The Lancet Global Health Commission on Financing Primary Health Care

Financing PHC in Ethiopia: overview of briefs

Strategic health purchasing—using evidence and information about population health needs and health provider performance to make decisions about which health services should have priority for public funding, from which providers those services should be accessible, and how and how much providers should be paid to deliver these services—is generally accepted in the global health community as a critical lever to facilitate progress toward universal health coverage (UHC) within fiscal constraints.[1-3] Health purchasing is carried out through a set of functions using policy instruments (benefit packages, contracting, provider payment system, and performance monitoring) that can be applied more strategically toward UHC objectives.

Evidence shows that strategic purchasing has the most power to advance UHC objectives when:[4,5]

- **Institutional arrangements:** Institutional responsibility for purchasing functions is allocated clearly—both across institutions and across national and sub-national levels.
- **Accountability:** Institutions are accountable for both health outcomes and good financial management.
- **Harmonization:** A large share of total health spending flows through a single (or few) health purchasing agency or system with minimal fragmentation.
- **Purchasing functions:** The purchasing functions are carried out in a way that is objectives-driven and makes the best use of available evidence.
- **Institutional capacity:** The institutions have capacity to carry out purchasing functions effectively.

A first briefing outlines the issues that the government of Ethiopia had identified as key to progress towards greater strategic purchasing. A further four briefings have tackled specific challenges within that reform agenda.

Key issues for strategic purchasing	Brief 1	Mapping research on Primary Health Care financing in Ethiopia
Institutional arrangements, accountability & harmonization	Brief 2	Institutional arrangements, accountability and harmonisation for strategic purchasing
Purchasing Functions	Brief 3	Managing fragmentation in benefits by moving towards an integrated benefits framework
	Brief 4	How to design a blended payment system for Primary Health Care providers in Ethiopia
Institutional Capacity Systems	Brief 5	What are the system requirements for strategic purchasing with multiple schemes?

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RESULTS FOR DEVELOPMENT

The Lancet Global Health Commission on Financing Primary Health Care

Mapping research on Primary Health Care financing in Ethiopia

1. ETHIOPIA'S PATHWAY TOWARDS UHC THROUGH BETTER FINANCED PHC

For several decades, Primary Health Care (PHC) has been recognised as a key stepping stone towards achieving Universal Health Coverage (UHC) in Ethiopia. Substantial progress has been made towards improving access to PHC services, for example through the Health Extension programme (HEP). However, despite its recognised importance, the allocation of pooled financial resources to PHC has been limited and fragmented, and purchasing approaches have lacked strategic direction.

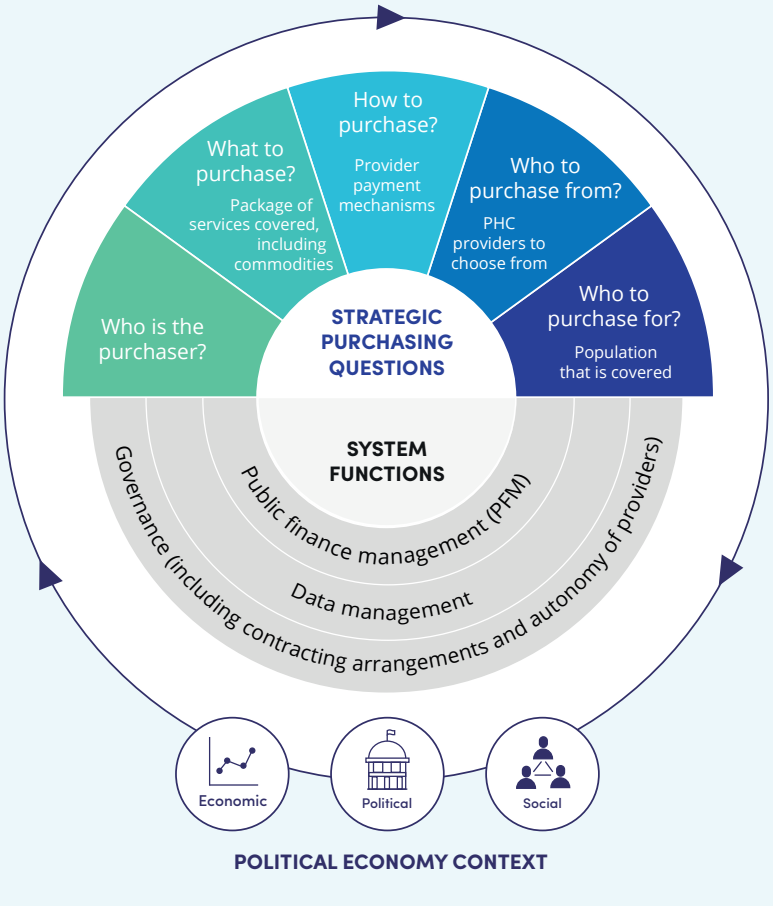
Multiple reforms are in motion to improve financial protection for the population and the way in which purchasing is organized. For example, a fee waiver system for a wide package of exempted services is in place (although underfunded) to ensure access to PHC services for vulnerable groups. Health insurance mechanisms are also being rolled out: community based health insurance (CBHI) schemes covering the informal sector at woreda levels have been compulsory since December 2022, and a social health insurance (SHI) scheme covering the formal sector will be operational soon. The CBHI and SHI schemes will be progressively pooled: firstly, CBHIs will be pooled at zonal or regional levels, then at the federal level together with the SHI scheme.

The Ministry of Health (MoH) is also working towards improving its purchasing approach, moving from retrospective input-based payments, such as fee for service reimbursements used by CBHI schemes, towards more prospective strategic purchasing.

2. WORKING TOWARDS GREATER STRATEGIC PURCHASING

Purchasing more strategically contributes to more and better funding for PHC. According to the World Health Organization, 'strategic purchasing aims to maximize health system objectives through an active, evidence-based process that defines which health services should be bought from whom, how these health services should be paid for and at what rate they should be paid'.[1] Facilitating functions will also need to be strengthened to progress towards more strategic purchasing. These include at a minimum: good governance of the health system, good data, and functioning public finance management (PFM) systems. The political economy context also needs to be supportive of the reforms.

Figure 1: Moving towards greater strategic purchasing – a framework



We map out the key issues to be addressed by the GoE for each of these questions. The World Health Organization definition of strategic purchasing has been slightly expanded:

