Key informants also indicated that the Health Harmonization Manual (HHM) deals with what things to consider in the allocation of resources to different levels of health service delivery and management units. "*...there are criteria that we use while allocating budget to regions*" said an official in the MOH. For the health interventions that are implemented across all regions of the country, directorates in the ministry allocate budgets from channel 2a based on agreed plans, and regions may receive resources in-cash and/or in-kind.

Box 1: Evidence based planning to guide resource mobilization and allocation

MOH, RHBs, and WrHOs planning staff go through similar series of steps when using the marginal budgeting for bottleneck (MBB) tool. There are three major steps: **resource mapping, target setting, and resource mobilization**. These major process steps relate to the five major objectives of evidence-based planning:

1. *Prioritizing high-impact interventions related to achieving progress toward targets*: High-impact interventions are defined as those that have a strong evidence base for improving health outcomes within a specific country context.
2. *Introducing, facilitating, and institutionalizing the use of evidence for planning at the woreda, regional, and national levels*: Institutionalizing evidence-based planning (EBP) involves creating a planning culture in which health, finance, and administrative officers value evidence and use it as a base for decision making.
3. *Aligning health priorities, plans, and budgets within the government and between the government and development partners*: Alignment is defined as being lined up with government priorities and the national strategic health plan.
4. *Harmonizing health plans, activities, and budgets between the government and development and implementing partners*: Harmonization is defined as the coordination of activities among all health sector stakeholders to reduce the transaction cost of delivering aid and services.
5. *Increasing funding for health*: Using data in advocating for more health sector funding is seen as crucial for increasing funding to health. EBP outputs can be useful for advocating for more funds from the government, donors, nongovernmental organizations (NGOs), and the private sector, among others.

Source: Adapted from Altman and others, 2012, p. 4.21,24

Key informants affirmed that resource allocation at the PHC level is guided by the One Plan, One Budget, and One Report system. Health plans are prepared through both 'bottom-up' and 'top-down' approaches. Indicative targets for priority health programs are sent from the centre to the lower levels, and the latter incorporates additional interventions aligning with those from the centre, and then send it back to the centre. There is negotiation between the MOH and regions and between regions and woredas on annual targets to reach consensus and understanding on capacities. Similarly, to facilitate the allocation of the PHC budget, implementing partners that operate at regional and federal level submit their plan to MOH, earmarking their resources and where and in what thematic area they are going to commit. Next, each directorate of the MOH aligns with respective implementing partners and produces a binding planning document for the ministry. The official from the Partnership and Cooperation Directorate describes the process as follows:

> *During the processes, as we have planning alignment with implementing partners, we do have with regions in such a way that core indicators are selected from each health program around March and April and sent to regions and woredas. Before the Ministry of Health starts planning in June. Planning starts from woredas which is termed as "woreda based planning" that is facilitated through the Policy Plan Directorate [at MOH]. In all regions, planning is prepared, compiled and sent to the ministry, then; the compiled plan will be aligned and sent back with regions. In doing all these, priorities are identified and known, or plan is endorsed showing to which health interventions resources will be channelled.*

For instance, an implementing partner that supports family planning aligns its plan with the maternal and child directorate, stipulating its resources and which woreda it plans to support. Consequently, the MOH fund from SDGPF will not go to that specific woreda to avoid duplication; instead, it will be allocated to thematic areas or programs that are not budgeted in either of Channel one or three. Despite the presence of the different coordinating mechanisms to manage donor resources in the health system, some felt that there is still fragmentation and duplication of efforts, especially at regional and woreda levels. This has led to the establishment of a directorate that works on donor coordination at the RHBs.

A review of aid effectiveness in 2013[26] demonstrated that the different channels of funding flows and the stewardship from the government in a coordinated manner have led to success in the Ethiopian health system. The report argued that:

> *"... the use of the Government preferred channels has played an essential role in improving the health of the Ethiopian people by (i) responding swiftly and flexibly to FMOH priorities; (ii) focusing on system strengthening interventions which other funding channels are unable to fund; (iii) reducing administrative cost for the government; and (iv) strengthen[ing] government systems by working through it."*

Hence, it is evident that aid effectiveness in the Ethiopian health sector has been one of the best practices through the 'One plan, one budget, one report' approach, whereby SDGPF, Global Fund (GF), GAVI, and to some degree by PEPFAR funds were successfully used for infrastructure development. A review of Public Financial

Management (PFM) in Ethiopia, however, argues that this is not being sustained due to (i) failure to sustain the strong government leadership for fostering coordination and partnership; (ii) donors backward shift towards project-based financing. A clear indication for this is that "the use of Ethiopia's public financial management and procurement systems has been declining with share of official development assistance routed through the country's PFM and procurement systems being less than 50% in recent years."[17]

This highly structured approach of planning and reporting, however, is not without challenges. One among these is the lack of transparency and reporting from donors and implementing partners functioning through channel 3.[17,19] This makes the resource mapping process at all levels difficult and affects alignment of allocations and planned activities among the different actors. Better information about planned activities and associated budgets at each level of the health system will enhance better coordination, reduce duplication of effort, and avoid wastage of health resources. One recent review of public finance management in Ethiopia concluded:

> *"There seems to be no systematically organized and comprehensive data available on a regular and consistent basis regarding the trends of aid flows to the health sector—either by MoFED or FMOH. Data sourced from budget documents/MoFED therefore do not reflect the exact amount of aid used in the health sector." 17*

Another critical challenge identified about this approach of planning, budgeting, and reporting is the dominance of the top-down negotiations and target setting. Stakeholders interviewed in a study of the evidence-based planning process suggested better balance between the top-down indicative targets (what the centre would like to achieve) and bottom-up targets (what the woredas can realistically achieve with their available resources, service delivery system, and management capacity).[21]

Third, regional and woreda health and finance offices tend to overly focus on Councils and Administrations and pay relatively little attention to development/implementing partners.[21] More importantly, the regions and woredas don't have authority to engage and negotiate with donors. However, they can readily negotiate with implementing partners functioning in their jurisdictions.

Finally, the 'One plan, one budget, one report' approach for planning may not be equally practiced in all woredas. An assessment in 2015 indicated that "*there is uneven implementation and variation in the steps and actors involved in the planning process. At sub-national level, the involvement of key players is limited and this may affect the funding level as well [as] the harmonization and alignment process.*"[19] Some respondents implied that the trend is using the plan of a year before the planning period as baseline. The head of a woreda health office said, *"We usually budget adding 10 – 15 percent of the last year's budget. We cannot actually change some permanent spending like salary and off duty payments."* He added, "*the budgeting is arbitrary, it does not follow some kind of guideline, the whole thing is dependent on the person in charge at the woreda level. For example, the head of finance and economic cooperation presents the budget for us. When the woreda leader [a*

politically appointed administrator] says 'remove this kind of budget', he [the finance and economic cooperation head] automatically removes the budget or amount." This demonstrates how unchecked influence of individual political leaders could affect the allocation of resources positively or negatively at the woreda level.

An earlier assessment also reported that although this approach has been in place since 2007, it is not yet *"integrated into the government's own planning and budgeting structures and processes, as there is ... separate planning and budgeting processes led by MoFED, BoFED and WoFED."*[19] This may relate to the fact that running this process requires as much as $1.6 million per year as reported in 2012 and this is entirely funded by partners.[21]

6. Financing for the PHC system: resource mobilization and allocation

6.1 Policy environment for resource mobilization and allocation

Two of the key principles of the 1998 Ethiopian health care financing (HCF) strategy reflect the existence of a favourable policy environment for mobilization and allocation of finances in the health sector. The first one aims at "*improving Government [Public] Heath Sector (allocative, therapeutic and operational) efficiency through improving allocation, organization and management of existing health resources."* The second one states: "*Generating additional and new sources of revenue (government allocation, revision of user fees, revolving drug sales, various private, community, employer-based social financing and insurance plans)."*[19] The strategy also specified that hospitals and health centres shall retain and use revenue collected through user fees for improving the quality and volume of services provided. However, facilities will assume greater "responsibility, authority, and accountability" in managing service delivery and the resources they retain through their own facility management boards.[19]

Key informants also indicated that health facilities generate and retain revenue through charging user fees and use it to improve quality and volume of services. "*The major reform in health care financing is retention and use of user fee charges at the health facilities"* said an official in a RHB. However, this is a recent phenomenon in the pastoralist regions like Somali. Untill recently, PHC facilities were totally dependent on the government's budget and support from some NGOs. According to a key informant from the Health Care Financing Process Owner at a predominantly pastoral region "*...in the past, health facilities such as health centres had no health care finance [from internal sources], but now they can even use their internal revenues [from user fees and other sources]."*

6.2 Revenue generated by the government

Revenue generated by the Ethiopian government happens at three tiers of the highly centralized federation. Each of the three levels (federal, regional, and woreda) have assigned types/segments of government revenue by the Constitution.

> *"Sources of revenue at the federal level include collection of customs duties, taxes and other charges on imports and exports, as well as taxes on federal-owned enterprises and on employees of the federal government, as well as on international organizations and corporations (other than entities owned by the regional states), federal stamp duties, monopoly tax, value added tax, national lottery, and fees from licenses issued by and services provided by organs of the federal government. The federal government also receives a share of royalties and taxes on natural resources."* [17]

The major share of revenue (70-80%) for the regional government comes from a block grant from the federal government. Other sources of revenues for regional governments include income taxes (personal, sales, corporate, profit, property), fees on agricultural land, licensing, royalty, forest resources, water use, and fees of health services. While the woreda government receives 80-90% of its revenue from the regional government as a block grant, it also has a mandate to collect personal income tax, agricultural income tax, rural land use tax, rental income tax, licenses and fees.[17]

In terms of performance of the government to collect revenues (table 1), the actual total revenue demonstrated an annual percentage change that ranged from 13.8 to 15.2 between the 2013/14 and 2016/17 budget years. The IMF projected that the percentage for total revenue for the country will continue to fall till 2022/23, while those of tax and non-tax revenue will be more or less stagnant.[27,28]

Table 1: Annual percentage change of revenue of the government

	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23
	Actual				**Estimated**	**Projected**				
Total revenue	13.8	14.4	15.2	14.3	12.8	13.0	13.1	13.3	13.5	13.9
Tax revenue	12.5	12.7	12.5	11.6	11.1	11.2	11.3	11.6	11.9	12.2
Non-tax revenue	12.5	12.7	12.5	2.6	1.8	1.8	1.8	1.7	1.6	1.7
External grants	1.1	1.0	0.9	0.7	0.8	1.4	0.6	0.5	0.5	0.4

Source: IMF Article IV Consultation Report, 2017 and 2018.[27,28]

6.3 Source of funds and channels of flow in the health sector

The Ethiopian health care system in general, and the PHC system in particular, has multiple sources of funds. Health sector funds mainly comes from government revenue, donors, and contributions from health service users in the form of user fees (out-of-pocket and to some extent insurance premiums). The financial resources generated from these sources flow and get allocated to the health sector through the following three channels.

