Strategic Health Purchasing in Ethiopia

An Assessment and Strategic Actions to Improve Purchasing

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Foreword

Over the past decade, the Ethiopian health system has undergone a series of health financing reforms to ensure access to high-quality health services while reducing financial barriers for all Ethiopians. One of the key achievements of the reform is increased public funding for health. Despite this increase, the fiscal space remains limited to keep pace with our universal health coverage (UHC) commitments, requiring us to do more with the current financial envelope. Strategic health purchasing is an important lever in this regard because it promotes effective use of the available resources by directing health funds to priority populations, interventions, and services as well as actively creating incentives for providers to use funds equitably and in accordance with population health needs.

This report examines the overall landscape of Ethiopia's health care purchasing arrangements and identifies barriers to and opportunities for building a foundation for strategic health purchasing. It also recommends strategic actions that, when implemented together, can support Ethiopia's move toward UHC.

Implementing the strategic actions will require strong political commitment and the active involvement of all key stakeholders, in line with their respective roles and responsibilities. Continuous public participation will also be critical for implementing the strategic actions.

The Ethiopian Health Insurance Service is committed to stewarding this process, in collaboration with the Ministry of Health, and will foster the enabling environment for successful implementation of the strategic actions.

I call upon all stakeholders to embrace the provisions stipulated in this document, and I look forward to working with all of them to achieve the goals of UHC.

Frehiwot Abebe
Director General, Ethiopian Health Insurance Service

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The Ethiopian Health Insurance Service (EHIS) extends its appreciation to all those involved in this study, including designing the strategic actions to improve strategic purchasing in Ethiopia and preparing this report. The effort involved a wide range of health purchasers and health facilities whose contributions EHIS greatly appreciates. Thanks to all the key informants who generously shared their time and experiences as they responded to the surveys and shared relevant information.

EHIS recognizes the important role in this study of the Strategic Health Purchasing Technical Working Group (TWG) established under our leadership. This TWG was constituted according to the terms of reference approved by the EHIS senior management team. Its members included representatives from the Ministry of Health (Health Services Quality Directorate, Medical Services Directorate, Partnership and Cooperation Directorate), EHIS (Claims, Member Affairs Directorate, Provider Affairs and Quality Assurance Directorate, Planning and Research Directorate), Amref Health Africa, Clinton Health Access Initiative, Ethiopian Pharmaceuticals Supply Service, Strategic Purchasing Africa Resource Center, local consultants, and the USAID-funded Health Financing Improvement Program. The TWG served as a technical clearing house, ensuring that all activities were performed per the terms of reference and providing overall technical input and guidance during the entire process.

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Abbreviations and Acronyms

BOF	bureau of finance
CBHI	community-based health insurance
CHE	current health expenditure
EEML	Ethiopian Essential Medicines List
EHIS	Ethiopia Health Insurance Service
EHSP	Essential Health Services Package
HC	health center
HFIP	Health Financing Improvement Program
MOF	Ministry of Finance
MOH	Ministry of Health
PBF	performance-based financing
PFM	public financial management
PHC	primary health care
RHB	regional health bureau
SNNPR	Southern Nations, Nationalities, and Peoples' Region
SPARC	Strategic Purchasing Africa Resource Center
TWG	technical working group
UHC	universal health coverage
WoFO	woreda finance office
WoHO	woreda health office

Executive Summary

Ethiopia is committed to achieving universal health coverage (UHC), as stated in the government's strategy documents. The country's 2022–2031 health care financing strategy aims to accelerate progress toward UHC by increasing access to primary health care (PHC), building on successful efforts such as subsidizing community-based health insurance (CBHI) schemes, subsidizing user fees through government budget allocations, and providing exemptions for priority interventions.

Making purchasing of health services more strategic—by deliberately directing health funds to priority populations, interventions, and services and actively creating incentives so funds are used by providers equitably and in alignment with population health needs—is seen as critical for countries to make progress toward UHC. Strategic 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. This study aims to fill that gap.

The primary objective of this study was to assess purchasing practices in Ethiopia's major health financing schemes for insights into how they are working, what needs improvement, and what lessons can be drawn to inform strategic actions for implementing more strategic health purchasing.

The assessment used the Strategic Health Purchasing Progress Tracking Framework as well as the Joint Learning Network for Universal Health Coverage's *Assessing Health Provider Payment Systems: A Practical Guide for Countries Moving Toward Universal Health Coverage*. The assessment was led by the Strategic Health Purchasing Technical Working Group (TWG) under the leadership of the Ethiopia Health Insurance Service (EHIS). The TWG developed the sampling frame of purchasers and providers to include in the study, adapted the tools, and led the data collection, analysis, and reporting. Data were collected from 11 purchasers and 17 public and private health facilities. The assessment was conducted with support from the Strategic Purchasing Africa Resource Center (SPARC) and the USAID-funded Health Financing Improvement Program.