STRATEGIC PURCHASING QUESTIONS	KEY ISSUES TO BE ADDRESSED BY THE GOVERNMENT OF ETHIOPIA
Who is the purchaser?	Different purchasers operate in Ethiopia: the MoH, the Regional Health Bureaus (RHB), the Woreda Finance and Economic Cooperation Office (WFECO), the Woreda Health Office (WHO), CBHI schemes and donors. These multiple purchasers have overlapping responsibilities and their resources are only partially pooled.
What to purchase? Package of services covered, including commodities	Various benefit packages coexist: the MoH defines the national Essential Health Services Package (EHSP). Although all 870 interventions within the EHSP should theoretically be provided free of charge to a target population (pregnant women, people living with HIV, TB, children under five, for example), in practice the implementation of exemptions is constrained by low resourcing.[2] The Ethiopian Health Insurance Services (EHIS) sets the benefit package for CBHI schemes, although this varies across woredas. Overall, the CBHI packages are not explicit and processes for their review are not well defined.[2] The inclusion of exempted services within CBHI benefit packages has been considered, but would be difficult as the cost of the exempted services package is high and could not be financially supported by CBHI schemes.
How to purchase? Provider payment mechanisms	Purchasers use different budget allocation and provider payment mechanisms. There are issues in the way resources are allocated and a variety of different payment mechanisms are used: • The allocation approach varies across each channel (1, 2 and 3). At the federal level, funds are allocated from the Ministry of Finance (MoF) to the MoH through programme based budgeting (PBB). From federal to regional and woreda levels, line item budgeting is used to allocate resources (90% of resources flowing to PHC are salaries, medicines and commodities).[2] These allocations are driven by historical budgets and input norms (final budgets have 49 line items).[2] At the woreda level, allocation decisions are mainly political, based on how well different sectors advocate for funding. The allocation of funds to exempted services which do not receive donor funding is either insufficient or non-existent. • CBHI schemes use a passive retrospective payment mechanism, fee for service (FFS). The FFS schedule varies in each region. Currently, woreda CBHI schemes purchase PHC and hospital care. EHIS purchase tertiary health care services from eight hospitals in Addis Ababa on behalf of CBHI schemes. Capitation is being piloted in SNNPR, Oromia, Amhara and Addis Ababa Regions, while PBF is piloted in Oromia region.
Who to purchase from? PHC providers to choose from	Strategic purchasing implies clear contracting mechanisms and autonomy of facilities to manage both financial and human resources. However, under current purchasing arrangements, public providers are automatically included with no explicit financial incentives that promote efficiency, service quality or better coordination.[3] The autonomy of PHC facilities is limited: whilst they are able to keep and manage the revenue raised through user fees, resources received from other channels face strict reporting requirements and, if unused, must be returned to the purchaser.[2]
Who to purchase for? Populations that are covered	Achieving UHC implies providing benefits to the whole population; however, in practice, countries must choose who to cover first. In line with the concept of progressive universalism, the most vulnerable parts of the population should be prioritized and this requires an understanding of various vulnerability measures in the country. Currently, who is identified as indigent depends on the woreda and it has been suggested that the very poor are not covered because of lack of fiscal space. PHC services were previously reimbursed for providing services to indigents through a fee waiver system. This has been replaced by the CBHI subsidization scheme which pays indigents' premiums via channel 1A, and entitles them to the whole CBHI benefit package including drugs. Facilities should receive reimbursements for the CBHI scheme and provision of exempted services through FFS although the reimbursement of exempted services is not happening as it should.[4]

Moving towards greater strategic purchasing also requires strengthening various system functions:

SYSTEM FUNCTIONS	KEY ISSUES TO BE ADDRESSED BY THE GOVERNMENT OF ETHIOPIA
Governance arrangements	As highlighted previously, the multiplicity of purchasers has led to fragmentation and overlapping roles. Clarifying who should play for what role is particularly important with the creation of the EHIS.
Data management	Good data are important to make evidence-based decisions in terms of the package of services needed and received, to understand and adjust the impact of the various incentives embedded in payment mechanisms, and to monitor the power of the contracting arrangements with facilities. While DHIS2 is operational in Ethiopia, it is minimally used to inform purchasing decisions.[2] Data collection and use outside of the DHIS2 effort also remains inadequate.[2]
Public Finance Management (PFM)	PFM systems are 'the institutions, policies and processes that govern the use of public funds'.[5] Well functioning PFM systems are key to ensuring that the right amount of resources are budgeted for UHC and flow through the system. Issues related to the execution of the budget have been identified for channels 2A and 2B, and for the resources flowing to CBHI schemes. There is also a lack of clarity as to what resources are available at the lowest levels of PHC, i.e., health centers and health posts.

3. CURRENT RESEARCH PROJECTS AND EVIDENCE GAPS

There is a lot of work underway that seeks to support the Ethiopian government strengthening these functions. Considering the complexity of the context, it is important to understand what is already known and what evidence is needed to inform policy reforms to achieve strategic purchasing. This section sets out the relevant research projects and the remaining evidence gaps.

WHO IS THE PURCHASER?

Ongoing research: Pooling CBHI resources across woredas at zonal levels (e.g., Amhara region)[6] is underway in several pilot level initiatives. Abt Associates is also leading pilots of higher-level pooling in Borana, Harari, Addis and two other areas.

Remaining gaps:

- How can the resources of different purchasers be pooled?
- How can CBHI and SHI be integrated at the federal level?
- What purchasing functions should take place at different levels (national/regional)?
- At what level should different funding flows be combined to reduce fragmentation/enable economies of scale but not undermine facility autonomy and responsiveness?

WHAT TO PURCHASE?

Ongoing research:

- Health Insurance/CBHI benefit package - WHO is working on the revision of the benefit package for the EHIS.
- Exempted health services benefit package – The Health Financing TWG is looking at the list of exempted services and potential to create a dedicated fund for health called the Resilience and Equity Fund, financed through innovative financing mechanisms, and used to purchase exempted services, emergency care, subsidizing the poorest in the population and supporting particularly those regions that are lagging behind.

Remaining gaps: This seems to be the most actively supported area of purchasing. However, no specific system approach as yet developed to understanding benefits packages and expansion paths towards greater coverage (at the population and service level).

HOW TO PURCHASE?

Ongoing research: CHAI is running a capitation pilot in four woredas in two regions[7] and CORDAID is running a PBF pilot. Preliminary results of the evaluation of the capitation pilot show some improvement of cost control in facilities receiving capitation payment, a reduction in the rate of referrals in the pilot region, problems with efficiency, and some improvement in the satisfaction of beneficiaries.[7]

Remaining gaps:

- Changing from FFS to prospective payments such as capitation will require a good understanding of the political economy of this reform. Undertaking political economy analysis of reforming provider payment mechanisms could be useful.
- How to align, or blend, different provider payment mechanisms could also be a focus area, learning from other countries' experience to learn what blended provider payment systems look like in practice.
  - What are the contributions of the different payment mechanisms (including supply-side financing) to the total?
  - What are the system requirements for blended payment and how can these be harmonized across different purchasing mechanisms / provider payment mechanisms?
- Bringing international evidence to inform how to purchase exempted services is also needed.
- Understanding how other countries have integrated PBF in their national financing systems is important to ensure that, if PBF is scaled up, it is integrated from the start and doesn't operate as a further, parallel funding flow.

WHO TO PURCHASE FROM?

Ongoing research: None identified.

Remaining gaps: No research proposed around how to improve contracting arrangements, nor whether to improve the level of autonomy of providers.

WHO TO PURCHASE FOR?

Ongoing research: None identified.

Remaining gaps: Undertaking a benefit incidence analysis or broader equity analysis to identify who benefits from public subsidy would help inform the targeting approach.

GOVERNANCE

Ongoing research: None identified.

Remaining gaps: How could the governance of the health financing arrangements be improved, and in particular what role should the EHIS play?

DATA USE AND AVAILABILITY

Ongoing research: None identified. Regional Health Accounts have been developed for in Oromia (by FENOT), although there are no details on PFM processes per se.

Remaining gaps:

- Lack of understanding of the alignment (or mis-alignment) between PFM processes and MoH's approach to budget formulation and execution.
- Understanding what the blockages are in terms of budget execution across channels 2A and 2B.