6.3.1 Channel one: Ministry of Finance and Economic Development (MoFED)

The finances in this channel come from government revenue and contributions of bilateral and multilateral funders who agree to the One Plan, One Budget, and One report system. Chanel 1a is for funds that flow to federal and regional government entities as a block grant. The MoFED collects budget requests from all sectors of the federal government in March to allocate finances in the next fiscal year. After analysing the plans developed by the sectors, the ministry invites all sectors to present and defend their plan. Accordingly, MoFED allocates budget to all government entities known as cost centres and this flows through the treasury system based on the federal functions assigned to them. This stream of financing (essentially the Ministry of Health) is responsible for running specialized/referral hospitals and the development of policies, regulations, and standards. Hence, it is worth noting that whatever is allocated as a federal level budget to the health sector is not used to fund PHC.

According to an experienced expert in the ministry, *"...countries like Ireland and England give budget support [channel 1a] to the total [general government] budget. There are other countries like America, and Sweden that support out of this scheme and finance specific programs either by themselves or through implementing partners [channel 3 described later]."* There are also, donors who are willing to align their investment to government priorities and work through the government system to enhance aid effectiveness.

Through Channel 1a the federal government allocates the annual budget based on a national block grant allocation formula – population and need for development being some of the criteria - to regional states, which they in turn allocate to different sectors in their respective regions. This formula is revised every three years but has "*population and size of region/state, the proximity to the federal capital city, the socioeconomic development status (the needs of the region/state), earmarked external aid, and the ability to generate own revenues (state revenues such as property tax)"* as the key criteria.[29]. Population size takes the largest weight but has been changing over the years but ranges from 60%-65% in recent years.[30]

Similarly, funding below the regional level is based on an allocation formula (specific to each region) to woredas and/or zones (in case of SNNPR). According to a respondent from a partner organization, "... *in Southern Nations and Nationalities Region (SNNPR) for instance, zones and special woredas have the power and they act like regions and they get block grants [from the regional government]*." What is common, however, is for woredas to receive block grants and for them to make the

ultimate allocation of the finances to the different woreda government sector offices, including health.

Once the budget is sent to the regions, based on the formula from the House of Federation, regions have full authority. They have regional parliament and auditors, and federal government has no power to guide them on how to use the finances. The federal government's responsibility is to monitor the programs it finances either directly or through the regions. For these types of finances, regions have an obligation to report performances and the federal government makes sure that programs are properly run. A key informant from MoFED gives an example; "*...if the ministry finances a maternal health program in a certain region, the region must send performance report. However, if the federal government allocates ten billion Birr based on formula [house of federation formula], the region may allocate nothing to a certain health program.*" Table 2 provides the allocation formula for Amhara Regional State which shows health, education, agriculture, and water as the most essential sectors to determine allocation. Similarly, the seventh National Health Account (NHA) noted that "*health has been prioritized through a pro-poor policy that sees 70% of government expenditure going to the five pro-poor sectors of agriculture, education, health, roads and water*"[10]

Table 2: Budget allocation formula used by the Amhara Regional Council (to woredas)

Sector	Proxy variables	Weight in %
Education	Total weight	35
	Student to Classroom Ratio	17.5
	Enrolment Rate	17.5
Health	Total weight	30
	Health Personnel to Health Institutions Ratio	15
	Health service coverage	15
Agriculture & Rural Development	Veterinary Clinic to Livestock Ratio	20
Water	Water coverage	15
Total		**100**

Source: Alebachew and Alemu, 2010.[30]

The regional health bureau is responsible for health expenditure once it receives its share from the regional government. Key areas of expenditure responsibilities at the regional level include setting standards for regional health, vocational and technical training, hospitals (primary, general, and referral), control and prevention of HIV/AIDS, immunization, and coordination and execution of civil service reforms at regional level. Similarly, woreda health offices are responsible for the expenditure of health resources at the district level. Coordination of primary preventive and curative health care activities (health centre and health post levels), implementation of the health extension program, construction and administration of health stations, and health posts, control and prevention of common infectious diseases, and immunization program are the main areas of health expenditure at the woreda level.[17]

Further processes are being followed at the woreda level to allocate resources for PHC facilities. In the Oromia region, for instance, the five developmental sectors (education, health, WASH, agriculture, and roads) get priority in allocating finance. There is a coordinating committee containing eight members representing the different sector offices at the woreda level responsible for the allocation of budget in the woreda. The health office is represented in that committee. This committee verifies and approves the breakdown developed by a team at the woreda level called the 'Coordinating Committee' (CC). Despite the use of such committees, it is required that all sector offices submit their plan and budget to the woreda council for review and approval. Once approved at the woreda, it is sent to the regional council for final ratification. Table 3 below shows how grants received through channel 1a are used at different levels of the health system.

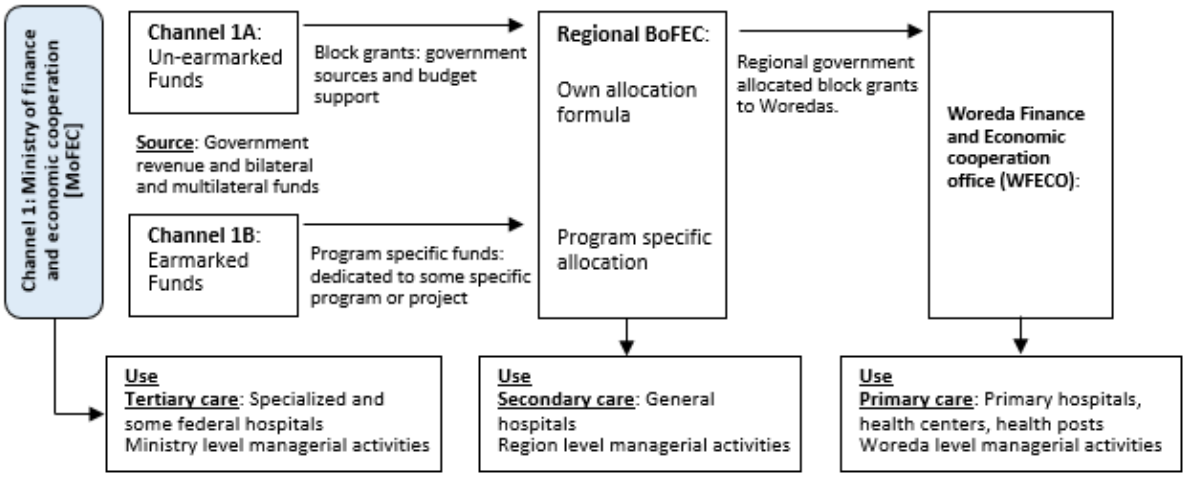
Table 3: Area of expenditure for grants received through channel 1a

Federal Level (MOH)	Regional Level (RHB)	Woreda Level (WHO)	
		Recurrent	Capital
Tertiary hospitals and parastatals	Secondary and primary hospitals, health worker training colleges, regional referral laboratories	Health centres and health posts • For health facility equipment and furniture • Per diem for routine immunization • Per diem and medicines for epidemic control • Procurement of malaria spray chemicals and associated per diem • Medicines • Recurrent budget for new health facilities	Construction of health posts and health centres

Source: Alebachew and Alemu, 2010.[30]

Another arrangement under this channel is Channel 1b, which is used to flow donor funds through the MoFED system but for specified project plans. In this channel, finances are earmarked for use for projects, activities, and outcomes agreed between the government and the contributing funder. Unlike the other donors using the One Plan, One Budget, and One report system, the funders using Channel 1b demand a "*separate planning and reporting document with their own format, as agreed with the government*".[17] Figure 5 provides a summary of the flow of finance in Channel 1.

Figure 5: Management of funds from the Channel 2, Ministry of Finance and Economic Cooperation (MoFEC)



6.3.2 Channel two: Ministry of Health (MOH)

The finances flowing through this channel come from contributions of donors and are managed by the MOH. This channel is further categorized as Channel 2a and 2b. Under this channel, grants may be un-earmarked (2a) or earmarked for specific projects (2b). A key informant from the MOH gives an example; "*for example, a grant from Global Fund [is dedicated] to malaria program only [channel 2b] or it can be flexible grant that we allocate based on priorities [channel 2a] such as for sustainable development goals Pooled fund. This fund comes from eleven donors.*" The fund in channel 2a is a sector basket fund, in the past known as MDG (Millennium Development Goal) Performance/Pool Fund and is currently renamed as SGD Performance/Pool Fund. This fund is managed by the MOH to be allocated and used for priority health initiatives which the Ministry dictates through its 5-year strategic health plans. On the other hand, channel 2b is for funds that still flow through the MOH but intended to fund initially agreed project activities. The accounting and reporting for channel 2b follow specific donor procedures, not that of the MOH.

The MOH prioritizes essential health services while allocating budgets from the flexible grant under Channel 2a or when negotiating the use of budget in Channel 2b with development partners. In other words, since resources are limited, the ministry gives priority to the most essential services while using the allocation formula to the regions. Regarding PHC, an official from the Partnership and Cooperation Directorate (PCD) said "*...PHC is already a priority in the health policy, HSTP and aligned to all [packages in the] health extension program such as family planning and disease prevention.*" At times, the formula set by the house of federation may be replaced by other considerations. For instance, there are resources allocated based on disease burden according to an official from the ministry. He explained, "*...malaria is endemic to specific areas and when budget is allocated for both prevention and curative services, target population and epidemiological disease pattern are considered.*"

Several respondents recalled that the then Minister of Health negotiated with regions to make accelerated expansion of PHC their agenda. To accelerate the mobilization of resources for constructing 2,500 health centres as planned in the HSDP, FMOH introduced a 'matching health centre construction concept' where the regions were informed "*if you build a health centre, I will build one other health centre for you and equip both*." This resulted in a huge leap in expanding the number of PHC facilities (both health posts and health centres) towards the set standards of the catchment population. The significant success of the locally funded program attracted the attention of many donors. Although funders usually provide support for operational costs, there were instances where the HEP received funds for capital investment. A senior health financing expert said, "*Dr. Tedros did a presentation about the HEP in one international forum. The audience was taken by surprise on learning that Ethiopia received funds for the construction of 1000 health centres from the Global Fund*."

Even today there are several implementing partners (local and international NGOs) operating at the woreda level who directly support the operation of the HEP. Several major donors provide funding to these NGOs and support the government to run the HEP through the different channels described earlier. An expert in the MOH who formerly worked for the HEP and PHC directorate said: "*I can say, nearly 80% support to the HEP comes from donors. The government support is mostly for the salary of HEWs. Funding for logistics and capacity building was supported by donors and implementing partners*."

Changes were observed in the allocation resources over time. The HEP and PHC directorate expert gave the following as an example:

> *In the early 1990's, there was 'accelerating expansion of PHC facilities' and therefore, most of the fund went to expand health facilities. After that 'accelerating the human resource development' emerged and then 'accelerated health officer, midwifery program' and the like.*

In terms of financial flows to funding PHC activities, the initial years of the HEP were funded from the government treasury and community contributions (usually in-kind). This is because the donors did not show interest in funding the program. Hence, the government decided to fund the program with its own resources. This is mainly due to the high-level government commitment from the prime minster. Lavers explained that the desire of the ruling party to emphasis expansion of community health services emanates from the party's commitment for rapid and broad-based development to gain support of the peasantry.[31] This approach is actually a continuation of the party's approach before it came to power in 1991 during insurgency. Later, looking at the gains from the HEP, donors expressed interest in influencing the program, which the government initially resisted. This may be due to the refusal of development partners to support the program from the onset, or the government may have simply wanted to make the program locally funded.