The findings are summarized using the Strategic Health Purchasing Progress Tracking Framework and describe the governance arrangements, external factors, and core purchasing functions (benefits specification, contracting arrangements, provider payment, and performance monitoring). This report provides detailed findings for the public schemes—those administered by the Ministry of Health (MOH), regional health bureaus (RHBs), and community-based health insurance (CBHI); these have the broadest coverage and greatest leverage to improve strategic purchasing. The findings are broadly 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. 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 district (*woreda*) health offices counters the principle of a purchaser-provider split; this compromises quality assurance and accountability for use of resources.
- **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 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 current mix of provider payment methods 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 study's findings suggest some recommendations to improve strategic purchasing in Ethiopia, which are highlighted in the following table.

Key Recommendations for Policymakers

		Recommendations
Governance arrangements	**Institutional home**	• Clearly demarcate roles and responsibilities among all purchasing agencies and strengthen purchasing capacity at the regional and woreda levels • Include mechanisms for stakeholder engagement across all schemes
	Financial management	• Adequately resource CBHI schemes by increasing CBHI subsidies (targeted and general) and other resources • Enforce minimum reserve of 5% of CBHI contributions • Cross-subsidize by pooling at a higher level (e.g., regional) • Ring-fence or earmark resources for exempted health interventions at all levels • Strengthen the financial management and accountability system at the provider level • Strengthen the fund management and accountability system at the purchaser level
	Provider autonomy	• Build capacity of PHC facilities for planning, budgeting, and PFM so they can better manage the resources they receive • Improve system-level integration of funding flows and accounting systems and avoid duplication
Purchasing functions	**Benefits specification**	• Harmonize and standardize lists of exempted health interventions and their financing sources across regions • Develop a capital and human resource investment strategy to improve provider capacity • Develop and implement an explicit benefit package
	Contracting arrangements	• Develop accreditation guidelines to guide contracting of providers and quality improvement • Include standard treatment guidelines in contracts, and build capacity of MOH and RHBs for quality assurance to increase adherence to treatment guidelines • Scale up contracting arrangements between purchasers and providers, beginning with CBHI, and link to quality assurance mechanisms to improve provider capacity to deliver the benefit package • Develop platforms to engage private providers for inclusion in the schemes, including accreditation and contracting frameworks
	Provider payment	• Consider alternatives to line-item budgets based on inputs (e.g., a formula based on population size and health needs) to reduce focus on infrastructure and staff • Consider alternative mix of provider payment mechanisms for CBHI that considers level of care and incentivizes good-quality care and efficient service delivery • Harmonize responsibilities and processes for setting fee schedules for each level of the health system • Assess ongoing capitation and PBF pilots to draw lessons for designing the next generation of provider payment systems • Strengthen automation of claims management
	Performance monitoring	• Develop a clear strategy for performance monitoring that integrates and builds on existing platforms to create an integrated national platform • Strengthen the system of data collection and develop feedback loops to providers • Invest in information systems that can support performance monitoring and inform design of more complicated provider payment mechanisms over the long term • Improve performance monitoring capacity within MOH, RHBs, EHIS, zonal health departments, and woredas • Develop implementation guidelines for the EHIS manual for medical auditing of claims, and apply the guidelines consistently

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

Ethiopian Health Financing Context

Ethiopia, a low-income country in Eastern Africa, is the second most populous country in Africa. Over the past two decades, it has made notable gains in reducing maternal, under-5, and infant mortality rates. Between 2015 and 2019, Ethiopia's health spending increased from US$3.1 billion to US$3.62 billion, primary health care (PHC) coverage increased from 50.7% to 90%, life expectancy at birth increased from 64 years to 65.5 years, maternal mortality fell from 420 per 100,000 live births to 401 per 100,000 live births, and under-5 mortality decreased from 64 per 1,000 live births to 59 per 1,000 live births. These improvements were facilitated by investments in high-impact interventions through the country's flagship community-focused Health Extension Program.

During the same period, the health sector underwent a transformation to focus on addressing critical barriers to implementing the country's Health Sector Transformation Plan (2015–2020). In its first health care financing strategy, the Ethiopian government emphasized health financing as a tool to promote health equity, by implementing a broad exemptions program (providing services that are exempted, or free of charge, to the Ethiopian population), launching community-based health insurance (CBHI) schemes, and fully subsidizing CBHI contributions for the poorest Ethiopians. It also gave health facilities the autonomy to generate, retain, and use internally generated revenue to improve health service quality.