PUBLIC FINANCE MANAGEMENT

Ongoing research: None identified, although this field tends to be heavily supported by donors. There may be projects ongoing.

Remaining gaps: Identifying the existing data that could be used, and how to make greater use of this data, would be a useful first step towards ensuring that purchasing becomes more evidence based.

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Institutional arrangements, accountability and harmonisation for strategic purchasing

The objective of this brief is to provide evidence and country experience related to:

- Creating effective institutional arrangements for strategic purchasing—which institutions carry out which functions at which administrative level?
- Establishing accountability mechanisms—how can purchasers and providers be accountable for achieving objectives and advancing UHC outcomes?
- Harmonisation purchasing functions to minimise fragmentation.

INSTITUTIONAL ARRANGEMENTS

1. Who does what?

There is no clear guidance from country experience about which institutions should carry out which purchasing functions, but establishing clear institutional roles and relationship is essential. There should be clear guidance specifying which institution has the authority for which strategic purchasing policies and is accountable for implementing them, and in settings with multiple purchasers, which population groups and services each purchaser is responsible for funding. By contrast, unclear institutional relationships – particularly between a ministry of health and a separate purchasing entity, such as an insurance agency – can create inertia and sometimes conflict, both of which stall the implementation of strategic purchasing reforms.

The purchasing agency typically carries out most functions in a well-coordinated system, but some functions are distributed fully or partially to other institutions. Most countries separate the functions of benefits package design and purchasing the benefits package. For example, the Ministry of Health (MoH) sets a minimum package of services to be provided to all citizens in Brazil, Chile and the Philippines and the purchasing of benefits is done by the lower-level municipalities in the case of Brazil and by separate institutions in Chile – Fonasa for public insurance and Isapre for private insurance. In many countries even if the benefits package is defined by the MoH or through legislation, the purchasing agency can further specify the benefits to be purchased, define copayment rates, etc.

While the purchasing agency may have the authority to tie payment for services to quality standards, those quality standards are typically set by the MoH or other agency. In Ghana the National Health Insurance Agency (NHIA) manages the National Health Insurance Scheme (NHIS). The Health Facility Regulatory Agency (HeFRA) registers, inspects and licenses all health facilities. HeFRA registration is a prerequisite for contracting by the NHIA.

Most countries assign the function of payment rate-setting to the purchaser, but often with checks and balances and approval from the MoH or higher levels of government. For example, in Thailand payment rates for inpatient hospital services set by the national purchasing agency are capped at the regional level by the local budget bureau. In Estonia, the health insurance fund proposes payment rates, the MoH approves them and presents to the government for final adoption.

Institutional responsibilities may evolve over time as purchasing systems mature. For example, in the Kyrgyz Republic after the Mandatory Health Insurance Fund (MHIF) was established in the mid-1990s, the national reform plan specified that the national MoH was responsible for paying salaries, capital costs, and some high-cost specialized services, while the MHIF paid for all variable costs. Purchasing responsibility was consolidated over time, and currently more than 80 percent of government health expenditure is managed by the MHIF.[1]

2. Who does what at each administrative level in decentralised settings?

Even in highly decentralised settings, many countries centralise most purchasing functions. In many countries the movement toward a single health purchaser is occurring alongside decentralisation of service delivery, management and some financial functions to sub-national levels of government. These countries often opt to centralise purchasing functions to ensure equity and efficiency, while local governments have responsibility for overseeing and/or carrying out service delivery. In Chile, the delivery of primary health care services has been decentralised to the municipal governments, but the national health purchaser (FONASA) retains central control over most purchasing functions.[2]

Generally, benefits specification is a function managed centrally by MoH through a national minimum benefits package adapted by purchasing agencies. MoH also sets the standards for delivery of services and medicine formularies. In the devolved countries studied – Argentina, Brazil, Indonesia, Philippines – the transfer of resources to providers is a function of lower levels of government, but setting payment rates is at least guided centrally to ensure equity.

More centralised financing together with decentralised service delivery enables more effective purchasing. The countries that have been able to centralise financing and reallocate to sub-national levels through needs-based formulae and uniform provider payment methods have been most successful at achieving equity and efficiency in their systems. In systems such as in the United Kingdom that are mostly centralised in terms of revenue raising but have varying degrees of expenditure authority at subnational levels, health funding is pooled at the national level and then redistributed geographically using a needs-based allocation formula.[3]

A clear framework that specifies which functions are carried out at which administrative level, and guidance for how the function should be performed is helpful for communication and accountability Such frameworks are in place in Argentina and Chile, where the responsibilities between central and sub-national governments are delineated in performance-based contracts that specify indicators and targets.

ACCOUNTABILITY

Purchasers should be held accountable for achieving health policy objectives of equitable access and financial protection, not only financial management. Purchasers usually have clear financial obligations and rules they must adhere to, but they also have an obligation to achieve health system objectives of UHC. Financial stewardship is often emphasized more than health system objectives, particularly in settings with health insurance agencies, often resulting in weak linkages between purchasing and broader health sector goals and priorities. The Philippine Health Insurance Corporation (PhilHealth) is fully accountable to follow the government's public financial management rules, and it also has a clear health mandate articulated in its mission statement: "*Optimal benefits for every member; good quality service for all.*"[4]

Thailand's National Health Security Office (NHSO) is responsible for the Universal Coverage Scheme (UCS), and contracts the District health system (DHS) network to provide outpatient, health promotion and disease prevention services to the population. Inclusion of new interventions into the UCS benefit package is guided by evidence through economic evaluation, budget impact assessment and ethical concerns especially when there is limited supply-side capacity to offer new services equitably.

Sub-national governments can be held accountable for health objectives through collaborative processes and incentives. Autonomous sub-national levels can be guided through central government directives. In Argentina, Brazil, Philippines, Vietnam, the sub-national level has significant autonomy and political authority to set local priorities. These countries have a system of collaboration between central and sub-national level that recognizes the central governments' role in policy formulation and providing guidance for budgets and in some cases earmarks for health. In Kenya and Uganda, intergovernmental agreements are used between the national government and devolved government units that are responsible for service delivery, and they define roles and responsibilities between levels of government.

Performance-based contracts between national and sub-national agencies, such as in Argentina, can be effective at clarifying shared objectives and holding all sides accountable for achieving them. In South Africa, although provinces have significant authority for how health services are purchased, conditional grants from the central level maintain accountability for shared objectives related to primary health care.[5]

Health providers can be held accountable through formal or informal contracts. Contracts, both formal and informal, can be an important tool for communication and accountability between purchasers and providers. Rwanda's annual contracting process, involving the MoH and district administration, health facilities, and health workers, stipulates service delivery targets; this creates a culture of accountability for health system results that cascades upward from the district level to the national level.[6]

In Ghana, the NHIA contracts with providers include the services and medicines covered by the scheme, tariffs, claims submission, quality standards, time frame of the contract (usually one year), and termination clauses. Examples of quality benchmarks include average length of stay and minimum readmission period for in-patient services. If a hospital readmits the same patient within three days of the last admission, the hospital does not get paid as this is an indicator of poor quality of care and/or early discharge. In Uganda, the MoH uses soft tools such as memorandums of understanding (MOUs) rather than explicit contracts with private non-profit providers. Although these MOUs are less explicit, less formal, and have limited enforceability, they are credited with creating a culture of contracting and initiate a process of building trust.[6,7]

A holistic accountability framework can ensure that both health and financial management objectives are prioritized by purchasers and providers. The Superintendence of Health in Chile provides holistic accountability in the health sector, ensuring legal guarantees to the population are met, the compliance of health providers with accreditation standards, and the legal and financial obligations of health financing institutions.[8]

HARMONISATION TO MINIMISE FRAGMENTATION

Fragmentation in purchasing arises when there are multiple pools of funding each with their own purchasing rules and functions. Fragmentation may also exist in a single agency which has multiple smaller pools each with different purchasing rules. This may result in different benefit packages, different access to providers and payment modalities for different population groups which can hamper access and financial protection for households. Fragmentation may be minimised by taking a perspective of harmonizing the purchasing functions or creating a single channel of funds to provider level regardless of the revenue source.