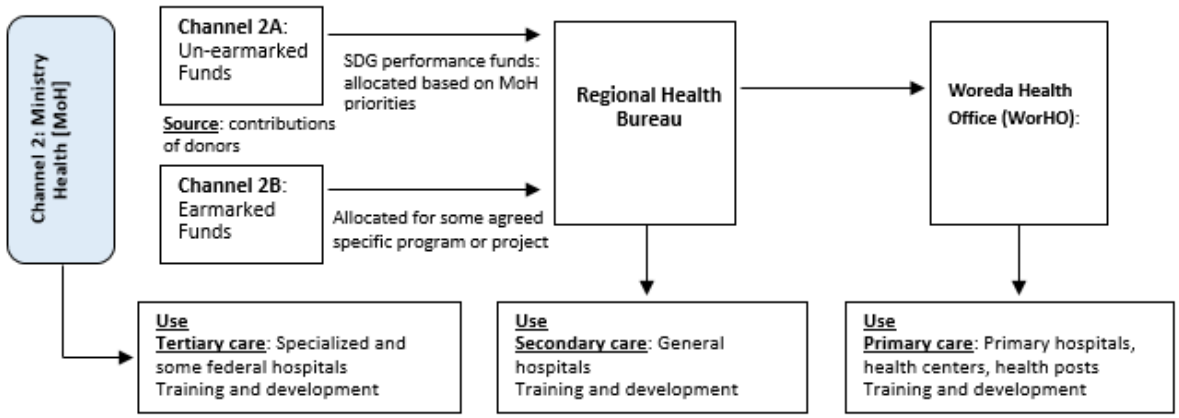
According to a HEP and PHC expert in the ministry, during the HSDP-III and HSTP IV periods (2005/6-2015/16) there was good support from donors to the HEP. However, support for the program gradually decreased and become very low during the HSTP I

period (2015/16-2020/21). Though external funds became lower, the government's allocation to the PHC has increased. Hence, a respondent advised, "*…you cannot predict the donor support worldwide, and what I understand these days is that we need to work on domestic [sources of] financing.*" By the same token, the 1998 HCF strategy emphasizes that the government takes primary responsibility to finance primary and preventive health care.[20]

A recently conducted national HEP evaluation reported that during the period of 2010/11 to 2016/17 HEP spending increased from 70 million to 148 million US$ per annum. An average of 86% of this spending went into recurrent costs (24% for human resources and 62% for drugs and other medical supplies) with the remaining 14% spent for capital expenditure.[3,9] According to the evaluation report, the percentage of government spending in HEP expenditure increased from 20.8% in 2010/11 to 40.4% in 2013/14. Similarly, government contributed 40.3% of HEP spending in the year 2016/17; hence, the contribution of external aid was high at 59.7% in 2016/17. Relative to total PHCU level spending and total health expenditure (THE), the finance that went into HEP has declined. The proportion of HEP expenditure out of THE and total PHCU level spending dropped from 8.9% to 7.1% and from 25% to 22%, respectively, during the period 2010/11 to 2016/17.[3]

Hence, although the PHC budget is increasing nominally, the increase does not seem substantial. The reasons are highlighted by a key informant from a partner organization "*… as the purchasing power of Birr is decreasing, in real terms the budget increase is not substantive though it seems increasing in nominal figures.*" The change is not substantive if we see it in US dollars. He also adds "*…taking into account the inflation rate and decreasing purchasing power of [the] Birr, you cannot buy an item with 500 Birr now, the same item you used to buy for 100 Birr seven years back. So, it is increasing, but it is so minimal in real terms.*" An expert from the Oromia RHB added, *"… the increase is basically [into paying] salary of primary health care professionals. The budget for primary health service activities (health promotion and disease prevention) seem stagnant.*" A similar trend of non-substantive increase in the actual budget for PHC activities is also observed for finances from external sources. Participants noted that funds and loans increased in absolute terms but not when calculated in per capita. A recent review indicated that development assistance for health per capita increased from USD 1.5 per capita to 10 per capita between early 2000 and 2013, but has declined since to USD 7.7 in 2016.[17] Others felt that the increases in PHC financing are not sufficient compared to the demand. An expert from MoFED even felt the increase of financing from domestic sources are more remarkable when he said *"… domestic financing is … increasing more than loans and donations."* Figure 6 summarizes source and flow of finance in channel 2.

Figure 6: Management of funds from Channel 2, Ministry of Finance and Economic Cooperation (MoFEC)



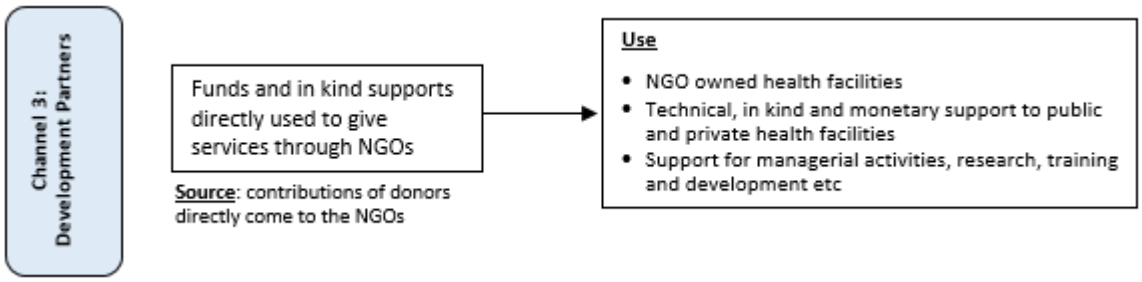
6.3.3 Channel three: Directly spent by development partners or their implementing agencies

This channel is also entirely funded by external sources. Government has limited oversight of these resources and the support is off budget. Major sources of finance for this channel are USAID, U.S. President's Emergency Plan for AIDS Relief (PEPFAR), and the CDC. Planning, budgeting, and reporting for this channel is independent of government budget although finances are on the One Budget of MOH. Hence, funds in this channel go directly to the implementing partners (local and international NGOs) which operate in the health system to strengthen its different functions down to the level of health facilities. These NGOs design their projects in line with the health sector priorities as outlined in the 5-year strategic health plan, such as the current HSTP II. The responsibility of the MOH in Channel 3 is to verify the design and planning of health projects, along with resource mobilization so that duplication of effort is avoided and ensure that limited resources are used efficiently. How the planning process in the health system assists in this harmonization effort is explained below.

During this planning process, one of the activities is aligning Channel 3 funds to the government budget using resource mapping that is executed every year starting in January. Resource mapping is performed in collaboration with partners in the regions. Implementing partners that operate at regional and federal levels, submit their activities and commitments to MOH earmarking their resources and where and in what thematic area they are going to commit. Then all directorates of MOH align with respective implementing partners and produce a binding planning document for the ministry. For example, a key informant from the ministry said: "*... an implementing partner that supports family planning aligns its plan with Maternal and Child [Health] Directorate stipulating its resources and which woreda it plans to support.*"

Figure 7 summarizes the source and flow of funds in channel 3.

Figure 7: Management of funds from Channel 3, funds from development partners



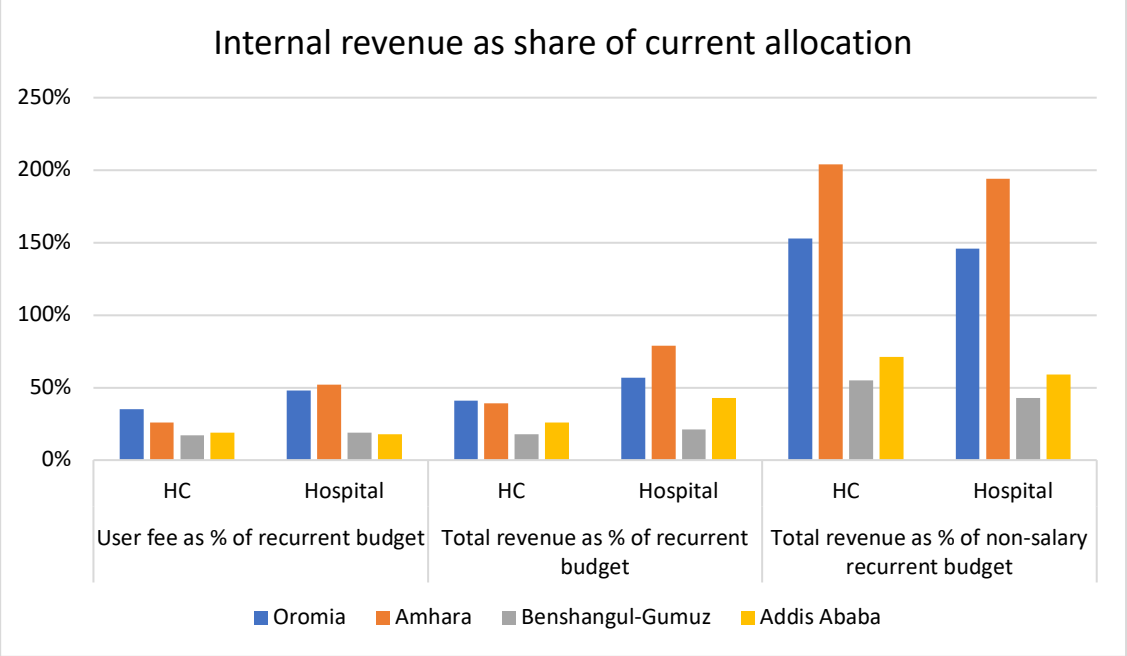
Source: Authors' own illustration

6.3.4 Revenue generated and retained by health facilities

The fourth source of financing at the level of health centres and primary hospitals is revenue generated through user fees and other means. Since 1998, health care financing reforms have been implemented and the current reform was developed in the 2009/10 Ethiopian fiscal year. This reform permits health facilities to generate revenue through user fee charges and use it to improve quality of service. "*The major reform in health care financing is retention and use of user fee charges at the health facilities*" said an official in a regional health bureau. Most health centres generate income by selling drugs and routine health services. But the source is not limited to selling drugs and medical services. Health facilities can create their own means of generating income, and some have been innovative in doing so, for example by: renting halls or indoor space, producing and selling crops on land in the compound, planting and selling trees, or participating in local businesses like selling tea and coffee to clients and local populations, especially in urban areas.

A review of the contribution of the 1998 health care financing strategy revealed that 17%–35% of the recurrent budget of health centres came from user fees. This figure ranged from 18%–48% for hospitals.[19] Figure 8 shows the percentage share of user fees and total revenue for the recurrent budget of the health facilities in Ethiopia.