ETHIOPIA AT A GLANCE (2019)

Population: 112 million*

GDP per capita: US$856*

Current health expenditure (CHE) per capita: US$36.40**

Public expenditure on health as % of CHE: 32.2%**

Out-of-pocket spending as % of CHE: 30.5%**

Donor spending as % of CHE: 33.9%**

*Sources: *World Bank Databank, **Ethiopia National Health Accounts*

The country's 2022–2031 draft health financing strategy builds on the previous strategy in accelerating progress toward universal health coverage (UHC) through PHC. It has not yet been formally endorsed by the Council of Ministers, but the strategy aims to finance proven essential health services for all segments of the population without causing financial hardship.

Study Rationale

Health purchasing, which refers to the transfer of pooled funds to health providers for the delivery of services to the population, is recognized as a key health financing function of health systems. *Strategic health purchasing* means deliberately directing health funds to priority populations, interventions, and services and actively creating incentives so funds are used by providers equitably and in alignment with population health needs. It involves using data to make three key decisions—what to include in the 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 high-quality services.

Making health purchasing more strategic is critical to making progress toward UHC.[1] Strategic purchasing is particularly important for Ethiopia because fiscal space is constrained and the government is looking to improve resource allocation and accomplish more with limited funds.

Health purchasing is considered strategic when allocations to providers are linked, at least in part, to information on provider performance and the health needs of the population served, with the aim of improving efficiency, increasing equitable distribution of resources, and managing expenditure growth. Although Ethiopia's draft health financing strategy lays a strong foundation for improving health financing functions overall, it is not explicit in defining strategic purchasing interventions. This study aims to fill this gap.

Objectives

The primary objective of this study was to assess the health purchasing functions in Ethiopia's major health financing schemes to gain insights into how they are working, what needs improvement, and what lessons can be drawn to inform strategic actions for implementing more strategic health purchasing.

Specific objectives included:

- Assessing the current practice of purchasing functions and governance arrangements in the major health financing schemes
- Reviewing provider payment mechanisms for insights into how they are working and what needs to be improved
- Drawing lessons to inform country dialogue and strategic actions for improving strategic health purchasing

Methodology

The study was led by the Strategic Health Purchasing Technical Working Group (TWG) under the leadership of the Ethiopia Health Insurance Service (EHIS). The assessment used the Strategic Health Purchasing Progress Tracking Framework[2] as well as the Joint Learning Network for Universal Health Coverage's *Assessing Health Provider Payment Systems: A Practical Guide for Countries Moving Toward Universal Health Coverage*.[3] The TWG developed the sampling frame of purchasers and providers to include in the study, adapted the tools, and led the data collection, analysis, and reporting. The TWG members are listed in Annex A.

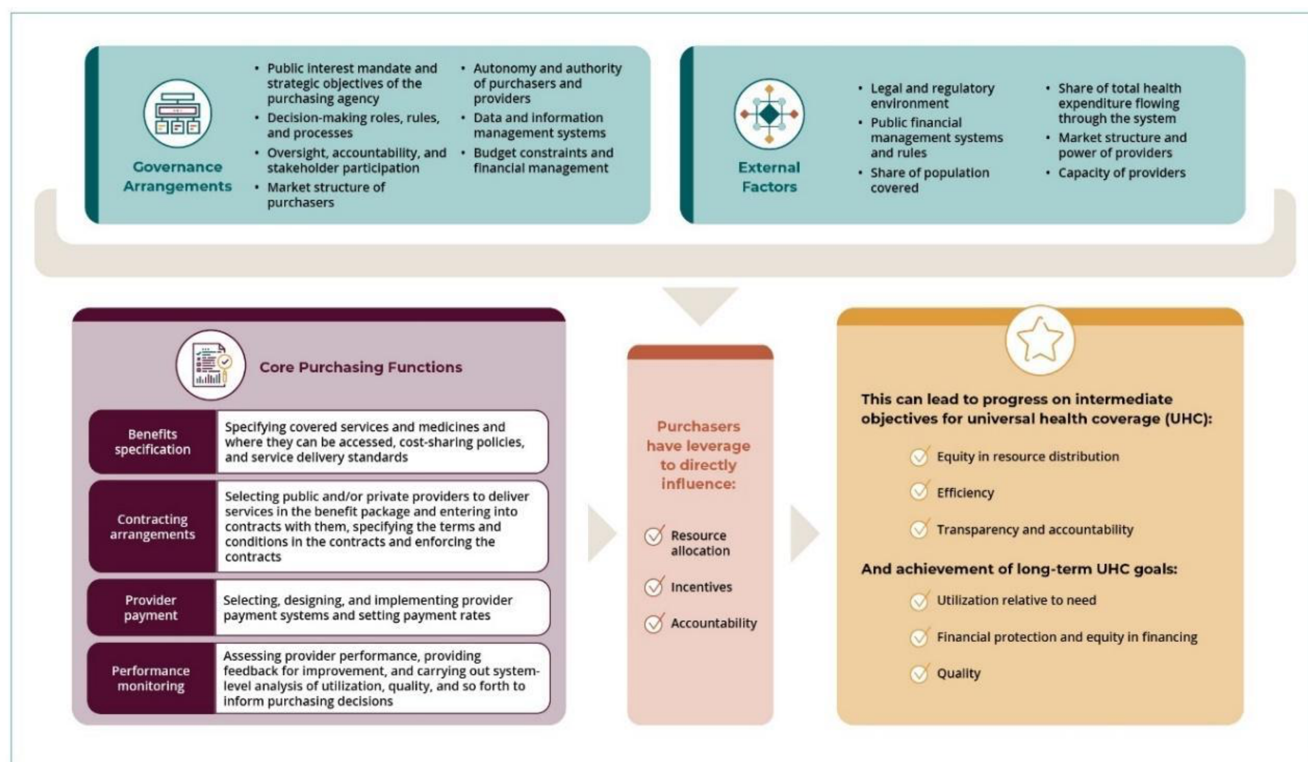
Data collection included a document review of health financing strategies, policies, and guidelines, supplemented with key informant interviews using structured questionnaires between December 2021 and February 2022 across 11 purchasers and 17 health facilities (see Annex B).