Existing fragmentation should be reduced as much as is politically feasible. Some countries are able to take the politically challenging step of consolidating different revenue sources and financing schemes to reduce fragmentation. In some countries, such as Indonesia, this is done in a single step. Indonesia merged existing insurance schemes, including district community health insurance schemes and government subsidized schemes, to create a single national pool under Jaminan Kesehatan Nasional (JKN), which was launched in 2014.

Other countries consolidate schemes more gradually. The Rwandan government transferred management of the Community-Based Health Insurance (CBHI) scheme from the MoH to the Rwandan Social Security Board (RSSB) in 2015 in an effort to consolidate management of the schemes and reduce administrative costs, but all revenues and purchasing functions have not yet been consolidated.[9] The local regions are responsible for collecting CBHI premiums, which are channelled to RSSB for purchasing from providers, while the MoH sets the benefit package.

Fragmentation can be reduced by harmonizing purchasing functions. Creating a coherent set of purchasing rules on benefit package entitlements and rules for access, contracting, and provider payment can help reduce fragmentation. In both the Ghana NHIS and the Thailand UCS, beneficiaries access the same benefits from the same providers and providers receive the same payment regardless of whether they are a contributing or a non-contributing member. However, between the Thai UCS and civil servants' medical scheme, there are differences in benefits and provider payment that result in inequities in access and outcomes between the two groups.

Argentina's Programa Sumar, Brazil's Family Health Program, Tanzania's Direct Health Facility Financing (DHFF), all allocate resources to lower levels of government (in Argentina and Brazil) and providers (in Tanzania) through a per capita allocation. This capitation payment matches population size to primary health care resources and ensures that resources reach the lower facility levels most commonly used by the poor and more vulnerable.

Fragmentation can be reduced for providers by consolidating funding flows. Providers may receive funds from different sources, but these multiple resource flows can create inefficiency or distort incentives, causing providers to treat patient groups differently depending on the purchaser. For example in Indonesia, providers receive different revenue sources for different categories of services, and are expected to use and account for these resources separately. Providers do not have the autonomy to reallocate across services creating funding and service delivery constraints at their level.

In contrast, on-budget donor funds were consolidated with the government budget to create a common Health Basket Funding (HBF) in Tanzania. In the DHFF reform, primary health care facilities were recognized as independent accounting units to enable them receive resources directly rather than through the districts. Health facilities receive funds from different sources such as health insurance payments in addition to HBF through DHFF, but have one budget and accounting framework for all resources received.

IMPLICATIONS FOR ETHIOPIA

A few key messages to consider are:

- **Clarify and regulate the roles of FMoH, RHBs, WoHOs, and EHIS.** This means clarifying which institutions are responsible for which roles in order to form coherent policies, allocate resources efficiently, and create clear signals for providers. This must consider horizontal divisions (between the EHIS and FMoH); and vertical ones (Federal vs. Regional vs. Woreda; and within organisations such as the EHIS, between the national and regional EHIS offices). It also requires strengthened vertical coordination structures between federal and sub-national health teams. As commodities are a large and costly component of service delivery, responsibility for market shaping approaches, procurement and supply chain should be integrated into purchasing policies with clear institutional responsibility. Performance-based agreements between federal, regional and woreda agencies may be a helpful tool to clarify responsibilities and accountability across levels of government.
- **Create a strategic purchasing institutional arrangements roadmap.** Where the responsibility for some purchasing functions needs to be added or changed, a high-level government steering group can develop and implement a roadmap to gradually transfer responsibility (as was done in Indonesia over a period of several years following the initial creation of JKN). The roadmap can specify steps to get to a harmonised benefit package, common contracting and payment policies to avoid creating inequities and financial barriers to access care between SHI and CBHI beneficiaries.
- **Explore the use of contracts between providers and purchasing agencies to create a culture of accountability.** Putting in place a basic contractual agreement between purchasers and providers, or even simple memoranda of understanding, may be a useful step to clearly communicate expectations, create transparency, and build a culture of accountability.
- **Analyze the flow of funds to frontline providers and identify opportunities for harmonisation and consolidation.** Collecting information about the different flows of funds and the incentives they create for frontline providers may help prioritize where fragmentation can be reduced and greater autonomy in the internal allocation of funds may increase the efficiency and effectiveness of service delivery.

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Managing fragmentation in benefits by moving towards an integrated benefits framework

The objective of this brief is to show how an integrated approach to understanding multiple coverage schemes can help to address in a systematic way the challenge of coverage gaps created by fragmentation across these schemes.

Many countries have achieved UHC through a "mosaic" of different coverage schemes in which schemes are expanded or new schemes are added to address the health needs of specific population groups. But in early stages of this development there will be gaps in population coverage, differences in co-payment rates, and differences in benefit packages. Thinking about how multiple schemes fit together, in an integrated way, can help to better understand the gaps in coverage and importantly, demonstrate possible expansion paths where coverage along one or more of these axes can be expanded to get closer to UHC. This extension simply involves breaking down the familiar UHC cube by scheme, with a focus on the population and service coverage axes.

A MOSAIC OF COVERAGE SCHEMES

Few countries have a single health scheme for the whole population. Thailand provides an example of a "mosaic" approach to universal coverage.[1] The Social Health Insurance programme covers private sector employees (but not their dependants) – about 15% of the population; the benefit package is comprehensive with a small exclusion list; members can use empanelled hospitals, of which 60 percent are private; and there is no co-payment if a SHI contracted facility is used. The Civil Servants Medical Benefits Scheme covers government employees, pensioners and their dependants – about 9% of the population; the benefit package is comprehensive without an explicit exclusion list and members can use private beds within public hospitals without co-payment. The Universal Coverage Scheme covers the remaining population (about 75%), for a comprehensive package of services with a small exclusion list, for services within mostly public hospitals. The scheme initially charged a co-payment (30-baht, approximately $1) but this was removed in 2006.