Figure 8: Internal revenue as a share of recurrent allocation for health facilities



Source: Abebe et al 2015.[19]; HC=health centre

Another measure of use of internal revenue collected by primary health care facilities is the proportion of 'appropriated' amounts as part of the annual government budget.

> *"Amount appropriated refers to the amount of money that is proclaimed by health facilities to be utilized during a specific fiscal year and is approved by respective Finance and Economic Development Offices. This sum could be less than, equal to or more than what is collected in [a given] year as health facilities are allowed to revolve funds."19*

According to Table 4, health facilities in SNNPR utilize a significant portion of appropriated amounts. However, those in Oromia, Benshangul-Gumuz and Amhara had not been able to utilize the amount approved for use. In terms of the amount collected, health centres in SNNPR and Amhara collected 120,793,144 and 117,259,286 Ethiopian birr in 2012/13 while hospitals in Benshangul-Gumuz collected the least amount (Table 4).[19]

Table 4: Performance of health facilities in using approved portion of retained revenue, 2012/13

Indicators	Health facilities	Oromia	SNNPR	Benshangul-Gumuz	Addis Ababa	Amhara
Amount collected (in birr)	Health centre	NA	120,793,852	7,284,144	33,710,820	117,259,286
	Hospital	NA	71,931,199	4,843,176	28,573,944	50,958,616
Utilized as proportion of collected	Health centre	NA	91%	62%	79%	48%
	Hospital	NA	90%	62%	68%	78%
Utilized as proportion of appropriated	Health centre	51%	98%	61%	102%	55%
	Hospital	81%	97%	53%	86%	104%

Source: Abebe et al, 2015.[19]

PHC financing through internal revenue retention is a recent phenomenon in the pastoralist regions like Somali. Formerly, PHC facilities were totally dependent on the government's budget and support from some NGOs. According to a key informant with knowledge of the health care financing process in the Somali region "*...in the past health facilities such as health centres had no health care finance [from revenues generated by facility], but now they can even use their internal revenues [from user fees and other sources].*"

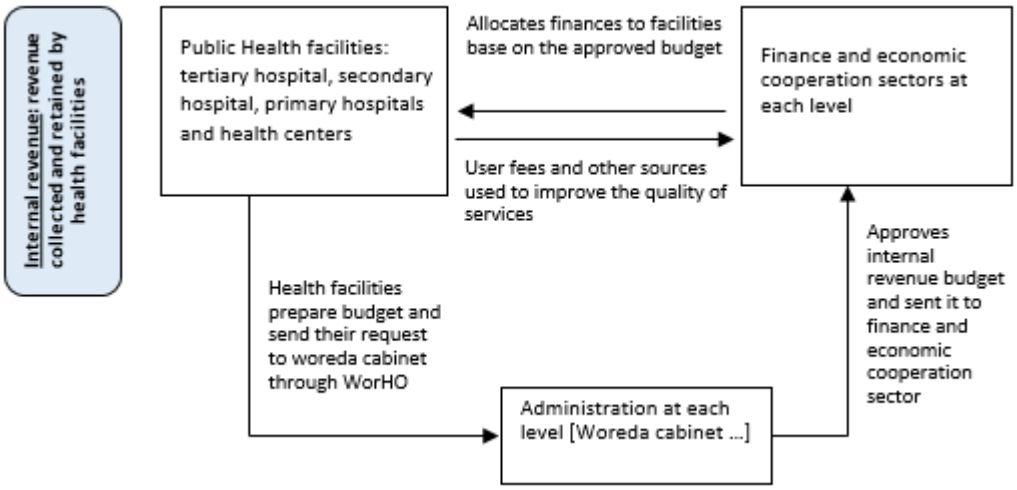
According to an informant from one of the agrarian district health offices, resource mobilization also occurs at the woreda level through an approach called "mobilization with community participation". At the facility level, the 1998 HCF strategy indicates active engagement of communities, who should play a vital role in the management of retained funds by local facilities and have a say in the overall running of health facilities.[20] The respondents also implied that the facility management teams and the facility governing boards play important roles in making decisions about the use of retained revenues. Both structures have community representatives as their members. However, the ultimate approval of the amount claimed by the health facility management committee and the boards is given by the woreda finance and economic development, as explained earlier.

In terms of resource mobilization, communities have the option of contributing in-cash and in-kind. The respondent from an agrarian regional health office explained, "*In a small cluster we may collect more than 100 quintals of cereals. It is a mechanism to collect finance or materials for mothers giving birth at facility. In this approach every "Geree" [a team of 30 households in a neighbourhood] is expected to contribute one quintal of cereals."* This approach is mostly used to fund maternity waiting homes and purchase ambulances. Usually, the collected amount would be surplus of the expenses in the maternity waiting homes. The leftover cereals are being sold and the money will become an additional source of income for the health centre. Interestingly, the 6th NHA provides a monetary value of the contribution of community volunteers. The NHA report estimated that community contribution through WDA and malaria control programs was at a nominal value of US$ 99 million in 2016/17.[10]

This does not apply to urban settings. For instance, a respondent from Dire Dawa City health office said "there is no such a thing [community contribution] in Dire Dawa. There is no cereal production here since it is urban, so they are very poor." There is also an approach of requesting wealthy people to contribute for the care of the poor. "Our intention is, if one rich person supports one poor [household], it will help to reduce the burden and also support the health insurance to have a good beginning," said an expert form the Dire Dawa health bureau.

Figure 9 provides summary of procedures for the use of internal revenue from user fees at the health facilities.

Figure 9: Use of income generated at the health facility level



Source: Authors' own illustration

6.3.5 Resource mobilization through insurance schemes

The government chose insurance as opposed to other strategies to achieve universal health coverage (UHC). For instance, abolishing user fees was incompatible with the ruling elites' desire for "rapid and broad-based development" for ensuring "self-reliance and community mobilization."[31] Hence, the policy decision to establish Community Based Health insurance (CBHI) and Social Health Insurance (SHI) schemes was a result of the political settlement of the ruling party. While implementation of SHI has been delayed, CBHI was piloted and scaled up in the years 2010/11 and 2013, respectively. Enrolment into the scheme was meant to be mandatory but later modified to be voluntary due to resistance from regional authorities.[31]

Significant money is being generated in the CBHI scheme. The resources pooled in this scheme are used to reimburse health facilities for the services they provide to members of the scheme. If it is implemented fully, engaging more members, this could be a significant way of resource mobilization. Currently, there is a huge movement at the woreda level to make rural households members of the scheme. A respondent from a woreda health office said, "... *for your surprise, before two years we enrolled about 9000 members of the CBHI scheme in a year. It is however, already about 32000 members this year even before the end of the year.*"

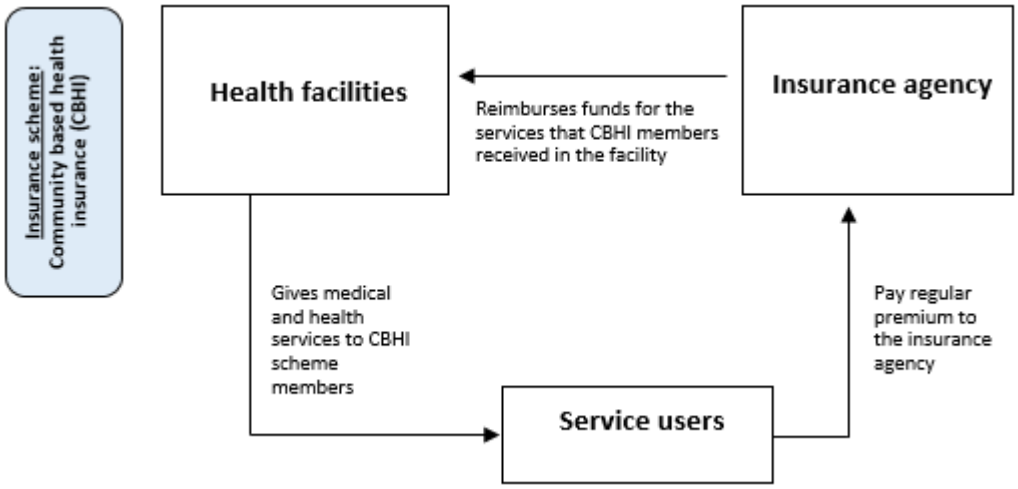
Likewise, a review of the implementation of the strategic plan of the Ethiopian Health Insurance Agency reported that the number of woredas implementing the CBHI scheme increased from 377 to 657 between 2016/17 and 2018/19. However, whilst these woredas that have established the scheme, not all have started service provision to their members and the number of Woredas with functional schemes is lower. Only 248; 360 and 507 schemes had commenced serving their members in 2016/17, 2017/18, and 2018/19, respectively.[32]

However, this figure had reached about 827 in 2019/20 and 770 of these woredas had managed to establish their scheme and initiate service provision to the beneficiaries. In 2020/21 the scheme managed to mobilize 1.8 billion Ethiopian birr in the form of premium from households. During this period, about 6.68 million households were provided financial protection while seeking health care. The total population covered by the CBHI scheme is much higher than this at 30.49 million beneficiaries who can access health services with no official requirement to pay at the point of service delivery. Of the total households enrolled, 78.8% were paying members, while the remaining 21.2% were indigent.[33]

A recent CBHI impact evaluation concluded that *"CBHI membership increased health service utilization; decreased the incidence of catastrophic health spending and narrowed socio-economic disparities in health service utilization."* Furthermore, the evaluation indicated that women who were enrolled into the scheme reported to have been better empowered in relation to health care use. Health facilities reported increased flow of clients and improved revenue. But health workers and communities expressed dissatisfaction since the increased flow of clients and revenue was not accompanied by improvement in the supply of inputs to the health centres.[34]

However, some interviewees had concerns about this approach of mobilizing resources for the health system. An expert who had several years of experience in the health system commented, "*I call [CBHI] a way of collecting more money without service improvement".* He added that its objective should be to expand the means of mobilizing resources while improving service availability at the participating health facilities. The review cited earlier, and an assessment of the HCF strategy also indicates that this concern is legitimate.[19,32] The former reported that there is a lack of drugs and laboratory services in the public health facilities contracted by the scheme. The drug availability in these facilities was estimated to be less than 70%.[32] Figure 10 provides a summary of the flow of finance between the insurance agency and the health facilities serving beneficiaries of the CBHI scheme.

