Advancing Strategic Health Purchasing in Ethiopia

Strategic Actions for Improving Strategic Health Purchasing in Ethiopia

Ethiopia, a low-income country in Eastern Africa and the second most populous country on the continent, is committed to achieving universal health coverage (UHC). The country's 2022–2031 health financing strategy aims to accelerate progress toward that goal by increasing access to primary health care (PHC), expanding subsidized community-based health insurance (CBHI) schemes, subsidizing user fees through government budget allocations, and providing exemptions (no-cost services) for priority interventions.

One approach that is considered critical for countries to make progress toward UHC is *strategic health purchasing*—deliberately directing health funds to priority populations, interventions, and services and creating incentives for providers to deliver care equitably and in alignment with population health needs. Strategic purchasing involves using data to make three key decisions: what to include in the covered benefit package, which providers to contract with to deliver those services, and how to pay those providers in a way that incentivizes them to provide good-quality services.

Strategic health purchasing is particularly important for Ethiopia because fiscal space is constrained and the government is looking to improve resource allocation and accomplish more with available health resources.

Although the country's draft health financing strategy lays a strong foundation for improving health financing functions overall, it is not explicit in defining strategic purchasing interventions. To fill this gap, a technical working group (TWG) under the leadership of the Ethiopian Health Insurance Service (EHIS) conducted a study to assess Ethiopia's health purchasing landscape, including provider payment mechanisms and purchasing practices in its major health financing schemes—those administered by the Ministry of Health, regional health bureaus (RHBs), CBHI, parastatals, and private insurers. The study focused in particular on the first three types of schemes, which cover the largest segments of the population and have the most leverage to influence purchasing decisions.

The assessment, which employed the Strategic Health Purchasing Progress Tracking Framework and its accompanying tools,[1] looked at health purchasing arrangements and provider payment mechanisms across 11 purchasers and 17 providers, as representative of the many schemes at the federal, regional, and district (*woreda*) levels. It yielded insights into how provider payment practices are working, what needs improvement, and what lessons can be drawn for policymakers.

The findings are detailed in Table 1.

ETHIOPIA'S PROGRESS IN IMPROVING POPULATION HEALTH

Over the past two decades, Ethiopia has made notable gains in reducing maternal, under-5, and infant mortality rates. These improvements were facilitated by investments in high-impact interventions through the country's flagship community-focused Health Extension Program.

	2015	2019
HEALTH SPENDING	US$3.1 billion	US$3.62 billion
PHC COVERAGE	50.7%	90%
LIFE EXPECTANCY AT BIRTH	64 years	65.5 years
MATERNAL MORTALITY	420 per 100,000 live births	401 per 100,000 live births
UNDER-5 MORTALITY	64 per 1,000 live births	59 per 1,000 live births

1 Cashin C, Gatome-Munyua A. The Strategic Health Purchasing Progress Tracking Framework: a practical approach to describing, assessing, and improving strategic purchasing for universal health coverage. *Health Systems & Reform*. 2022;8(2):e2051794.