AN INTEGRATED BENEFITS FRAMEWORK

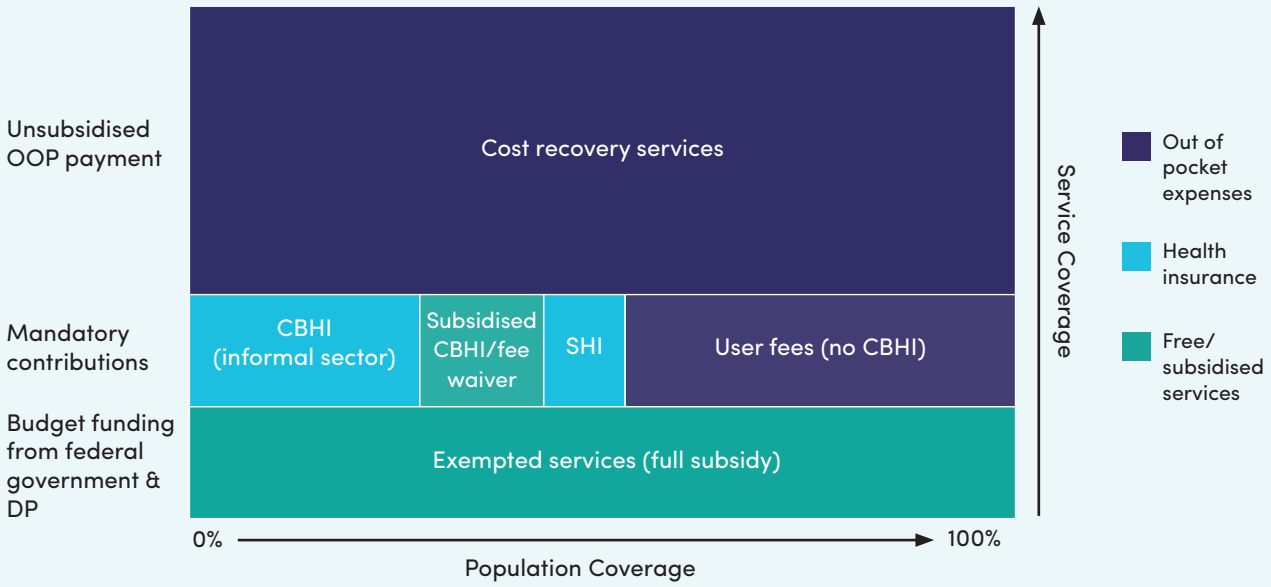
Ethiopia also has a mosaic of coverage schemes, but with considerable population and service gaps in coverage arising from the low level of resources available for health. Mapping the different schemes in a country by the generosity of their benefits package and their population coverage can help to reveal gaps.

An integrated benefits framework approach encompasses the entire population and all services that are at least partially subsidised for some of the population in any given year.[2] Such a framework acknowledges that while having comprehensive coverage for the entire population is a desired outcome, the route to universal coverage does not require everyone to have the same benefits and some kind of population and/or service targeting are possible and probably essential in the interim. Such an approach helps move from a focus on individual schemes to the coverage offered by the system as a whole. Finally, it allows policymakers to think about progress *towards* UHC.

Figure 1 gives a stylized picture of the benefits framework in Ethiopia. Exempted services are a set of interventions which are available to the whole population with full subsidy. Mandatory contributions are paid by those in the informal sector who belong to CBHI and those who benefit from subsidised or waived CBHI contributions. When SHI is introduced, it will cover formal sector employees. Those without any coverage pay user fees for services outside the exempted package. In addition there is a set of cost recovery services for which user fees are paid.

This figure also allows some design questions to be considered. For instance, will the SHI benefit package be more generous than CBHI (in which case the SHI pillar will be taller than the CBHI, representing higher service coverage)? And the number of services that can be fully subsidised in the exempted services package will depend on fiscal space available and willingness of development partners (DP) to finance.

Figure 1: Benefits framework in Ethiopia



EXPANSION PATHS

Seeing schemes together in this integrated way also allows policy options, reflecting different expansion paths, to be considered. Figure 2 illustrates some potential ways to expand benefits within this unified framework (all of these based on a scenario where the SHI benefits package has to be made more generous to attract contributors). The feasibility, costs and equity outcomes of different expansion options would have to be considered.

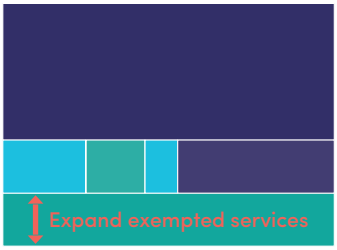
IMPLICATIONS FOR ETHIOPIA

Plotting out with real data the relative contributions of the current mosaic of schemes can help to identify coverage gaps in terms of populations and services. Both population and service coverage need to be adjusted to fiscal capacity. As fiscal capacity increases, different approaches to expanding coverage can be examined within this integrated benefits framework.

Figure 2: Potential ways to expand benefits within a unified framework

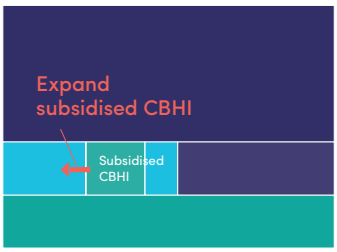
EXPANSION 1

If more government or DP funding were to be available, it would be possible to expand the set of exempted services. If resources are insufficient to fully fund this package, the effects of restricting it can also be seen.



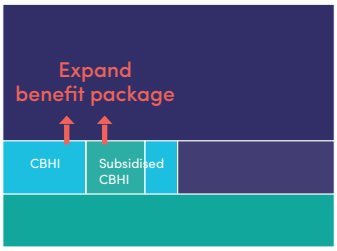
EXPANSION 2

If more resources were available it would be possible to extend the group eligible for subsidized or waived CBHI.



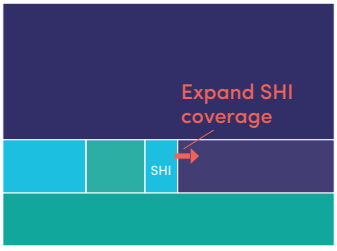
EXPANSION 3

The benefit package for CBHI could be expanded to include a wider range of interventions.



EXPANSION 4

If SHI takeup can be increased, this would lead to an expansion of SHI coverage.



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RESULTS FOR DEVELOPMENT

The Lancet Global Health Commission on Financing Primary Health Care

How to design a blended payment system for Primary Health Care providers in Ethiopia

The objective of this brief is to understand how to design a blended payment system for paying public Primary Health Care (PHC) providers in Ethiopia. In doing so, we consider three aspects:

1. How to design a blended payment system that gives appropriate incentives for PHC providers to offer good quality healthcare for everyone?
2. How to integrate this blended payment system into the government Public Financial Management (PFM) system to ensure frontline providers receive the payment?
3. Recognising the existence of multiple purchasers in Ethiopian health system, how to harmonise multiple payment systems to avoid double-budgeting and minimise inefficiency? (A further brief in this series presents an integrated approach to understanding the contributions of different schemes to population and service coverage).

DESIGNING A BLENDED PAYMENT SYSTEM

All of the main methods available for paying providers alone may create adverse incentives and unintended consequences, thus a balance of multiple methods is more desirable. Methods for paying PHC providers include input-based budgets (payments to cover salaries, medicines, utilities, etc.), fee-for-service (based on units of service offered, illness episodes or visits), or capitation (a fixed payment for each person enrolled with the provider). Payments or bonuses for specific behaviours such as improvement in the quality of care (pay-for-performance) can be added on to any base payment system. None of these methods in isolation is likely to be an ideal provider payment method, and different payment methods are often mixed to create the right balance of incentives. There are many permutations of all possible combinations of blended payments and a country may have a very complicated system that fits to the context of their economic, social, and political environment. Getting the mix right is important, and the "right" mix may evolve over time. This means that it is necessary to consider carefully the existing payment structure into which new payment systems are introduced and to design blended payment models to maximise the likelihood of intended outcomes and minimise the likelihood of unintended consequences.[1]

Incentives of blended payments system should be designed to be complementary and compensatory to each other and encourage health providers to deliver efficient, equitable and quality services and prioritise cost-effective care.[2] Incentives should be designed to encourage desired institutional behaviour, and facilities should be able to determine whether and how to cascade incentives to individual health workers.