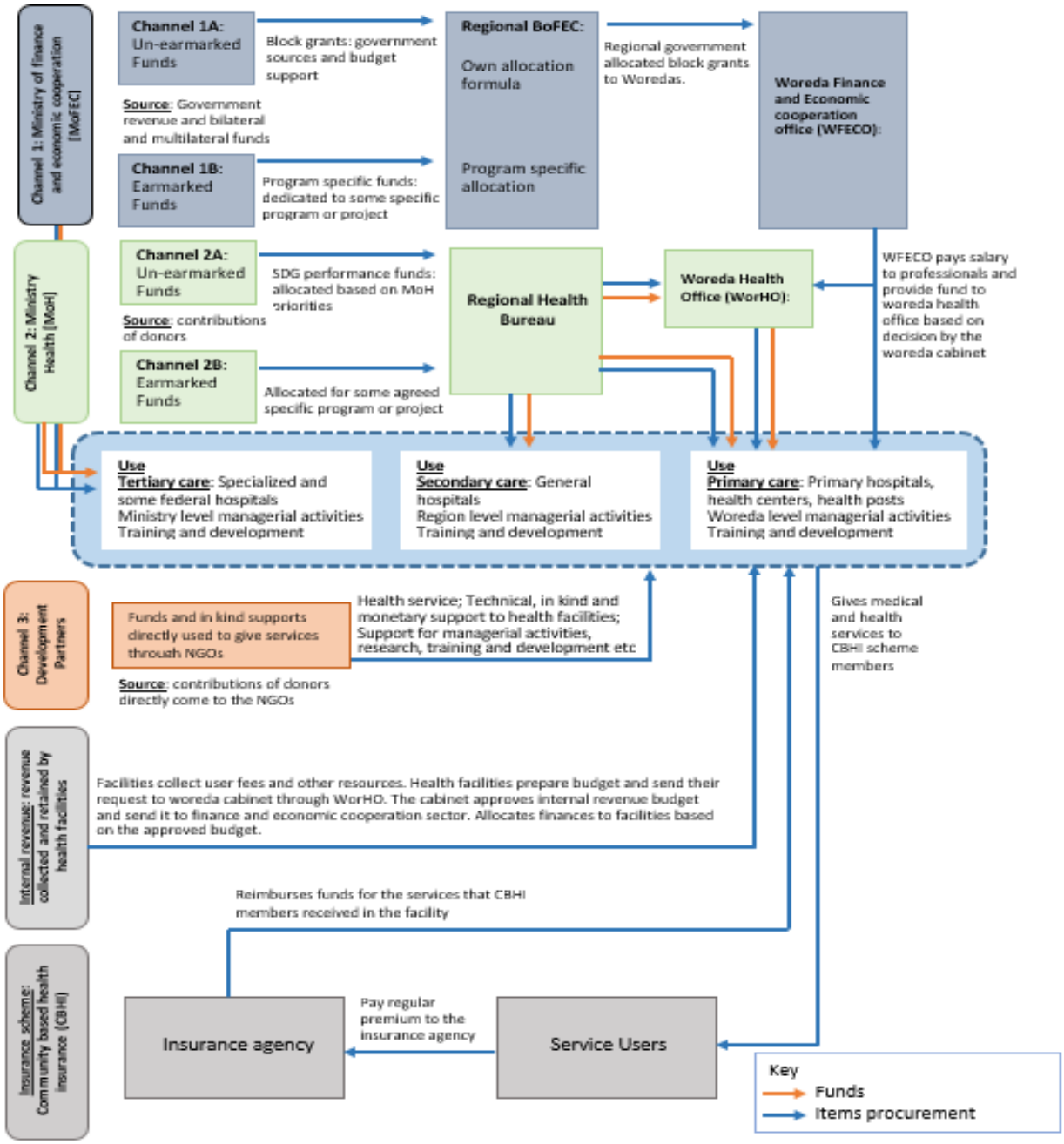
Figure 10: Revenue obtained with Community Based Health Insurance (CBHI) scheme



Source: Authors' own illustration

Figure 11 summarizes the sources of monetary funds and mechanisms of channelling the funds down to the health facility level. PHC facilities receive funds, supplies, and technical support through all the three channels. In terms of accessing health commodities, the health centre is the lowest level of allocation, and it is responsible for allocation of supplies and commodities to the health posts under its catchment. It is also important to note that the other two sources of financing for health facilities, user fees and reimbursement from insurance schemes, are indicated (Figure 11).

Figure 11: Sources of health care financing in Ethiopia



Source: Authors' own illustration

7. Facilitators and barriers related to resource mobilization and allocation

Facilitators to the resource allocation and use in the PHC relate to the political structure and support. The major driver here is the government's policy towards poverty reduction and significant budget support being provided by development partners to ensure implementation of this strategy. For instance, the budget support provided by some development partners (e.g., DFID, WB, and AfDB) prioritize the allocation of block grants to these priority sectors. An official from the MOH Partnership and Cooperation Directorate said: "*Both the political economy and its structure play positive role for primary health care because I think no political elites want to function in a dysfunctional health system, rather; they [politicians] prioritize health sector and this also relies on our [those in the health sector] capacity to negotiate with both government and the community about financing the health sector.*"

According to Lavers (2019) the success of the Ethiopian government in health and other development endeavours is a result of "*mass recruitment of local government officials—kebele (sub-district) managers, development agents and health extension workers—to improve service delivery and strengthening local administration.*"[31] Since the ruling party was committed to "*delivering tangible, broad-based socioeconomic progress and ethnic-self-determination through … ethnic federalism*"[31] any departure from attaining this goal would have threatened local officials' stay in office. Furthermore, sectors such as education, health, and agriculture have always been priorities for the ruling party which largely drew its popularity and support from the rural peasantry at the kebele level.

Another political feature that facilitated success in the expansion of PHC to the grass root level is the ruling party's narrative of being a developmental state. This demands that "*social policies must not only protect the poorest, but also make a productive economic contribution. Second, social policy emphasizes self-reliance, with anyone who is able to contribute—with labour or financial resources—expected to do so in exchange for support.*"[31] This has led to the active engagement of political administrators at all levels in the development and expansion of PHC facilities and the associated mass mobilization of communities to develop their own and their families' health.

Various strategic plans and policy documents demand the participation of different actors to support the health system. Since 2007, the government has striven to implement various activities through the woreda based plan. Political/government commitment has a key role in development and implementation of this plan.[21] The support of the woreda governments has proved to be essential. An informant from an agrarian region said: "… [in *a woreda in Eastern Hararge Zone], the governor of the woreda and the members of the cabinet led the health initiatives and created a model woreda. As we observed, when the woreda administration makes health issue its own agenda, good results were recorded*…" Respondents noted that when political will is not there, resource mobilization and implementation of health initiatives fail to succeed.

Hence, a critical facilitator of resource mobilization at lower levels is commitment of the woreda government. For instance, an informant from a woreda in an agrarian region indicated that they have mobilized resources with strong support from the woreda cabinet members for the purchase of three ambulances. "*It was unthinkable without the help of political leaders,*" the key informant said. Similarly, these political leaders supported the implementation of CBHI schemes at the woreda level. Describing their recent success in enrolling new members to the CBHI scheme, one of the woreda health office heads said: "*we can never achieve the current level of insurance membership level without the participation of political actors*".

These examples are underpinned by the Tigray People's Liberation Front (TPLF), the dominant party of the ethnic collation which has governed the country for almost three decades, with an ideology of providing health care based on the "*principle of self-reliance and community participation, with health workers selected according to their desire to serve the community for free.*"[31] The party had the experience of organizing and running community health systems where community members are engaged in planning, financing and implementing. Even during the insurgency, the party managed to successfully build 88 health stations, recruit and train 3,000 community health workers and traditional birth attendants in the Tigray region.[35]

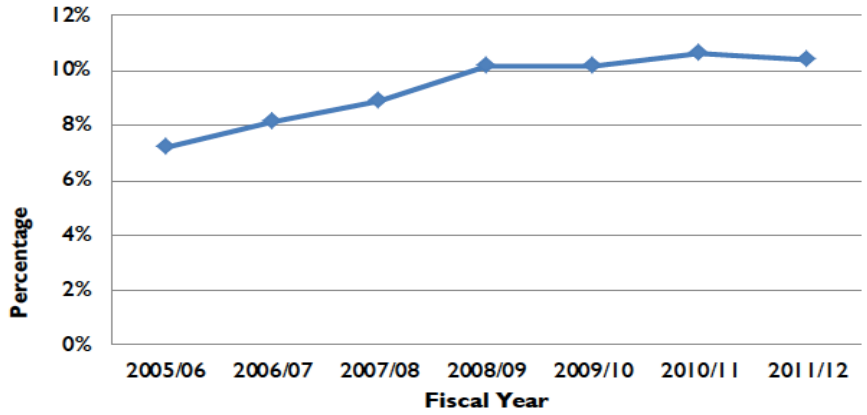
In contrast, a retired health economist who used to work for the MOH argued that success at the woreda level had little to do with political will. He added that even those at a higher level of the health system are instruments for realizing the directions from the centre. He described the health managers as "*underdogs!"* He added*, "They receive what is given to them and others expect [them to comply]. The only thing they ensure is to pay salaries of [their] workers,"* referring to lower-level health authorities. He also emphasized that the woreda and kebele administrations *"are not being heard"* by those at the centre. Furthermore, he added that the potential of the health staff at the central level (i.e. MOH) to negotiate with donors is not optimal. He explained, " *"When they [donors] provide you money for vaccine, for instance, it is required to negotiate for getting the infrastructure in addition to the vaccine because we don't vaccinate under the tree."*

Others explained that the allocation of resources at the woreda level is problematic at times. Respondents indicated that funds from the government treasury are allocated inequitably among different sectors especially at the woreda level. A district health office head said: "*There are unreasonable cadre decisions. For example, what you do with large amount of finance in the culture and tourism office? What things you change in our area? They have to scan the situation when they allocate finance to the sectors."* However, a review of expenditure patterns as reported in different documents clearly shows that health has remained one of the top priority sectors for more than two decades even at the woreda level.[19,21]

A report on the assessment of the 1998 HCF strategy indicated that the share of health budget from the overall government budget (channel 1) increased both at regional and woreda levels. At the woreda level, out of total woreda government spending (considering only channel 1 donor support) spending on health grew from 7% in 2005/06 to about 10% in 2011/12. This proportion is similar to the 8%–10% share at the

regional level. The assessment also reported the share of health spending at the woreda level to be as high as 21% and 15% in Benishangul-Gumuz and Afar regions, respectively.[19] The difference between woredas in this regard may relate to the lack of good advocacy on the side of the health office. Figure 12 shows the increasing trend in government spending on health at the woreda level.

Figure 12: Share of health out of overall government budget at the woreda level

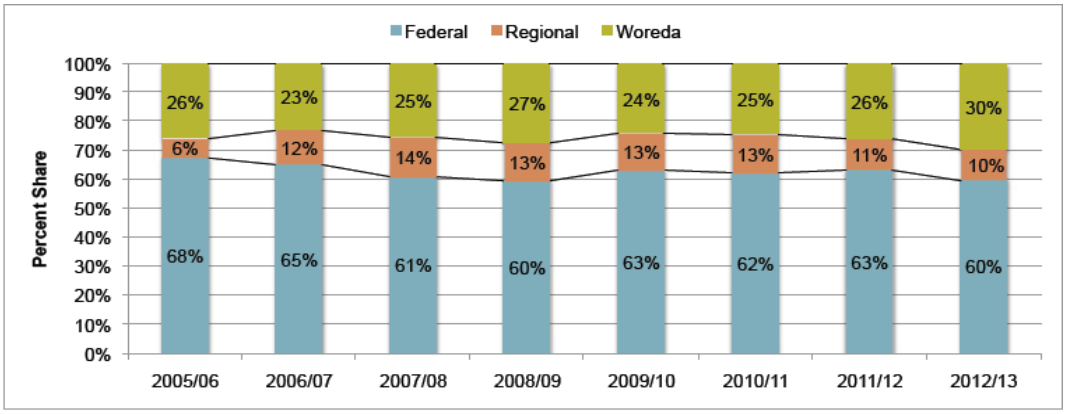


Source: Altman and others, 2012, p. 29.[21]

There are also key challenges affecting resource mobilization for the health and PHC. First, although the government has been successful in mobilizing a significant amount of external funds, little attention has been paid to increasing domestic sources of health financing. The gains in improving coverage for HIV/AIDS, immunization, family planning, malaria prevention and treatment, and prevention and management of TB are largely attributable to funding from external donors, mainly through the purchase of health commodities for these programs.