Table 1. Assessment of Health Purchasing in Ethiopia's Three Main Schemes

	Indicators	MOH	CBHI schemes	RHBs
	% of population covered or target population (2020–2021)	102,846,974 (target population for exempted services)	58% of eligible population (~40 million)	Sampled RHBs: Addis Ababa: 3,770,442 Oromiya: 37,692,797
	% of current health expenditure (CHE) flowing through the scheme	15% (19,017,205,410 Ethiopian birr)	1.7% (2,210,980,882 birr)	7.3% (9,315,285,433 birr)
Governance arrangements	Purchasing functions have an institutional home with a clear mandate and allocation of functions.	Different departments within MOH are involved in financial management, benefits specification, and payment monitoring, but mandates are not clearly defined and capacity is weak.	EHIS and woreda schemes are responsible for carrying out contracting arrangements and performance monitoring. They do not set payment rates.	RHBs or their departments are responsible for carrying out one or more purchasing functions, but mandates are not clearly defined and capacity is weak.
	Providers have autonomy in managerial and financial decision-making and are held accountable.	Public providers have limited financial and managerial autonomy. They do not retain unused funds and need approval to use internally generated revenue. They also need consent from the Ministry of Finance (MOF) or woreda finance office (WoFO) to transfer funds. Accountability mechanisms are weak.	Public providers have financial and managerial autonomy. They can retain unused CBHI funds. Accountability mechanisms are weak.	Public providers have limited financial and managerial autonomy. They cannot retain unused funds and need approval to use internally generated revenue. They also need consent from MOF or the WoFO to transfer funds. Accountability mechanisms are weak.
Financial management	Purchasing arrangements incorporate mechanisms to ensure budgetary control.	A defined process is used to set the purchaser's budget, and mechanisms are in place to track budget execution/spending. These mechanisms are enforced, but budget overruns routinely occur.	A defined process is used to set the purchaser's budget, and mechanisms are in place to track budget execution/spending. These mechanisms are enforced, but budget overruns routinely occur.	A defined process is used to set the purchaser's budget, and mechanisms are in place to track budget execution/spending. These mechanisms are enforced, but budget overruns routinely occur.
Benefits specification	A benefit package is specified and is aligned with purchasing arrangements.	A benefit or service package is defined, reflects health priorities, and is a commitment, but it is not well specified and/or not aligned with purchasing mechanisms.	A benefit or service package is defined and is a commitment, but it is not well specified and/or not aligned with purchasing mechanisms.	A benefit or service package is defined, reflects health priorities, and is a commitment, but it is not well specified and/or not aligned with purchasing mechanisms.
	The purchasing agency further defines service delivery standards when contracting with providers.	The purchaser defines some general standards for delivering services in the package (e.g., for gatekeeping), but enforcement through contracts is weak.	The purchaser does not define service delivery standards.	The purchaser defines some general standards for delivering services in the package (e.g., for gatekeeping), but enforcement through contracts is weak.

	Indicators	MOH	CBHI schemes	RHBs
Contracting arrangements	Contracts are in place and are used to achieve objectives.	Loose agreements are in place. Service delivery guidelines from MOH are used.	Loose agreements (not legally binding) are in place between the purchaser and public providers for specified services in exchange for payment. Formal agreements are in place with some private providers for medicines and laboratory diagnostic services.	Loose agreements are in place. Service delivery guidelines from MOH are used. RHBs contract with providers for CBHI schemes.
	Selective contracting includes service quality standards.	No selective contracting	The purchaser has loose, nonselective agreements or contracts with all public providers and contracts with some private providers for medicines and laboratory diagnostic services.	No selective contracting
Provider payment	Provider payment systems are linked to health system objectives.	Line-item budget	Fee-for-service is the predominant payment method, but capitation is being piloted in four woredas in two regions.	Line-item budget Capitation payment and performance-based financing are being piloted in the Oromiya region.
	Payment rates are based on a combination of cost information, available resources, policy priorities, and negotiation.	Rates are based on the purchaser's available budget.	MOH sets payment rates.	Rates are based on the purchaser's available budget.
Performance monitoring	Monitoring information is generated and used at the provider level.	Some form of monitoring happens at the health provider level (e.g., supportive supervision visits, monthly activity reporting).	Some form of monitoring happens at the health provider level (e.g., supportive supervision visits, monthly activity reporting, claims audits, quality audits).	Some form of monitoring happens at the health provider level (e.g., supportive supervision visits, monthly activity reporting).
	Information and analysis are used for system-level monitoring and purchasing decisions.	Information and analyses are not used to make purchasing decisions.	Medical audit findings are used to penalize underperforming providers. Other information and analyses are not used to make purchasing decisions.	Information and analyses are not used to make purchasing decisions.

Broadly, the findings are summarized below:

GOVERNANCE ARRANGEMENTS

Institutional home: The three major schemes—MOH, RHBs, and CBHI—each have an institutional home and a mandate to carry out purchasing functions at various levels of government.[2] For example, the MOH sets facility user fees for federal hospitals and university teaching hospitals in consultation with the Ministry of Finance (MOF), and the fees are approved by the Council of Ministers; RHBs set user fees for regional public health facilities, and the fees are approved by the regional cabinets. In the Southern Nations, Nationalities, and Peoples' Region (SNNPR), facility boards have the mandate to set user fees for public facilities. The MOH defines the national Essential Health Services Package (EHSP), Ethiopian Essential Medicines List, and standard treatment guidelines, all of which are adopted by other schemes. The CBHI scale-up strategy, implementation manual, and regional-level CBHI directives provide a guiding framework for the CBHI schemes. The current management of CBHI within the woreda health offices (WoHOs) counters the principle of a purchaser-provider split; this compromises quality assurance and accountability for providing services as agreed upon.