Badly designed blended payments that create conflicting incentives can lead to undesired consequences. We identified three types of undesired effects:[3]

1. **Resource shifting:** Providers may shift resources in order to provide services under a particular funding flow. For example, providers could discriminate against patients covered by a scheme with unpredictable funding flow.
2. **Service shifting:** Providers may shift service provision under a less favourable funding flow to a more favourable one. For example, providers could recommend patients to pay for branded medicines instead of generic medicines covered by a government scheme.
3. **Cost shifting:** Providers may shift costs by charging higher rates for the same service to one funding flow, so as to compensate for a lower payment from another funding flow. For example, providers could charge higher fees to compensate for the loss of providing free care to exempted patients.

While each country has a different way of blending payment systems, a pattern emerges in more strategic systems where a close-ended base payment is complemented by explicit incentives to achieve a particular objective such as quality.[4] Close-ended payment imposes limits on how much one provider can

bill, or imposes caps at other parts of the system such as total expenditure on hospital services or geographic caps. The closed-ended base payment should be designed so that it creates incentives to achieve the main health system objectives. For example, capitation could be selected to pay PHC providers if the main objectives are to provide equitable access to all and keep the population healthy.

The base payment can be complemented by additional forms of payment to balance incentives or achieve other objectives. For example, capitation plus an allowance for facilities in rural areas may achieve the additional objective of accounting for low population density and high fixed costs in rural areas. Some relatively small variable payments that explicitly reward measurable aspects of health system objectives can also be added, e.g. quality of care. In OECD countries, primary care is often paid using blended payment that combines capitation with regulated fee-for-service payments for some high-priority services.

Some examples of blended payment systems include the following:

1. Family physicians under contract with the Estonia Health Insurance Fund are paid through a combination of a fixed monthly allowance (20%), an age-adjusted capitated payment per enrolee per month (50%), some fee-for-service payments (24%), additional payments based on the distance to the nearest hospital (2%), and performance-related payment through the Quality Bonus System (4%).[5]
2. In England, general practitioners (GP) practices are paid by risk-adjusted capitation (50%), performance-related payment through the Quality and Outcomes Framework (10-20%), and enhanced services bonus payments to incentivise specific services such as adult and child vaccinations, health care for disabled patients, and participation in primary care networks (20-30%).[6]
3. In Thailand, the Universal Coverage Scheme (UCS) pays providers by age-adjusted capitation, with a fee schedule for some high-cost conditions (e.g., chronic kidney disease and HIV/AIDS), and project-based block-grants for community-based health promotion and disease prevention services.[7]
4. In 2016, Burkina Faso adopted a national user fee exemption policy for women and for children under 5, called the Gratuité policy. The government pays facilities an amount in advance based on the expected revenue from fee-for-service with a spending limit. The funds are pre-paid at the district level quarterly. Health facilities may request commodities, drugs, and medical supplies based on earmarked funds per health facility.[8]

Experience across many countries in many different settings indicates that there is one payment method to be avoided: unregulated fee-for-service. This is because of the cost-escalating incentives it generates for providers to produce excess services and the difficulty of addressing this problem through other measures.[2]

While blended payment systems in middle and high income countries may look sophisticated and daunting to implement, they all started from a simple model. For example, in the early years of PHC reform in Estonia, one of the strategic policy decisions was to keep the financing model simple. Considering the background of the doctors having mostly worked as employees, and not being used to taking financial risk, the most modest form of integrated capitation was selected by incorporating an amount of funding to cover defined expenditures, such as laboratory tests and examinations.[5] Over time, the purchasers (i.e., EHIF) reduced the share of capitation to make space for regulated FFS and additional allowances in response to changing needs and priorities in the service delivery model. In Thailand, the UCS started paying PHC providers through simple capitation which has been adjusted in recent years to achieve a more equitable distribution of resources. Since the UCS expanded its benefit packages over time to include several high-cost conditions, such as renal dialysis and HIV/AIDS, it has introduced a fee schedule for these services to control the cost.

INTEGRATING BLENDED PAYMENT INTO GOVERNMENT PFM SYSTEMS

Some adaptations in the PFM system may be necessary to pay providers using output-based blended payment. The PFM system typically involves setting budgets, executing payments, transferring funds between different levels of government, operating banking arrangements, and managing financing relationships with public service delivery agencies. The integration process will involve the technical breakdown of each of these PFM process, however we only identified good evidence on how to ensure that publicly **provided annual non-wage recurrent** output-based financing can reach primary care facilities, specifically performance-based financing.

Every country has their own specific challenges in the financial management environment in which the output-based payments will sit. These challenges depend on the legal environment for handling public funds, the institutional structure of government, the legal status of the facility, the financial management capacity of facilities, and the institutional view of the Ministry of Finance regarding uniformity in public expenditure management.

Output-based blended payment may be particularly challenging when health facilities are not visible in the PFM system. In light of these different challenges, we identified some common approaches based on the **legal status of the health facility** and **their visibility in the national Integrated Financial Management and Information System (IFMIS)**. Considering the Ethiopian PHC system context, we will discuss the approach where health facilities are government spending units outside the IFMIS.

In this model, a health facility operates outside of IFMIS – but is still considered a government institution – and receives a transfer of finance (a grant) to fund its activities. This is a relatively common way of financing facilities. Typically, a transfer is provided from one level of government to another within IFMIS; and then from this lower level of government the money leaves the IFMIS to arrive at the health facility. Since the health facility operates outside IFMIS, it will need to establish its own systems for making payments, accounting for transactions, reporting its finances, and auditing these reports. Given that financing for facilities will be recorded within the IFMIS system as a transfer to an external entity, it should be possible to run simple reports to determine whether facilities have indeed received their output-adjusted capitation finance.

Challenges

- **Diversion of funds by intermediate layers of government.** In a situation where the budget is not fully funded (common in many low-income countries) the higher levels of government may decide to finance their own activities first, and then transfer only a portion of the remainder to lower levels of government. If the health facility is at 'the end of the chain' it may end up with substantially smaller financing during the year than set out in its annual budget.
- **The health facility may not actually manage its finances.** Smaller facilities are still managed day-to-day by local government with a pooled account that finances many different budgets. This means the facilities still need to negotiate with local government for each payment they wish to make, and the system needs good accounting practices to isolate facilities' financial activities within a shared account.

COUNTRY EXAMPLE

Uganda story in mainstreaming results-based financing (RBF) into a national PFM system

An externally financed RBF project in Uganda has helped reverse the long-term (real per capita) decline in non-wage recurrent budgets for local health services. Facilities could receive over 5 times more funding in 2021/22 than they did in 2017/18 (prior to the introduction of RBF) in absolute terms. A major policy challenge for mainstreaming RBF going forward is that the government will not have sufficient financing through the budget to compensate for the end of the programme. At an operational level, RBF also used different payment, accounting, and reporting systems and allowed facilities to use funding in different ways (e.g., for drugs purchases and staff bonuses). The mainstreaming process will involve changes to the structure of intergovernmental fiscal transfers to incorporate separate allocations for input-based and performance-based funding (with separate windows for quantity and quality) and for local government departments and health providers.