Findings

Annex C summarizes the findings using the Strategic Health Purchasing Progress Tracking Framework (Figure 1) and describes the governance arrangements, external factors, and core purchasing functions (benefits specification, contracting arrangements, provider payment, and performance monitoring).

This report details findings for the public schemes administered by the Ministry of Health (MOH), regional health bureaus (RHBs), and community-based health insurance (CBHI); these schemes have the broadest coverage and greatest leverage to improve strategic purchasing. Within the RHB and CBHI schemes, we also describe the functions of zonal health departments and woreda (district) health offices (WoHOs).

Figure 1. Strategic Health Purchasing Progress Tracking Framework



Governance Arrangements

Health purchasing is carried out by an institutional home that transfers the funds (the main "purchasing agency"), although other institutions may be responsible for supporting or carrying out some of the purchasing functions. Governance of health purchasing includes the systems and structures for stewardship of the system and strategic direction to ensure coherence, oversight of the various actors, definition of roles and responsibilities, and accountability measures.

Purchasers need clear governance arrangements without overlaps or gaps in responsibilities in order to carry out the core purchasing functions. The critical elements are 1) an institutional home with a clear mandate and capacity to carry out purchasing functions, 2) financial management, and 3) provider autonomy to use funds flexibly.

INSTITUTIONAL HOME

All of the schemes have an institutional home with a mandate to carry out purchasing functions. But there is a lack of uniformity for some functions, such as the setting of user fee schedules by the MOH, RHBs, and health facility boards in some settings. The MOH sets facility user fees for federal hospitals and university teaching hospitals, in consultation with the Ministry of Finance (MOF), and these are approved by the Council of Ministers. RHBs set user fees for their regional public health facilities, and these are approved by regional cabinets and facility boards in the Southern Nations, Nationalities, and Peoples' Region (SNNPR); RHBs also have a mandate to set user fees for public facilities in the SNNPR. The MOH defines the national Essential Health Services Package (EHSP), Ethiopian Essential Medicines List (EEML), and standard treatment guidelines, all of which are adopted by other schemes. The roles and responsibilities for stakeholder engagement within purchaser governance arrangements are not clearly defined.

The MOH is mandated by Proclamation No. 1263/2021 as the highest body for public health concerns. It sets standards, formulates health policies and guidelines, defines intervention priorities, and mobilizes resources for health care delivery. The MOH leads the development of the EHSP and the EEML. It also has the mandate to set fee

schedules for federal teaching and university hospitals, which are approved by the Council of Ministers, and to set service delivery regulations for public and private providers.

RHBs are responsible for implementing the national health policy in their regions. They also provide support and technical assistance to the WoHOs. In the SNNPR, zonal health departments (zones are subunits of the region) provide support to the WoHOs directly and report to the RHBs. Woredas are responsible for delivering PHC services in their jurisdiction. Study interviewees reported that RHBs, zonal health departments, and woredas have weak technical capacity and insufficient resources to implement the purchasing functions assigned to them—such as periodically revising user fee schedules and allocating resources to providers.