Financial management: All purchasers set budgets at the beginning of the fiscal year for their operational costs and for implementing core purchasing functions. Budget deficits do occur and are supplemented through reallocations or additional resources. Unused funds are returned to the treasury in the MOH and RHB schemes; they are retained by

2 The full report, *Strategic Health Purchasing in Ethiopia: An Assessment and Strategic Actions to Improve Purchasing*, can be found at ehiagov.com.

CBHI schemes. However, CBHI schemes face sustainability challenges, and not all schemes are able to retain the stipulated 5% contribution as reserves. Multiple accounting systems are in use for the different revenue streams, which is burdensome to providers.

Provider autonomy: Public facilities have autonomy to use internally generated revenue (user fees) and retain unused funds, but public resources received from the MOF, regional bureaus of finance, and woreda finance offices must be used strictly according to public financial management rules and unused funds are returned to the treasury.

PURCHASING FUNCTIONS

Benefits specification: All of the schemes have benefit packages that broadly cover population health needs, but those packages are not explicit, and processes for their review are not well defined. The MOH defines the EHSP, and EHIS sets the benefit package for CBHI schemes based on the EHSP. The EHSP lists 570 interventions that it suggests be made exempt, but implementation is constrained by low resourcing. Standard treatment guidelines exist, but adherence by providers is low.

Contracting arrangements: The MOH, RHB, and CBHI schemes use loose agreements with providers. Public providers are included automatically, and no accreditation processes or mechanisms exist to contract with private providers beyond private pharmacies and diagnostic facilities.

Provider payment: The dominant payment methods in use are fee-for-service and line-item budgets; capitation and performance-based financing are being piloted in few regions. Line-item budgets are based on historical expenditure for inputs such as staff, medicines, and commodities. The fee-for-service user fee schedule is set by the MOH, RHB, or facility board, as described above. The mix of provider payment methods currently in use does not give incentives to providers for efficiency or quality.

Performance monitoring: All of the purchasers have a system to monitor provider performance. Routine data collection and reporting occur through the DHIS2 platform and monitoring mechanisms for service delivery indicators, but the data are rarely used to inform purchasing decisions. Other processes are ad hoc and largely paper-based.

Ethiopia has made remarkable gains in increasing resources for health and improving access to health care, as evidenced by increased per capita health spending, increased access to PHC, and declines in infant and maternal mortality rates. However, more public funding is needed to further increase access to good-quality health services and achieve UHC, and more can be done within the current financial envelope.

The TWG prioritized the most critical of the recommendations in order to propose a set of strategic actions to Ethiopia's stakeholders. These actions require a well-defined regulatory framework to support strategic purchasing.

They include:

- **Clearly defining the roles and responsibilities of all purchasing agencies to resolve conflicts and overlaps, while ensuring adequate lines of accountability for strategic purchasing**
- **Ensuring that adequate resources and effective purchasing mechanisms for PHC take precedence over efforts to develop complex provider payment methods for secondary-level care**
- **Harmonizing and standardizing lists of exempted health interventions and their financing sources across regions**
- **Developing a strategy for contracting arrangements and engaging public and private providers**
- **Developing a clear performance monitoring strategy that incentivizes good provider performance and good-quality care and integrates and builds on existing platforms to create an integrated national platform**
- **Investing in information systems that can support the design of more complex provider payment systems over the long term**

Table 2 lists strategic actions for consideration to improve strategic purchasing in Ethiopia.