The RBF mainstreaming policy builds on the existing practice of providing financing directly to facilities. **Facilities in Uganda are not separate legal entities but have been allocated financing directly since around 2015 as part of the non-wage recurrent primary health care grant.** Facilities can use these funds flexibly during the year (for a limited set of inputs outlined in the sector grant guidelines) and can retain funds across fiscal years. However, **not all the flexibilities allowed in the original model will be maintained in the national RBF system** – at least initially.

Under the RBF mainstreaming strategy, local governments and health facilities will adhere to routine financial reporting and internal auditing requirements and procedures. At the local government level, non-wage fiscal transfers are budgeted as a grant to primary health care facilities, with each facility listed in the budget estimates at the local government level. Data is available for each local government online. Sub-accountants from the responsible lower-local government will be expected to help the facility to accurately record expenditure in the cash book and conduct monthly bank reconciliations. **The capacity of facilities to adhere to these procedures has not yet been discussed in the government strategy** or in published documents.

The mainstreaming of a performance-orientation in the budget and payment system for local health services involves setting up several new procedures. The Government is planning to adapt some of the basic features of the original RBF model, **by assessing performance and setting grant budgets on an annual basis (rather than quarterly).**

HARMONIZING BLENDED PAYMENT SYSTEMS ACROSS MULTIPLE COVERAGE SCHEMES

It is common to find multiple schemes with overlapping coverage and different payment systems, which may provide conflicting incentives. For example, two or more schemes may provide maternity benefits to the same group of women residing in the same geographic area; and/or gaps in coverage because resources are focused on a few benefits e.g. communicable diseases while excluding others e.g., non-communicable diseases.

Harmonising payment methods across all schemes has proven difficult and requires active engagement with key stakeholders across payers. One good example of a move towards harmonised payment method can be observed in Thailand where both Social Health Insurance and Universal Coverage Scheme are using capitation to pay for outpatient care. Another example is in Colombia where the contributory and subsidised schemes agreed to follow a unified benefit package after several years consultation among key stakeholders to adjust to a similar per capita level of funding.[9] In addition, both schemes pay providers through capitation but at a different rate. The agenda of future reform is to adjust the appropriate level of capitated funding from both schemes to avoid undesired consequences.

IMPLICATIONS FOR ETHIOPIA

- Design a blended payment system with a mix of close-ended base payment to cover the majority of health care costs and a variable added payment to reward good performance in health facilities. The system should start simple but must have a close-ended nature to avoid unnecessarily high cost.
- Establish a seamless funding flow from the central government to health facilities. While the funding may be parked at the regional or woreda level, health facilities need to have substantial power to secure the funding and manage the budget effectively. Health facilities may require accounting support from the regional/ woreda level which should be discussed at the early stages to avoid low budget absorption.
- While RBF might help inject more funding into the Ethiopian health system, it is a temporary measure that might exacerbate fragmentation in the health system and create adverse incentives at health facilities when the donor funding eventually stops. The RBF programme should be designed future-proof by taking into account how it will be integrated into the existing government system. Therefore, it is necessary to design all the RBF functions (i.e., level of payments, funding flows, performance checks, etc.) in a way that follows the existing PFM system rather than create a parallel system.
- Recognising the existence of multiple purchasers in Ethiopia (i.e. MoH, Regional Health Bureaus, Regional Finance Bureaus, EHIS, and donors), harmonising multiple funding flow is essential to avoid adverse incentives in health facilities. Thinking about how to harmonise or align benefit packages across schemes should be considered to avoid double payments to providers and minimise coverage gap for the whole population.

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RESULTS FOR DEVELOPMENT

The Lancet Global Health Commission on Financing Primary Health Care

What are the system requirements for strategic purchasing with multiple schemes?

The objective of this brief is to provide evidence and country experience related to the system requirements to implement strategic purchasing approaches in systems with multiple financing schemes and how countries take steps to build them, including:

- **Governance structures to oversee and harmonize purchasing across schemes.**
- **Technical capacity to carry out strategic purchasing functions.**
- **Operating systems.**

GOVERNANCE STRUCTURES TO OVERSEE AND HARMONIZE PURCHASING ACROSS SCHEMES

Effective governance structures are needed to facilitate coordination across schemes and key actors engaged in strategic purchasing. Governing bodies should have the authority and capacity to establish the vision for purchasing arrangements and strategic plans for their evolution, and actively manage the roles and relationships between different health purchasers. They should be able to set clear rules for decision-making and develop and enforce regulations.[1] Governing bodies require access to information and system intelligence that allows them to monitor the implementation of strategic purchasing across schemes and institutions and make real time course correction or longer term plans to reallocate functions across institutions.

Governance structures can take different forms depending on the country context, but they are most effective when they have a higher level of authority than the agencies implementing purchasing policies so they can enforce coordination and harmonization efforts, engage in dialogue on equal footing with finance authorities, and influence political decisions necessary to enable the implementation of strategic purchasing policies. Examples of governance structures range from the highly formalized Superintendence of Health in Chile that provides oversight and governance for public and private health financing agencies and public and private health care providers,[2] to more informal working group structures as in Indonesia that sit at the level of the Minister of Health and coordinate strategic purchasing policies across different actors.

In Ghana, the National Health Insurance Authority (NHIA), the main purchaser of health services, is governed by a multi-stakeholder board directly under the president. The board includes representation from a wide range of institutions, including the Ministry of Health (MoH), the government provider organization Ghana Health Service (GHS) and others.[3]

Strong governance capacity for strategic purchasing includes establishing the right balance of autonomy and accountability for health care providers. For strategic purchasing to be effective, frontline health providers need to have authority to make internal decisions on budget allocation, service delivery etc. in order to respond to incentives in the system and serve their populations most efficiently and effectively. With greater autonomy and more control over internal decisions, providers need the data and management capacity to make those decisions well and systems to be held accountable for both good financial management and service delivery outcomes.

A number of studies show that provider autonomy introduced as part of performance-based financing schemes or other public financial management reforms have had positive effects on efficiency and service delivery outcomes. There is evidence of district and facility managers re-allocating staff in order to meet performance targets, and some facilities upgrade in order to be able to offer priority services, such as deliveries. These studies also show evidence of providers finding creative solutions to shortages of drugs and supplies leading to lower stock-out rates.[4]

TECHNICAL CAPACITY TO CARRY OUT STRATEGIC PURCHASING FUNCTIONS

The key institutions involved in strategic purchasing need to have the technical capacity — the systems, knowledge, skills, and expertise — to carry out their roles and responsibilities related to the purchasing functions. Purchasers need to have systems to select and contract with providers, design provider payment systems to meet specific objectives and manage them effectively, and be able to monitor provider and system outcomes.[5] Providers should know how to manage resources, have the authority to do so, and know how to produce and submit accurate data required by the purchaser. Sub-national levels of government should be able to manage financial flows effectively to ensure health objectives are met at the local level.

Investments in technical capacity are needed at both the institutional and individual level. Institutional capacity requires creating the necessary departments, systems, and teams equipped to manage all aspects of the purchasing functions. Investment is also needed in individual knowledge and skills in technical areas such as health policy, health economics and financing, and actuarial analysis. As systems increase in complexity, this capacity building will need to be increasingly specialized , focused on topics such as case-mix analysis, risk adjustment, and health technology assessment.