Although practices have varied across regions, CBHI schemes were initially managed under the woreda administration offices, which mobilized communities to join CBHIs, collected premiums, generated additional revenue for the schemes, and paid providers, while the WoHOs provided oversight of PHC health facilities. This introduced a purchaser-provider split—the principle of separating service provision from purchasing and creating clear lines of accountability for health facilities. In some instances, the WoHOs were also responsible for purchasing and oversight of PHC facilities.

After an assessment of CBHI implementation, the management and administration of the schemes was transferred to WoHOs, due to the competing priorities and responsibilities of the woreda administration offices. This shifted all responsibilities to the WoHOs, including community mobilization, purchasing of PHC services, and oversight of PHC facilities.

EHIS was mandated by the House of Peoples' Representatives to manage and implement the country's social health insurance system. Regulation No. 191/2010 established EHIS as an autonomous federal government agency, with the objective of implementing the health insurance system. Currently, CBHI schemes purchase PHC and hospital care and EHIS purchases tertiary care services from eight hospitals in Addis Ababa on behalf of CBHI schemes. EHIS receives subsidies from the federal government, which recently increased from 10% to 25%, and transfers those subsidies to CBHI schemes through EHIS branch offices. EHIS deducts from the subsidies the resources required for tertiary services from contracted tertiary hospitals, based on the amount paid for each patient from each woreda CBHI scheme. The CBHI scale-up strategy, implementation manual, and regional-level CBHI directives provide a guiding framework for the CBHI schemes. The general assembly and board of directors of each CBHI scheme are mandated to oversee the governance of the scheme at the woreda level.

FINANCIAL MANAGEMENT

All of the purchasers set budgets at the beginning of the fiscal year for operational costs and for implementing core purchasing functions. When budget deficits occur in CBHI schemes, they are supplemented through reallocations or additional resources. Budget deficits at the MOH and RHBs are supplemented through reallocations. Unused funds from the government budget are returned to the source, which may include the national treasury / MOF, bureau of finance (BOF), or woreda finance office (WoFO). CBHI schemes can retain funds that are unused at the end of the year. Although financial management, financial documentation, and archiving procedures exist, they are poorly implemented and financial documentation at the purchaser and provider levels is weak.

Processes for developing government budgets and annual planning at the federal, regional, and woreda levels are well defined. The government budget is supplemented by donors and other external resources. The MOF allocates funds from the federal budget to the MOH, using program-based budgets, for federal-level functions. Regional governments receive block grants from the federal government to allocate to local priorities and woreda councils. Woreda councils review and approve the health plan and receive a budget from the WoHOs, while taking into consideration other social priorities (including water and sanitation and education). Health budgets vary between regions and woredas, depending on historical expenditure.

EHIS receives funding from the MOF for operational costs and manages the CBHI general subsidy from the federal budget. It returns unused funds at the end of the fiscal year to the MOF. CBHI schemes retain unused revenue for the next fiscal year. However, due to the small size of pools at the woreda level, CBHI schemes are not able to raise

sufficient revenue through contributions and general and targeted subsidies, and deficits are common. CBHI premiums are set very low because of members' limited ability and willingness to pay. No evidence-based process is in place to review and revise insurance contributions.

Deficits at the MOH, RHBs, and EHIS can be met through a request channeled to the MOF, BOF, or WoFO for an additional budget transfer or reallocation across line items. CBHI schemes are expected to reserve 5% of their annual premium collection to cover unexpected future deficits, but this is not practiced by all schemes due to inadequate collection of contributions from members.

PROVIDER AUTONOMY

All public health facilities have autonomy to generate, use, and retain internally generated revenue, but public resources received in the form of budget from the MOF, BOF, and WoFO must be used strictly according to public financial management (PFM) rules and unused funds must be returned to the treasury at the end of the fiscal year.

Public health facilities use internally generated revenue to supplement public funding received through the budget, to improve the quality of services. Budgets allocated from the treasury are insufficient to finance exempted services, so the facilities are compelled to use part of their retained revenue to buy pharmaceuticals for free maternal and child health exempted services. University teaching hospitals receive an operational budget as a cost center within their university through the Ministry of Education. Public facilities apply user fee schedules approved by the requisite authority. Public and private facilities have autonomy to hire and dismiss staff, in accordance with public service servants' laws (for public facilities) and employer and employee regulations (for private facilities). Although public facilities have the flexibility to develop a single plan and budget based on the MOH principles of Three Ones—one plan, one budget, and one report—this has not cascaded to the facility level, and facility financial management capacity remains too weak to develop a single plan and budget and execute the budget against the plan.

Providers have autonomy to procure medicines and supplies but have to follow rigid procurement guidelines and are limited to a few suppliers. This compromises choice and availability of medicines at the facility level.

Purchasing Functions

The core functions that any purchaser needs to be able to carry out include 1) benefits specification, 2) contracting arrangements, 3) provider payment, and 4) performance monitoring. These are described in the following sections.