Table 2. Strategic Actions to Improve Strategic Health Purchasing in Ethiopia

	Gaps and challenges	Short-term actions: next 24 months	Medium-term actions: 25 to 60 months	Long-term actions: 60+ months
Governance arrangements				
Institutional home	· Duplicative and overlapping purchasing functions	· Assess mandates across purchasing agencies and generate recommendations for policy dialogue and advocacy with relevant stakeholders (MOH, RHBs, EHIS)	· Update legislative frameworks, policies, strategies, and guidelines as needed (MOH, RHBs, EHIS)	· Implement legislative frameworks, policies, strategies, and guidelines (legislature, MOH)
	· Weak capacity at the subnational levels to carry out purchasing functions	· Build the capacity of purchasers, including insurance scheme staff at all levels—federal, regional, zonal, and woreda (MOH, RHBs, EHIS)	· Conduct scoping/preparatory work for health insurance pre-service education program (EHIS)	· Integrate health insurance into relevant pre-service education programs (EHIS)
	· Lack of mechanisms for stakeholder participation or engagement	· Conduct stakeholder analysis and mapping (MOH. EHIS) · Develop stakeholder engagement strategy (MOH, EHIS)	· Establish platforms for stakeholder engagement (MOH, EHIS)	· Sustain stakeholder engagement platform (MOH, EHIS)
Financial management	· Weak financial viability of CBHI schemes · Fragmented CBHI pools	· Conduct exploratory study on additional revenue sources for schemes (MOH, MOF, EHIS) · Enforce minimum reserve for CBHI schemes (RHBs, EHIS) · Develop strategy and implementation guide for progressively higher-level pooling (RHBs, EHIS) · Design evidence-based risk mitigation mechanism (RHBs, EHIS)	· Develop guidelines for managing future investment (EHIS) · Advocate for and prepare cross-subsidization guidelines for implementation of subnational-level pools (MOH, MOF, EHIS) · Implement the risk mitigation mechanisms (MOH, RHBs, EHIS) · Initiate policy dialogue and advocacy for higher-level CBHI pools and social health insurance pool (EHIS)	· Implement cross-subsidization guidelines (MOH, EHIS)
	· Insufficient resources for exempted interventions	· Estimate resources for exempted interventions (MOH, RHBs, EHIS, zonal health departments, WoHOs) · Explore additional financing options for exempted health services, to cope with the decline in external sources (MOH, EHIS) · Create advocacy strategy for sustainable financing of exempted health services / domestic resource mobilization by MOF (MOH)	· Delineate responsibilities for provision and financing of exempted interventions (MOH, MOF, RHBs, EHIS)	· Develop policy and guidelines on mechanisms for co-financing exempted services (MOH, EHIS) · Implement domestic resource mobilization strategy (MOH)
	· Insufficient mechanism for setting evidence-based contribution rates	· Initiate policy dialogue, advocacy, and consultations with communities (RHBs, EHIS, WoHOs) · Enforce mechanisms for identification and membership of eligible households for CBHI (RHBs, WoHOs) · Establish a structure for CBHI community engagement and mobilization at the *kebele* level (WoHO)	· Establish premium-setting guidelines based on clear and transparent criteria (RHBs, EHIS, WoHOs)	· Develop strategy to link insurance contributions to general tax collection (e.g., by linking SHI contribution collection to payroll taxes or linking CBHI contributions means testing to assets such as land)
	· Weak financial management, financial documentation, and archiving system · Weak financial accountability and governance system	· Build capacity of CBHI scheme staff (EHIS, WoHOs) · Pilot an automated financial management and documentation system at the woreda level (MOH, EHIS, WoHOs) · Expand financial auditing of schemes (RHBs, EHIS) · Explore viable opportunities for investing insurance funds (MOH, RHBs, EHIS, WoHOs)	· Scale up automation of the financial management system (MOH, EHIS) · Implement fund management structures (e.g., auditing) (MOH, RHBs, EHIS, WoHOs)	