Second, although government financing for health is increasing at lower levels of the health system, budgeting for health facilities does not fully cover operational costs. Hence, health centres are forced to use retained revenue to cover some operational expenses (e.g., uniforms for staff, fuel, and tyres for ambulances) although this was not the original intention of the policy. This is the result of declining non-salary operational budget allocation at this level. This challenge is further complicated by the lack of adequate and timely reimbursement of the facilities (health centres and primary hospitals) for the exempted services they provide. The exempted services (e.g., ANC, delivery, and neonatal care services) mostly fall under the PHC level and the woredas rarely have the capacity to compensate facilities for providing these services. This is partly the result of the imbalance between functions and expenditure at the federal, regional and woreda levels.[19] Figure 13 below shows consistent allocation and use of at least 60% of the total resources available at the federal level over a period of 8 years.

Figure 13: Annual fiscal space by level of government in Ethiopia



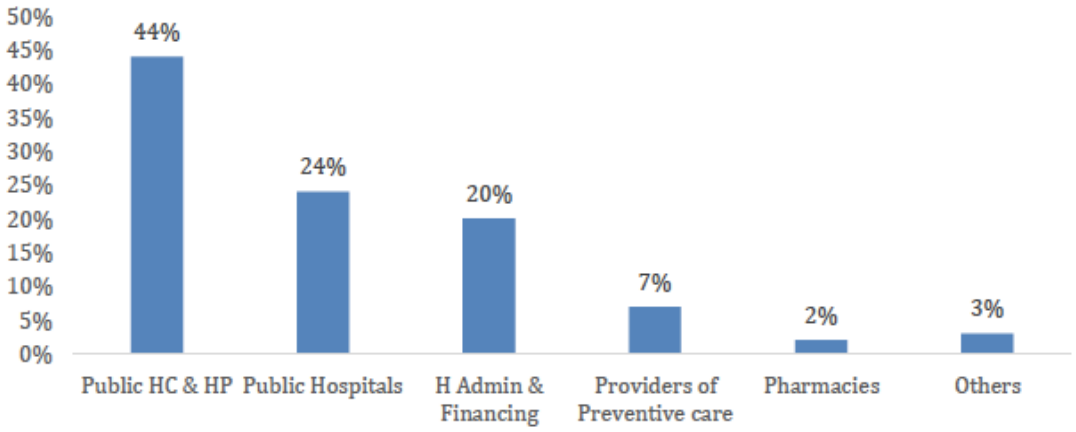
Source: Alebachew and others, 2015, p. 81.[19]

A health manager at the MOH felt that a lot is already going into the PHC services. The manager further elaborated that much of the health resources go into procurement of supplies used to deliver PHC services:

> *"Much of the budget channelled in Channel Two is dedicated to procurement of commodities supplied by Ethiopia Pharmaceutical Supply Agency (EPSA). Majority of the commodity procurement is for family planning, immunization, nutrition etc. are supplied as PHC service components. As we know, immunization service is given mostly by health extension workers and at health centre level, still; there is huge amount of budget allocated to this service. The same is true for family planning services and the expenditures are maintained high. In short, high budget allocation and expenditure is seen for PHC."*

According to an expert from HEP and PHC directorate, "Regarding the share, nearly 60% - 70% is allocated to PHC interventions ... there are interventions which cannot be included in PHC and taken to hospitals, ... 60% to 70% of the total health budget goes for PHC." The 7th NHA shows the proportion of government recurrent health spending used at the different levels of care. As in the figure below, the report indicated that the largest share (44%) of government recurrent health spending went into running health centres and health posts followed by 24% share for public hospitals. The report further indicated that 72% of the 24% used for public hospitals was used in primary hospitals, which are part of the primary care level in Ethiopia (Figure 14).[10]

Figure 14: Government recurrent health spending by type of providers



Source: NHA 7th, 2019.[10]

At the regional level, except for capital costs such as for construction of facilities and salaries of health workers, most of the revenue is allocated for PHC. Given all the service delivery units are PHC units in the woreda, most of the finance is used for running PHC service delivery except some expenses for managerial activities at the woreda health office.

Other barriers identified by the respondents include changing pattern of diseases in the population and poor quality of care for those enrolled in the CBHI scheme, which affects further enrolment by other households and renewal by old members. The increasing burden of non-communicable diseases is taking a significant share of the health budget which may shift some resources from PHC services to hospital level services.

8. Potential of actors for efficient and equitable resource use

8.1 Capacity for appropriate use of resources

There is a lack of capacity in mobilizing, allocating and using health resources at different levels in the health system. Some regions (e.g., Oromia and Amhara) have established health care financing units at regional, zonal, and woreda levels to facilitate implementation of reforms. The MOH provides capacity building support to healthcare financing experts at regional levels who are supposed to train woreda experts accordingly. In addition, the Ministry has also carried out an assessment, in collaboration with donor partners, to better understand the status of health expenditure at the national level. Further, limited capacity building is given to woredas and facilities on generating evidence and negotiation skills.

There are several problems related to financial management at the woreda level. According to a study, limited awareness of the HCF reform was identified by 56.4% as

the major issue, followed by insufficient budget (55%) and limited technical capability (43%). Inadequate consideration paid to Woreda officials, critical personnel shortages and high staff turnover were indicated by 40%, 30% and 27% of the participants, respectively.[36]

The other concern identified by participants about use of resources at lower levels related to the attitude and motivation of the health staff themselves. An informant said, *"When I was working at the MOH, I used to be surprised … 'when we tell them [health staff at woreda and regional levels] to come and take vehicles, they always were coming promptly even reached a day ahead; whereas when we tell them to come and collect drugs and [vaccination or other] cards, we had to beg them since they did not care'. The vehicle can be used for other [personal] purposes."*

There is inadequate follow up and supportive supervision of the health centres to properly collect, plan and use their internal revenues. The regional BoFEDs are not discharging their responsibility of auditing the use of retained fees at the health facilities. The WrHOs and WoFEDs are not collaborating on this owing to staff shortages for accounting and auditing functions. This leads to an absence of regular audits of the health centres which may result in the lack of timely "measures to circumvent possible leakages or misuse".[19]

The need to improve efficiency has increasingly been recognized in the Ethiopian health care system. Recent studies have demonstrated real concerns about how existing resources are used in the health sector. A few studies conducted in limited geographic areas indicated that most PHC facilities are not efficient enough.[37–39] A nationwide study conducted among health centres indicated that expenditure at health centres grew as the number of outpatient-equivalent visits increased. Some health centres had high budget but poor output. Other health centres tended to be more efficient with low levels of cost compared to health output.[40]

Interestingly, however, key informants indicated that there is a system to transfer resources, especially drugs, from one PHC facility to another if there are surplus in one facility. This flexibility helps the health system to use resources efficiently.

8.2 Equity

Equity and quality are among the pillars of the transformation agenda in the Ethiopian healthcare system. This strategic objective is addressed during budgeting because equity and quality are among the pillars of the health sector strategic plan. The federation formula for resource allocation, described earlier, is being utilized with the objective of equitable resource distribution. For issues related to geographical and other equity components, there is a responsible directorate in the ministry called Health System Special Support Directorate. A respondent from the Partnership and Cooperation Directorate disclosed, "*It [Health System Special Support Directorate] focuses on working in the four developing regions and currently, equity strategy is being developed.*" Social, economic, and political considerations are taken into account to address special needs of the four developing regions (Afar, Benshangul-Gumz, Gambella, and Somali). About 30% of the government's finance goes towards addressing equity gaps in the country, according to a key informant from MoFEC.

The 2019 Public Expenditure and Financial Accountability (PEFA) performance assessment report provides the formula for the percentage share of each region and subsidy received by each of the regions for the year 2018/19.[29] The table below provides the formula percent share of each region in the year 2018 (Table 5).

Table 5: Share of regional states based on the general-purpose formula for regional subsidies, 2018

REGION/ADMINISTRATION	FORMULA % SHARE	TREASURY IN US$	ASSISTANCE IN US$	TOTAL SUBSIDY IN US$
TIGRAY	6.03	7,909.80	29.77	7,939.56
AFAR	3.02	3,956.40	19.96	3,976.36
AMHARA	21.6	28,280.70	159.51	28,440.20
OROMIA	34.46	45,281.80	90.83	45,372.65
SOMALI	9.98	13,115.50	24.88	13,140.42
BENSHANGUL-GUMUZ	1.83	2,385.80	23.74	2,409.52
SNNPR	20.11	26,414.80	63.55	26,478.35
GAMBELLA	1.33	1,721.40	29.75	1,751.18
HARARI	0.76	997.50	3.19	1,000.67
DIRE DAWA	0.88	1,155.00	3.70	1,158.67
TOTAL	**100**	**131,218.70**	**448.89**	**131,667.58**

Source: PEFA performance assessment report, 2019.[29]

There are also mechanisms to safeguard those who cannot pay for health services at the PHC level. The health care financing manual states that the government pays or subsides the medical costs for the poorest segments of the population, commonly known as 'poor of the poor', according to an official at the MOH. If we look at the fee waiver system's process, health facilities record all the prescriptions and expenses of people with a certificate of 'indigent family'. Health facilities have a separate record for this purpose. The finance department of the health centre regularly compiles and sends reimbursement requests to the woreda administration office, which are then paid to health facilities. In urban settings there is also a service called the 'family health team'. If an individual gets sick and cannot afford to pay for health care or medicine, the family health team provides services for free at their home.

These measures are expected to improve the uptake of PHC services; however, some reports show that the coverage of the poor with the fee waiver programs is very low. For example, in one of the regional states, only 7% of households living below the poverty line were covered.[19] The fee waiver program covers only 10% of the population while the share of the population living in poverty is at least 20%. This is mainly due to the lack of budget to cover relevant expenditures by the woreda governments. Another issue in relation to the waiver program is the lack of "*adequate and strong administrative accountability mechanisms in the fee waiver guidelines to ensure woredas do not default on payment to health facilities.*"[19] In many instances the woreda administrations issue the waiver certificates to people without allocating a budget to reimburse health facilities. Furthermore, the are also concerns about leakage and under coverage in this program.[40,41]

According to a key informant from one of the agrarian woreda health offices, the woreda reserves 10% of the health care budget for reimbursement of indigent family health service expenses at public health facilities. Overall, the woreda covers 30% of the health expenses to cover the poor and the region covers 70% of the expenses; however, most of this goes to payment for indigent CBHI members who could not afford the premium. The region directly sends the reimbursement to the facility.