BENEFITS SPECIFICATION

Benefits specification includes specifying the services and interventions in the benefit package, the service delivery standards, where and how the services can be accessed (including gatekeeping policies), how much of the cost will be covered by the purchaser (and accompanying cost-sharing policies), and which medicines will be covered. The schemes all have a similar benefit package, based on the EHSP, that broadly covers most population health needs, but these packages are not explicit about the specific services covered and excluded. Health facilities procure medicines, which are dispensed according to MOH standard treatment guidelines.

The EHSP highlights the government's priority interventions and provides guidance on the essential services required by patients at each level of care. The services include 1) exempted (free) services, 2) services offered on a cost-sharing basis (partially subsidized), and 3) services provided on a cost recovery basis.

The MOH led a participatory, inclusive, and evidence-based process to revise the EHSP in 2019 for the next five years (2020–2025). It used seven prioritization criteria: disease burden, cost effectiveness, equity, financial risk protection, budget impact, public acceptability, and political acceptability. It identified 1,018 interventions for inclusion, of which 570 were proposed as exempted services. The MOH used the One Health tool to estimate resources required to deliver the EHSP for 10 years (2020–2030). The EHSP recommends a referral system and gatekeeping arrangements for implementation, and the MOH specifies service delivery standards and treatment guidelines for the interventions adopted by RHBs and CBHI schemes.

The CBHI benefit package is not made explicit in the CBHI directive. The directive lists broad categories of services: outpatient, inpatient, laboratory, imaging, and pharmaceuticals. Eyeglasses, dental implants, kidney dialysis, some specialized procedures, and cosmetic procedures are excluded. The benefit package does not specify copayments or cost-sharing arrangements because services other than the excluded ones are provided free to CBHI members. EHIS is currently revising the CBHI benefit package to make it explicit, by defining services to be delivered at each level of care. CBHI schemes expect facilities to follow MOH treatment guidelines, but adherence to these guidelines is low.

CONTRACTING ARRANGEMENTS

Contracting arrangements include the systems and policies for selecting public and/or private providers to deliver services in the benefit package, entering into contracts with them that specify terms and conditions (e.g., at which level specific services can be delivered and data reporting requirements), and enforcing the contracts. The MOH, RHBs, and CBHI schemes do not selectively contract with public providers, who are included automatically. No mechanism exists to contract with private providers for delivery of health services, other than laboratory diagnostic services.

EHIS contracts with eight tertiary hospitals in Addis Ababa on behalf of CBHI schemes for tertiary-level services only. But no explicit criteria are specified for selecting and contracting with tertiary hospitals. Some CBHI schemes contract with private facilities for laboratory diagnostic services and medicines, to counter medicine shortages in public facilities. Selection of these private providers is based on price and negotiation. Kenema (Urban Dwellers Association) and Red Cross pharmacies are the designated suppliers of medicines within Addis Ababa, but other private providers can be included as suppliers if the two pharmacies do not have sufficient supplies. RHBs lack selective contracting processes, but Addis Ababa RHB contracts with hospitals for CBHI members who are referred by health centers.

PROVIDER PAYMENT

Provider payment includes the systems and policies for selecting, designing, and implementing provider payment systems and setting payment rates. A detailed description of the provider payment mechanisms in use and their implementation arrangements is included in Annex D. The dominant payment methods are fee-for-service and line-item budgets; pilots are being implemented for capitation in the SNNPR, Oromiya, Amhara, and Addis Ababa regions, and performance-based financing in the Oromiya region.

Ethiopia began implementing program-based budgeting in 2005–2006 on a pilot basis and scaled it up to all federal agencies in the 2011–2012 fiscal year. At the federal level, program-based budgeting is used to allocate resources to the MOH. RHBs allocate line-item budgets to hospitals, and WoHOs allocate line-item budgets to health centers, based on historical expenditure.

CBHI schemes pay providers using fee-for-service, based on the facility's user fee schedule for health services. Public facilities have the autonomy to add a 25% to 30% markup on the cost of medicines. Health facilities submit paper claims on a quarterly basis, either to the woreda CBHI schemes for PHC services or to EHIS for tertiary-level services. Tertiary hospitals in Addis Ababa submit electronic claims. CBHI schemes and EHIS are required to pay the claim within a specified period of time; this varies across regions, and payment usually takes longer than expected. Some regions have different procedures for verifying and paying claims. For example, in the Amhara region providers are paid after a claims audit, which usually takes three to six months; in other regions, the trend is to pay 75% of the claim upon receipt and 25% after a claims audit. However, providers in the SNNPR report that the 25% is usually not paid.