	Gaps and challenges	Short-term actions: next 24 months	Medium-term actions: 25 to 60 months	Long-term actions: 60+ months
Provider autonomy	· Low budget execution of multiple funding channels due to stringent funder rules and accounting requirements · PFM rigidities in how funds can be spent by providers, due to strict line items	· Build capacity of PHC facilities for planning, budgeting, and PFM so they can better manage the resources they receive (RHBs, EHIS) · Enforce harmonization and alignment of planning, budgeting, and reporting at the facility level (MOH, RHBs, WoHOs)	· Support implementation of the decentralized legal framework (MOH, RHBs, zonal health departments)	
Purchasing functions				
Benefits specification	· Lack of standardization of exempted interventions across regions	· Advocate for harmonization of exempted services (MOH)	· Update legal framework on exempted services (MOH, RHBs) · Standardize exempted health interventions across regions (MOH, RHBs)	
	· Weak provider capacity to deliver services in the EHSP and CBHI benefit packages at lower levels of the health system	· Develop a strategy to upgrade the capacity of PHC facilities (health posts, health centers, and primary hospitals) to provide services in the EHSP and CBHI benefit packages and according to standard treatment guidelines; include a capital and human resource investment strategy (MOH, RHBs) · Develop guidelines for PHC facilities to deliver EHSP services (MOH, RHBs) · Implement guidelines for PHC health facilities for delivering EHSP services (MOH, RHBs)	· Enhance implementation of the strategy for strengthening capacity of PHC facilities to provide comprehensive services per the EHSP, including capital and human resource investments (MOH)	
	· Low adherence to standard treatment guidelines	· Build the capacity of MOH and RHBs for quality assurance to increase adherence to treatment guidelines (MOH, RHBs) · Expand clinical auditing and quality improvement initiatives to improve adherence to standard treatment guidelines (MOH) · Increase provider awareness of the regulatory framework for quality assurance (MOH, RHBs)	· Implement quality assurance mechanisms to identify areas for capacity improvement and ensure adherence to standards (MOH, EHIS)	· Implement the comprehensive clinical governance framework (MOH, EHIS)
	· CBHI benefit packages that are not explicit and vary significantly across the country	· Complete the EHIS redesign, building on the EHSP, and harmonize CBHI benefit packages (EHIS)	· Develop processes for regular revision of benefit packages (MOH, EHIS)	
Contracting arrangements	· Weak quality assurance, with no strategy or consequences to improve service quality	· Initiate dialogue and advocacy on an accreditation roadmap (MOH, EHIS) · Approve and implement accreditation roadmap (MOH)	· Establish a national accreditation agency, or house the function in an existing agency (MOH, EHIS)	· Develop policies and procedures for managing contracting with accredited facilities (MOH, EHIS)
	· Loose agreements between purchasers and providers	· Update contract agreement templates to make terms and conditions explicit and binding, including benefit package and service guidelines (EHIS)	· Design implementation mechanisms for contracting, in consultation with relevant stakeholders (EHIS, attorney general)	· Develop a schedule to pilot contracting arrangements and gradually introduce contracting between CBHI and providers (EHIS)
	· Lack of legal frameworks and mechanisms to engage and contract with private providers	· Develop private-sector engagement strategy (MOH, EHIS) · Develop feasibility study for private-sector engagement (EHIS) · Create platforms and dialogue to engage EHIS, private providers (EHIS)	· Design a provider payment mechanism and rates, including case scenarios for scheme viability at different prices, for private-sector engagement (MOH, EHIS)	· Implement selective contracting according to the strategy (EHIS) · Strengthen contract management (EHIS)

	Gaps and challenges	Short-term actions: next 24 months	Medium-term actions: 25 to 60 months	Long-term actions: 60+ months
Provider payment	· Line-item budgets that are based on historical expenditure and favor urban facilities with better infrastructure and staffing · Cost escalation due to fee-for-service payment and user fee schedules set by multiple agencies · Inadequate mix of provider payment mechanisms that are not linked to incentives · Low awareness of provider payment mechanisms · Administrative burden related to generating, tracking, and reconciling claims · Low automation of claims management	· Draw lessons from ongoing capitation and performance-based financing pilots to inform design of the next generation of provider payment systems · Engage stakeholders in identifying how existing provider payment incentives can be aligned or redesigned to fit the country context (MOH, EHIS) · Develop a strategy for provider payment reform over 5 years (MOH, EHIS) · Define responsibilities and a process for setting fee schedules (MOH, RHBs, EHIS) · Strengthen automation of claims management (EHIS, WoHOs)	· Design a provider payment mechanism that considers population size and health needs for resource allocation and reduces administrative burden (MOH, EHIS) · Integrate quality incentives (penalties and rewards) into provider payment mechanisms and link to quality assurance mechanisms (EHIS)	· Build human and institutional capacity at different levels of the health system to support provider payment reforms (MOH, EHIS)
Performance monitoring	· Multiple platforms for performance monitoring and weak performance monitoring for exempted services in both public and private facilities · Poor-quality, fragmented data generated by providers, which cannot be used for purchasing decisions · Low capacity for performance management	· Develop strategy for performance monitoring (MOH, EHIS) · Develop data requirements for provider payment changes, and initiate data collection process (MOH, EHIS)	· Develop system requirements and an investment plan for the integrated platform (MOH) · Introduce a data collection system for provider payment—initially manual and then automated over time (MOH, EHIS) · Improve capacity within MOH, RHBs, EHIS, and woredas for performance monitoring (MOH)	
	· Insufficient implementation of guidelines in the CBHI medical audit manual, and payment of claims regardless of quality of care	· Develop implementation guidelines for the medical audit manual (MOH, EHIS) · Strengthen medical audit system in core priority areas—clinical care, pharmacy, quality, referrals (MOH, EHIS) · Engage MOF and BOF to improve financial audit processes (EHIS)		

CBHI = community-based health insurance
EHIS = Ethiopian Health Insurance Service
EHSP = Essential Health Services Package
MOF = Ministry of Finance
MOH = Ministry of Health
RHB = regional health bureau

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