A recent impact evaluation of the CBHI scheme supports these findings. In the CBHI scheme there are two forms of subsidies aimed at protecting the poor: general and targeted. In the general subsidy, the central government subsidizes 10% of the total CBHI contribution. During 2016–2020, this subsidy increased from 28.1 million to 157.7 million ETB. The targeted subsidy is the amount of money secured to pay for households who are unable to pay: 70% is covered by the regional government and 30% by the woreda government. The targeted subsidy by regional governments increased from 42.6 million to 326.6 million during the same period.[34]

In the pastoralist woreda the same practice is in place. However, the amount is much less at 20% of the overall health budget according to a key informant from a pastoralist woreda health office. Currently, these indigent families are being included in the CBHI scheme with no premium payment. Instead, their premium is covered by the woreda and the region. There are, however, some malpractices related to the selection of indigent households at the kebele level. A key informant from a woreda health office indicated:

> *"There are poor people, the problem is these poor people are not identified fairly [appropriately]. For instance, there are some people who come to health centres by mule [very expensive animal being used for transportation] having certificate for indigent households. In most cases these people are relatives of the kebele administrator."*

Besides the fee waiver services there are some exempted services for reproductive, maternal, neonatal, and child health (RMNCH) services and other prevalent health problems. The major source of funds for these services, according to an official from the MOH, is external donations while little is contributed from domestic sources. "*If we see TB specifically, it attacks poor community members and the treatment is given free, so this is evidence for pro-poor focus of the health system,*" added the official.

Despite the importance of the exempted services to enhance uptake of PHC services, there are some challenges to this provision. There is lack of consistency in the list of exempted services promoted by the MOH and RHBs and those provided at the facility level. Some facilities may have extra support from an implementing NGO to provide some exempted services and others fail to continually provide some exempted services due to a lack commodities (mainly for program drugs).[19] Health centres report that their resources are taken up by exempted services since no third party reimburses their expenditures.[42]

8.3 Response to disasters and shocks

Ethiopia has encountered various shocks that have both direct and indirect impacts on the health system. "*…as a region, recently, we have encountered lots of disasters and internal displacements*" says a director at one of the RHBs. The COVID-19 pandemic is the most recent health emergency impacting the health system tremendously. During the pandemic, for instance, a national resource mobilization committee was established which coordinated resource mobilization activities from the community, aiming to reduce the amount of budget that health facilities might divert to COVID-19 prevention programs.

At the regional level, a key informant said, "*during these kinds of situations we primarily use what we have at hand. Either the regional government or Disaster Prevention and Preparedness Commission reimburse the finance later. For instance, in relation to COVID 19, the federal government directly supports some awareness creation and prevention activities to the population.*" However, health centres diverted a significant portion of their budgets to procure additional personal protective equipment which the pandemic demanded. Further, the resources used to respond to the pandemic were not reimbursed. A respondent from a woreda health office said:

> *"According to the guideline, all the expenses for these kinds of spending should be reimbursed by a government body. However, no one reimburses the expenses practically. During COVID 19 some directors of health centres told me that they were forced to spend more for personal protective equipment like face mask, sanitizer etc. But there was no clear guidance on how these additional expenses of health centres could be reimbursed."*

A recent review of the public health emergency management (PHEM) system in Ethiopia has reported findings that are helpful to explain this situation. It was found that there is a lack of finance to budget for emergency preparedness and response plans at all levels of the health system. The entire health sector in Ethiopia received only 16% of the funding required for PHEM in 2018, and the nutrition sector received only 22%.[43]

Moreover, the situational assessment for the development of the PHEM strategic plan for the country indicated that, except for staff salaries, PHEM in Ethiopia is entirely funded by development partners. Currently, contingency funding is practiced only at the woreda level. The contingency fund at this level, however, is very limited and, since it is not specific to health and nutrition emergencies, it can be used by any of the sectors as deemed necessary by the Woreda Council. Due to this lack of domestic financing and contingency funding, response efforts are at times severely hampered. Hence, available funding channels are neither responsive enough to deal with sudden-impact and rapidly evolving emergencies, nor flexible enough to cater for pre-emptive preparedness and containment measures.[44] This ultimately affects the delivery of PHC services since the health centres and primary hospitals are at the forefront of health emergency response and management.

9. Monitoring and control of resource use

9.1 Autonomy of PHC providers

The Ethiopian government system is decentralized into regional states, zones and woredas. The health system management is also decentralized based on the country's political structure. The central government allocates resources to regions and regions to woredas and woredas to health facilities under their jurisdiction. Regions are autonomous, with the freedom to use treasury budget and resources they get from partners that operate locally. They are also responsible for ensuring the budget is used for their priority programs, which are usually aligned with those of the centre. Similarly, facilities are also free to use the finance they generate from internal sources (user fee charges and others) at their discretion. Whether facilities generate and retain funds or not, the central or regional governments are not supposed to deduct their share from the treasury budget because internal revenue is believed to fill the budget deficit or gaps in improving quality and service availability.

The facility governing board has a strong say in approving and monitoring the use of internally generated revenue. The whole government budget and internal revenues are then managed by the health centre's director who is overseen by the woreda health office. The woreda health office has a mandate to appoint and fire the director of the health centres and therefore, can indirectly influence directors' decisions.

However, the influence on health centre directors is not limited to those by the woreda. Even the woreda administration has its own influence on the resources of the health sector. Regarding this an experienced expert in the ministry said that; "*...the main point here is that some woreda [administrators] were saying to health managers 'since you have budget [those coming from external sources, e.g. for vaccination campaign and others] and we lack for agriculture, let us reduce yours' while others said 'you can do what you want but only if we allowed you to do so'*."

9.2 Influence and control by the centre

At the central level, the MOH's finances are generally managed and controlled by MoFED. From the very beginning, the targets set by the health sector are submitted to MoFED. These targets are used to monitor performance, which is then reported to donors, MoFED and implementing partners. A key informant from MoFED says, "... *there is one department in channel one that deals with financial management of funds and my department [Monitoring and evaluation] also involve in performance evaluations*". The main point here is that most funds and loans are based on performance. MoFED expects reports every quarter from implementing sectors including the health sector. It is after the reports are sent to donors that money is liquidated. Therefore, evaluating performance is the main input to receiving subsequent funds.

From the perspective of the health system, the PHC system is led according to the woreda based plans. Health plans in all the regions are prepared based on the woreda based planning guidelines. The compiled document from each of the regions

is aligned at the ministry and sent back to the regions. After planning, there is routine monitoring and evaluation system. Currently, there is an electronic reporting system called District Health Information System 2 (DHIS2). All woredas and health facilities send monthly reports according to the preset indicators in DHIS2. This system is the main monitoring and evaluation tool to track what is going on in the delivery of PHC services by the MOH and the RHBs.

All MOH directorates monitor the PHC system according to the directorate's specialty and if capacity building is needed, they provide it through their respective regional counterparts. There is also a Joint Steering Committee (JSC) where regional health bureau heads and MOH senior management are members. This group hold meetings every two months. In the meeting, budget utilization is evaluated, and regions have their own platforms to monitor budget utilization.

Leading and controlling resources at the PHC level demands a more systematic way of management. The HEP roadmap, a broad document to strengthen PHC, has recently been launched and its implementation manual is under development. Financial components are included in this manual to some extent, and this document will be very helpful to continue to work on existing and newly included components of PHC. However, it is essential to note that the roadmap entirely focuses on HEP and there is a need to develop revised norms and standards for the implementation of the new EHSP.

9.3 Methods of monitoring and control

Health care finance is not solely managed by the health sector. The lion's share of managing financial resources for health is taken by the finance and economic cooperation branch of government from the centre to the woreda level. The role of RHBs relate to compiling both activity and financial expenditure (liquidation) reports to be submitted to the MOH. These may vary across programs depending on whether they are responsible only for implementation or for financial utilization (expenditure) as well.

At the PHC facility level, follow-up is expected to be conducted by the governing board of the health centre. One assessment reported that more than 82.4% (2,748 out of 3,335) of health centres have established facility governing boards (FGBs). The presence of these boards has helped to devolve the responsibility and authority from the regional level and reduced the complexity of financial management (particularly for retained internal revenue). Some of the challenges faced by the FGBs are high turnover and absenteeism, lack of regular meetings, and lack of knowledge on their roles and responsibilities.[19]

There is also a controlling body at the regional level to monitor use of revenues generated by facilities. This structure was available only at the regional level until 2020 when it was also established by the zonal health departments. This serves the purpose of providing immediate solutions for issues related to PHC financing in a decentralized system.

There are various mechanisms to monitor and evaluate resource use at the woreda level according to a health office head. First, the health care finance process follows a public financing system. All the processes are being led by financial principles. A woreda health office head said: "*…we have to report the financial issues to the management every other week. There is also a monthly financial report [to the woreda finance and economy office]. The financial utilization are also being audited periodically.*" Furthermore, there is an appraisal system in the woreda health office. The expenses and spending are followed up per financial code. The reporting chain is linked to the region.

In relation to the financial monitoring and evaluation activities, there are problems at each level of PHC administration. There are weaknesses in relation to following up the source of funds and monitoring whether these resources are being used at the service delivery level. The key informant from a RHB associated this gap with the current financial approach. He said: "*…this happens because, either in the region or at the country level, there is a direction that every health care finance needs to be controlled by a separate office, Finance and Economic Cooperation.*"

The other basic issue at the woreda level is the absence of controlling mechanisms for the resources being used by the HEP. Regarding this, a woreda health office head said: "*…When HEWs take medications from health centres, there is no controlling mechanism in the kebele. Some may sell the drugs and use the money for themselves. These kind of malpractices may happen sometimes.*"

10. Conclusions and recommendations

The remarkable improvements in health status in Ethiopia is often attributed to its focus on primary health care. The health extension program has been used as a pragmatic platform for taking PHC services to communities and households. This report sought to understand the organization of the PHC system - particularly the relationship between the centre and regions - in resource mobilization and allocation.

The following summarizes the key lessons for other countries:

- The political system in Ethiopia is a devolved one with regional states and woredas having the ultimate authority of decision-making for planning and implementation of health services. The ruling party, however, has proved to be influential in resource allocation and priority setting to the grass-roots level through its recruitment and engagement of administrators at all levels as its members. Hence, the focus on primary health care at the centre has remained a priority at regional and woreda levels to ultimately result in the expansion of PHC infrastructure and services to communities across the country.
- The combined bottom-up and top-down planning with significant influence from the centre to set health sector priorities has two-fold advantages. Firstly, it aligns activities by all actors in the health system owing to its participatory nature during preparation. Secondly, it serves the purpose of being a coordination mechanism to enhance aid effectiveness. Moreover, the different

channels of finance flow have enabled the health system to ensure funding of priority health interventions while striving for accountability at all levels.