Table 1 summarizes the views of purchasers and providers on how the different payment systems have contributed positively or negatively to provider behavior.

Table 1. Provider Payment Mechanisms in Ethiopia: Perspectives of Purchasers and Public and Private Providers

Payment mechanism	Positive features	Negative features
Line-item budget	• Predictable budget for purchaser • Usually no payment delays	• Rigid rules for using funds • Insufficient resources • Unused budgets cannot be retained after the fiscal year
Fee-for-service	• Providers incentivized to provide high-quality care to attract beneficiaries and increase volume of services • Source of flexible funding for providers	• High expenditure/claims through increased service volume and increased markup on medicines threatens financial sustainability of schemes and the purchaser's budget • Payment delays • Supplier-induced demand to increase their revenue • Administrative burden of processing claims • Unfair distribution of resources due to differing fee schedules • Focus on curative rather than preventive care
Capitation	• Providers paid on time (advance payment) • Predictable budget for purchaser and provider • Incentive for providers to deliver cost-effective services • Provider autonomy to manage resources • Low administrative burden in CBHI schemes	• Lack of data for base rate calculation • Administrative burden transferred to providers • Quality of care may suffer or providers may underprovide services in order to contain costs • More referrals to higher-level providers
Performance-based financing	• Financial incentive to providers • High-impact interventions given priority • Focus on service quality • Well-defined performance monitoring and verification system	• Administrative burden on providers and purchasers • Expensive to implement and therefore not sustainable in the long run

PERFORMANCE MONITORING

Performance monitoring includes systems and processes for assessing provider performance, providing feedback for improvement, and carrying out system-level analysis of utilization and quality to inform purchasing decisions.

All of the purchasers have a system for monitoring provider performance. Routine data collection is carried out using the DHIS2 platform and health management information systems for service delivery indicators, but the data are rarely used to inform purchasing decisions. Other processes are mostly ad hoc and depend on availability of resources, and they largely use paper-based processes.

The MOH collects routine health facility reporting data through DHIS2. It also regularly conducts service availability and readiness assessments and service provision assessments. The MOH, RHBs, and EHIS use additional platforms—community forums, supportive supervision visits, and review meetings—to monitor provider performance. On occasion, these activities are implemented jointly, but they remain largely ad hoc and depend on available budget. EHIS and CBHI schemes conduct biannual clinical audits to monitor health service quality and quarterly claims audits before paying providers.

Discussion

Ethiopia has made remarkable gains in increasing resources for health and improving access to health care. While increased public funding for health is widely seen as essential for achieving UHC, more can be achieved within the current financial envelope. Furthermore, the health financing landscape is fragmented in Ethiopia, with multiple schemes at the federal, regional, and woreda levels and a multiplicity of agencies that carry out core purchasing functions.

In looking at health care purchasing arrangements and provider payment mechanisms, the study found a need to increase resources flowing through the schemes, reduce the number of CBHI schemes/pools, and harmonize purchasing functions across agencies to facilitate strategic purchasing. The implications of the findings are discussed in more detail below.

Governance Arrangements

Good stewardship, institutional capacity, and sufficient autonomy are of paramount importance for strategic purchasing. Equally important are the purchasers' financial management procedures and the autonomy that providers have to receive and flexibly manage the resources they receive and to respond to incentives created by the provider payment mechanism.[2]

INSTITUTIONAL HOME

The study identified regulations that broadly define roles and responsibilities, but with some overlaps across MOH, RHB, and CBHI schemes that affect purchasing functions. This is similar to other low- and middle-income countries, such as Cameroon, China, Indonesia, and the Philippines, where the lack of a policy and regulatory framework for strategic purchasing or a weak framework has affected the ability of purchasers to use their purchasing power to improve resource allocation, provide coherent incentives to providers, and ensure provider accountability.[4–8] Lack of policy coordination for setting user fees across the federal, regional, and woreda levels leads to duplicative functions and affects equity because the fees differ depending on the locality. The MOH is working to introduce tools for costing and setting user fees to standardize practices across the country, with the support of the USAID-funded Health Financing Improvement Program.

The current administrative arrangements in CBHI schemes, in which the WoHO manages all functions of revenue generation and purchasing while also overseeing health facilities, runs counter to the principle of a purchaser-provider split, which was initially desired. This compromises the accountability of the woreda schemes for quality of care and use of resources received. The CBHI schemes could benefit from clarifying the roles of the woreda and EHIS regarding designing benefits, setting user fees, and monitoring quality of care.

FINANCIAL MANAGEMENT

All of the purchasers have well-defined processes for developing annual budgets and plans, and they follow PFM rules in executing their budgets, but deficits occur and require budget reallocation. Implementing the MOH's Three Ones plan[*] and cascading it down to the RHBs and woredas may improve resource planning for the health sector more broadly. Weak financial management and documentation at various levels of the system and weak implementation of accountability mechanisms compromise financial management.