Most countries adopt both a long-term strategy for building technical capacity and short-term measures to bring in knowledge and skills immediately. As an example of a long-term strategy, in Thailand the Ministry of Health established the International Health Policy Program (IHPP) in 2001, around the time serious commitments to universal health coverage were made by the government. IHPP was established to act as the technical arm of the MoH and provide technical capacity in health economics and financing. IHPP has evolved time to provide knowledge generation, capacity building and technical support to health policy making for Thailand and increasingly serves as a global resource and training centre.[6] In the initial years of Ghana's NHIS the government funded young scholars to study abroad to obtain graduate education in health economics and policy while strong academic departments were built in domestic universities on these topics.

In the short term, countries adopt a number of approaches to build technical capacity quickly, including training-of-trainer programs for implementers, targeted short-session sensitization for key stakeholders, web-based information exchange, implementation research to identify challenges in policy or implementation, and secondments and practitioner-to-practitioner exchanges with strategic purchasing leaders and implementers in other countries.[7]

Institutional capacity may initially focus on strengthening the core purchasing functions and then become more sophisticated as purchasing approaches become more complex. Purchasing agencies often start by establishing core departments engaged in purchasing the benefits package with capabilities in contracting providers and processing payments to them for delivering services in the package. In Burkina Faso, the Gratuite program is managed out of a single department of the MoH that contracts with providers, processes payments, and manages the digital reporting system.[8] Over time institutional capacity can become more sophisticated as purchasing policies become more complex. Ghana's NHIA initially had few departments focused on contracting providers and processing claims for payment. As the purchasing approaches became more sophisticated, provider payment and quality assurance departments were added, and eventually a strategic purchasing department was established with additional capabilities such as technology assessment.

As systems become more complex, other organisations can be linked into a broader "task network"; for example in Ghana and Thailand, accreditation of health facilities is through a separate organization, and accreditation by these entities is a pre-requisite for inclusion as a provider by the national health insurance agency.

OPERATING SYSTEMS

Operating systems need to be in place to carry out strategic purchasing functions. Operating systems that support strategic purchasing functions include provider accreditation and empanelment; contracting; provider payment system selection, design and implementation; provider performance and quality monitoring; and others that strategic health purchasers rely upon daily to fulfill their responsibilities and accomplish their goals. All of these systems should be underpinned by a well-functioning integrated information system. The operating systems should be flexible enough to be refined and updated as new challenges emerge.[9]

When operating systems are functioning properly, purchasers are able to contract effectively with providers, validate claims, manage payments to providers, and monitor delivery of services for beneficiary populations. By contrast, weak systems impose risk that the potential benefits of a strategic

purchasing system, such as greater equity or improved efficiency, will not be achieved, and financial sustainability of the system is sometimes threatened.

Operating systems should start simple and evolve over time with the purchasing functions. Simple operating systems are often sufficient to carry out most purchasing functions and even preferable to more complex systems with high administrative burden. Complex, paper-based operating systems in particular can create significant bottlenecks, such as delayed payment to health providers, which creates inefficiency and erodes trust in the system.[3] Claims-based provider payment systems such as fee-for-service can add tremendous administrative burden, even when information systems are functioning well, and reduced administrative costs is often one argument for shifting to capitation, global budgets and other payment systems that are not tied to the volume of services.[10]

If full automation is not possible, simple targeted information systems (such as the facility Financing Accounting and Reporting Systems supporting Tanzania's Direct Health Facility Financing) or even Microsoft Excel-based data systems can provide some degree of automation and streamlining of operating systems and generate analysable data for monitoring and system improvement over time (as in Ghana's early Excel-based claims submissions).

As information systems are put in place for different purchasing functions, there should be a view toward interoperability and eventually integrating across information systems to avoid the common challenge of highly fragmented information systems. Even countries such as Rwanda that have made significant progress establishing health information systems have faced challenges with information system interoperability, which limits the ability to provide the necessary data and evidence to make timely decisions. For example, in Rwanda electronic medical records systems are advanced but they are not interoperable with DHIS2 and 3MS, resulting in duplicative data collection by health facilities, Rwanda Social Security Board and the MoH.[11]

Verification and claims vetting processes should be in line with the actual threat of fraud and abuse to be cost-effective. Purchasing systems often over-emphasize the threat of fraud and abuse and put in place burdensome verification processes that are not cost-effective. Evidence from performance-based financing systems has shown that although they often strengthen routine health information systems, the elaborate verification systems that are often put in place create administrative burden and rarely detect significant abuse.[4] Closed-ended provider payment systems with appropriate contract monitoring and risk-based verification or clinical audit typically provide the most cost-effective safeguards against fraud.[9]

IMPLICATIONS FOR ETHIOPIA

- **Establish an overarching governance mechanism that has the authority and capacity to oversee the multiple financing schemes in place and to manage their harmonization.** Create a strategy to harmonize duplicative and overlapping purchasing functions among MoH, RHBs, WoHOs, CBHI management and EHIS. A first step may be to review all of the legal and regulatory directives related to the different financing schemes and how they purchase services to identify any overlaps or gaps, including the SHI Proc. (2010) + Regul. (2012), CBHI directive (2011), and CBHI Procl (2022).

- **Review current regulations and PFM rules related to provider autonomy and identify opportunities to increase autonomy of frontline providers over the use of all sources of government revenue.** Compared to many African countries, health facility managers have significant autonomy to manage resources they collect from user fees and CBHI payments which make up more than 50% of flexible resources they receive. Resources received through Channel 1 and 2 are usually based on fixed line items and have less flexibility. Ethiopia may consider building the capacity of health facility managers in financial management to understand the opportunities presented to them through their user fee and CBHI payments to prioritize these resources on local priorities, procuring medical supplies and commodities in order to complement the more rigid funding streams through Channel 1 and 2. The financial management manual could also be reviewed to allow for greater flexibility in the use of Channel 1 and 2 resources across budget lines for example.

- **Develop a short-, medium- and long-term plan to build institutional and individual capacity in strategic purchasing across the relevant institutions.** The Technical Working Group for Strategic Purchasing can build on existing institutional analyses and conduct a detailed map of capacity across institutions and administrative levels to identify technical capacity gaps. The mapping can be used to develop a long-term plan to allocate and/or consolidate purchasing functions and fill technical capacity gaps, with a focus on strengthening capacity at the woreda level and management capacity among providers.

The long-term plan should be complemented by a short-term plan of skills-building, leveraging existing resources partnerships with the Joint Learning Network for Universal Health Coverage (JLN) and the Strategic Purchasing Africa Resource Center (SPARC) for access to peer expertise and collaborative learning.

- **Assess current operating systems and identify opportunities to simplify, streamline and automate them.** Current operating systems are manual paper-based systems but there are aspirations to automate to improve efficiency of the CBHI claims management processes and to facility evidence-based purchasing decisions by all purchasers. The short term plan may be to improve the accuracy and timeliness of the data from paper-based systems while building the foundations for automating data collection and claims processes that can serve the insurance system and the Ministry of Health.

- **Invest in key information systems to carry out purchasing functions with a view toward interoperability.** Assess the extent to which current health information systems support harmonized strategic purchasing functions and identify areas to prioritise. For example, build on the adapted DHIS2 information system to generate the data needed to improve purchasing functions such performance monitoring.

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