- Ethiopia has successfully attracted significant donor funds to advance PHC infrastructure and service delivery. The government share of health expenditure is increasing at all levels of the health system. More than a third of government recurrent health spending is spent on running health centres and health posts. At the regional level, except for capital costs such as for construction of facilities and salaries of health workers, most of the funding is allocated for PHC. Given all the service delivery units are PHC units in the woreda, most of the finance is used at this level for running PHC service delivery, except some expenses which are for managerial activity at the woreda health office.
- The health system continues to retain user fee revenues as a means of mobilizing local resources to run facilities. This is coupled with extensive waiver and exemption mechanisms to protect those who are unable to pay for services and to enhance uptake of essential health services, respectively. Interestingly, PHC facilities are authorized to retain and use internal revenue generated from user fees and other sources. The precondition is that facilities need to make a request for appropriation of use of these funds to the woreda finance office through their facility governing boards.
- CBHI has recently become a significant source of local revenue for the health system. Premiums are subsidized by the federal, regional, and woreda governments. The regional and woreda governments allocate budgets to cover premiums for households who can't afford the premiums.
- In addition to the safety measures to protect those who are unable to pay for services, the budget allocation for the different regions is also equity oriented. Both the federal and regional governments allocate funds using transparent criterion. The federal government considers population size, socioeconomic status, proximity to the capital city, and availability of earmarked donor funds when allocating block grants to the regions. The regions, on the other hand, allocate block grants to woredas based on level of development needs in education, health, agriculture, and water.

There are, however, critical areas of concern demanding the attention of the Ethiopian government:

- Since donor funds are clearly going down, there is a need for targeted mobilization of domestic resources for funding the PHC system in Ethiopia.
- The declining allocation of budgets to cover non-salary operational costs for PHC facilities has impacted how the internal revenues of the facilities are used. Hence, due attention should be given to improve the situation so that health facilities can use their internal revenue to improve health services quality as originally planned.
- The exempted services (e.g., ANC, delivery, and neonatal care services) mostly fall under the PHC level and the woredas rarely have the capacity to compensate for the expense to facilities for providing these services. This is partly the result of the imbalance between functions and expenditure at the federal, regional and woreda levels. Hence, there is a need to revisit this imbalance to make sure that health facilities are fully reimbursed for the exempted services that they deliver.

- Similarly, waiver mechanisms serve the purpose of protecting the poor. However, delayed, or inadequate reimbursement to health facilities compromise the quality and volume of services delivered at the PHC facilities. Hence, regional and woreda governments should make sure that there are adequate finances allocated to cover the expenses of the health facilities.

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Annexes

Study participants: list of key informants

Descriptor	Category	Level	Number
National PHC directorate	Policy-maker	National	1
National Partnership and Cooperation Directorate	Policy-maker	National	1
Senior Health Economist (retired, worked at different levels of the health system)	Health financing expert	National	1
Ministry of Finance and Economic Cooperation	Policy-maker	National	1
Regional Health Bureau PHC directorate – Agrarian	Health manager	Regional	2
Regional Health Bureau PHC directorate – Pastoralist	Health manager	Regional	2
Regional Health Bureau PHC directorate – Urban	Health manager	Regional	1
District Health Office Manager	Health manager	District/Local	2
Abt Associate Inc.	Partner	National	1
The World Bank	Partner	National	1

Interview guide for key informant interviews

Preamble: In this interview we are seeking your opinion and explanations about how resources for financing PHC are mobilized and allocated in the Ethiopian health system. You are selected for the study because of your experience in PHC financing in the country. The information you provide will be used only for the purpose of the study. Moreover, all the information you will be sharing with us will be kept confidentially and we will not mention your name or position in the study report.

Organization: _____

Role/Position:_____

Years of experience in your current role: _____

S. No.	Main questions	Probes/follow ups
1.	How are resources for PHC financing mobilized in Ethiopia?	Describe sources of finances for PHC?
		How has this changed over the years?
		Are there peculiar approaches for mobilizing resources for financing PHC?
2.	What are the different processes/models through which the central government allocates health budgets?	Are there any guidelines or criteria?
		Can you describe the changes over the years?
		Are there measures in place to address equity? political, economic or social considerations
		Are there any pro-poor focus during the last few decades? If yes, how?
3.	How do you describe the relative proportion of health budget allocated for PHC in Ethiopia?	How has this changed over the years?
		Did interventions for COVID-19 affect availability of resources for financing PHC?
4.	How does the centre influence the use of financial resources for PHC at lower levels of the health system?	What policy and finance instruments does the central government have to ensure that regional and woreda authorities spend the funding allocated for PHC?
		Are there pre-defined standards (e.g. how many HEWs, capacity per population) that the decentralized authorities are expected to fund?
		How much freedom have the latter to mobilise and allocate resources in order to meet the needs of the local population?
5.	How is the use of financial resources to deliver PHC service monitored at all levels?	What degree of financial autonomy is provided to PHC service providers?
		What expenditure and responsibility standards are assigned to local authorities?
		What is the role of adhering to standards and norms set by the central government for local authorities in the monitoring process?

		Are there any recent reforms to improve efficient use of resources to finance PHC? If yes, how successful were these?
6.	What is the potential of actors at lower levels of the health system (regional, woreda, facility) to mobilise and use resources efficiently and equitably?	How do you rate the ability of the woreda to provide evidence and advocate for more resources at the woreda level? Are there any barriers to the woreda's ability to mobilize or allocate resources for PHC? If yes which?
		Are there any such initiatives currently implemented?
		If yes, do you think they are being properly rolled out?
		How is health/PHC made agenda for the woreda as a whole (the cabinet) not just health?

7.	What factors hinder or facilitate the mobilization and allocation of financial resources for PHC?	• Policy, strategy, international norms/standard such as WHO recommendations
		• supportive health system structures/processes (e.g. supply chains, HR and information systems)
		• political economy, including
		  • role of donors, political structures and interest of key actors,
		  • social norms
		  • economic factors such as GDP growth leading to greater fiscal space for health and PHC?

8.	Do you have any further issues you would like to mention?	

Information for Participants

You are invited to take part in our research study. Please take time to read the following information carefully and to talk to others about the study, if you wish. Please also ask us if there is anything that is not clear or if you would like more information.

1. What is the purpose of the study?

We are conducting a country case study to identify how countries can use health financing tools to improve efficiency and equity of primary health care. Specifically, this study will

- define how financing functions can support the good performance of a fundamentally people-centred PHC system;
- analyse how health financing can be used to align the incentives of different actors to both support and drive this approach to PHC delivery;
- examining how sufficient resources can be raised and allocated so as to actually uphold the promise of leaving no one behind

2. Why have I been chosen?

You are recognised as a key expert with an expertise of health financing in your country.

3. Do I have to take part?

It is up to you to decide to join the study. We will describe the study and go through this information sheet. If you agree to take part, we will then ask you to sign a consent form. You are free to withdraw at any time, without giving a reason.

4. What do I have to do?

Read this information sheet and consent form. We will review them both with you at the time of the interview. If you agree to participate, complete the consent form and send it to [Prof. Mirkuzie Woldie at mirkuzie@yahoo.com].

The interview will take place if and immediately after you consent to participating in the study. This interview will be conducted remotely by telephone or Skype/Zoom, according to your preference. With your permission, this interview will be audio recorded so that it can be transcribed. You also have the option to conduct the interview via video call, and we will seek your permission to do so.

This interview will take between 60 – 90 minutes.

5. Expenses and payments

There is no need for reimbursement of expenses, as participation in any interviews should not cost you anything.

6. What are the possible disadvantages and risks of taking part?

As you will be answering questions about health financing functions in Ethiopia, it is our hope that nothing that is upsetting or contentious will be discussed with you. However, if you feel at any point that you do not want to answer a question, you can refuse to do so. Similarly, if you want to end your participation in the interview at any point, you are free to do so without consequence.

7. What are the possible benefits of taking part?

Your insights are invaluable to the study we are undertaking. It is our hope that we can generate actionable and evidence-based policy recommendations on financing primary health care. Your responses will enable us to achieve this aim.

8. Will my taking part in the study be kept confidential?

Yes. All information collected about you during the course of the research will be kept strictly confidential. All transcripts of interviews will be anonymised and the only information linked to you directly will be generic descriptors of your position and/or workplace. However, you should

be aware that because of the small number of respondents we cannot guarantee your confidentiality. We may wish to use (unattributed) verbatim quotations in the paper but we will verify these with you before including them.

9. What will happen to the results of the research study?

We may use the information you provide in the paper that comes from this research, and information from the paper may appear in the final report of the Lancet Commission on Financing PHC. With your permission (see consent sheet) we will acknowledge respondents in the paper but will not attribute directly any information presented to you individually.

11. Who is organising and funding the research?

The London School of Hygiene & Tropical Medicine (UK) has commissioned Prof. Mirkuzie Woldie and his team to conduct this case study. This study is funded by the Bill and Melinda Gates Foundation.

12. Who has reviewed the study?

The entire study by the Lancet Global Health Commission was given a favourable ethical opinion by the research ethics committee at the London School of Hygiene and Tropical Medicine.

13. Contact Details

If you have any questions or concerns about this study, please contact:

Email: Kara.Hanson@lshtm.ac.uk

Principal Investigator:
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Local investigator:
Prof. Mirkuzie Woldie
Senior Research Advisor,
Ministry of Health, Addis Ababa, Ethiopia
Telephone: 0917804051
Email: mirkuzie@yahoo.com

You will be given a copy of the information sheet and a signed consent form to keep. Thank you for considering taking the time to read this sheet.

Informed Consent Form

Statements	Please circle as appropriate
1. I confirm that I have read and understood the participant information sheet for the above study. I have had the opportunity to consider the information, ask questions and have had these answered fully.	**Yes/No**
2. I understand that my participation is voluntary and I am free to withdraw at any time without giving any reason.	**Yes/No**
3. I understand that an anonymised transcript of my interview may be looked at by responsible individuals from the London School of Hygiene & Tropical Medicine (UK). I give permission for these individuals to access my interview.	**Yes/No**
4. I agree with the **audio** of the interview to be recorded for transcription purposes.	**Yes/No**
5. I agree with the **video** of the interview to be recorded for transcription purposes if the interview is being conducted by video conference.	**Yes/No**
6. I agree for my (unattributed) verbatim quotations to be used in the publication or report released on the study.	**Yes/No**
7. I agree to take part in the above study (Note: you do not need to agree to all six statements above to participate in this study)	**Yes/No**

Name of Participant (printed)	Signature	Date
Name of Person taking consent	signature	Date

One copy for the participant; one copy for interviewer

Contact information	**Local Investigator:**
Principal Investigator: Professor Kara Hanson London School of Hygiene and Tropical Medicine 15-17 Tavistock Place, London, WC1H 9SH Tel. +44 20 7927 2267 Email: Kara.Hanson@lshtm.ac.uk	Prof. Mirkuzie Woldie Senior Research Advisor, Ministry of Health, Addis Ababa, Ethiopia Telephone: 0917804051 Email: mirkuzie@yahoo.com