CBHI schemes have varying levels of financial viability. Although increasing CBHI enrollee contributions may seem like an attractive option, this needs to be weighed against members' ability to pay in the large informal sector. Experience from low- and middle-income countries has shown that contributory health insurance has not been very successful in improving equitable access to health care.[9-13] Ethiopia can learn from these lessons as it considers

[*] The overall idea of one plan, one budget, and one report is that all stakeholders' plans and budgets should be reflected in one strategic plan, which is then broken down into annual plans. Implementation is monitored using an agreed-upon set of indicators and reporting formats.

options for CBHI and the forthcoming Social Health Insurance system and considers the best practice of increasing public resources—or, in the case of Ethiopia, increasing the CBHI subsidy from the federal government.[14,15] Increasing enrollee contributions may seem feasible, but experience has shown that this can lead to a "death spiral" in which raising contribution rates leads to lower renewal rates and a smaller pool of high-risk individuals, which then increases claims costs and eventually renders the CBHI pool unsustainable.[16,17]

In addition, pooling at the woreda level may not be sufficient for adequate cross-subsidization of risks within each scheme. The larger the pool of funds, the more predictable and stable the finances of the scheme. A system of cross-subsidization or risk equalization may be required to allow for redistribution across CBHI schemes at the zonal, regional, or federal level. It is promising that EHIS and regional governments are considering regional pools that may gradually grow to become a national CBHI scheme that covers more members and generates larger pools of resources. Roles for woreda offices, RHBs, and EHIS should be clearly defined. Reforming provider payment, particularly for CBHI schemes, could help address the deficits caused by the current fee-for-service payment method.

PROVIDER AUTONOMY

Health facilities have varying levels of managerial and financial autonomy, depending on the scheme. They must use funds received through line-item budgets according to PFM rules, which may limit the flexibility to direct the resources to local priorities. The line-item budget is not sufficient to cover the benefit package, which can lead to rationing of services, draining of internally generated revenue, and concerns about equitable access to priority services.

Internally generated revenue through user fees and CBHI fee-for-service payments provides flexible funding, but the challenge of insufficient funds can also limit the ability of facilities to respond to local priorities by redirecting their revenue to unfunded mandates (such as medicines for exempted interventions). Furthermore, issues with multiple channels of funding to providers, which have been well studied in Kenya and Nigeria, can result in incoherent incentives to providers. For example, both countries found that health facilities provided faster access to services for beneficiaries of schemes that paid more or more quickly, while sidelining beneficiaries of other schemes.[18,19]

Facilities have autonomy to use resources but do not fully exploit this autonomy. The MOH may consider building public facilities' financial and managerial capacity so they can each create a unified plan and budget to address local priorities and use those funds better.

Purchasing Functions

Purchasing functions exist in all health financing systems, and they fall along a continuum from more passive to more strategic. The core purchasing functions should be carried out through strategic, objectives-driven policies that aim to get more value from existing funds, be more responsive to population health needs, and advance progress toward UHC.

BENEFITS SPECIFICATION

Benefits specification is strategic when a package is well defined, reflects health priorities, serves as a commitment to the covered population, and is periodically revised through a transparent process.[2] The EHSP developed by the MOH and the interventions provided in the form of exempted, partially subsidized, and high-priority services reflect population health priorities.[20] However, exempted services are not standardized across regions, and many health facilities do not provide the service package at the expected level of quantity and quality. Some of the exempted interventions (prenatal care, delivery, postnatal care, and child health services) are unfunded mandates at public health facilities. Providers are required to comply with MOH service guidelines when providing health care, but quality assurance mechanisms are weak. The MOH and RHBs could aim to standardize benefit packages across public providers, review the list of exempted services to ensure that it is realistic in relation to available resources, and develop quality guidelines and benchmarks to ensure that providers deliver services as specified in the benefit

package. Removal of user fees or expanding exempted services without providing an alternative source of revenue to health facilities can reduce equitable access of services, introduce informal payments, and decrease the quality of services and availability of medicines.[21-24] The MOH and RHBs could also consider reimbursing providers for forgone user fees for exempted interventions, borrowing lessons from successful examples from Eastern Africa and West Africa.[25-27]

EHIS is currently revising the insurance benefit package. This process could build on existing processes for EHSP development to make it a more explicit commitment to CBHI beneficiaries and for resource estimation to inform revision of contributions, CBHI planning, and provider payment mechanisms. EHIS and CBHI schemes could collaborate in communicating entitlements to beneficiaries so they understand what is covered and what is not.[28]

CONTRACTING ARRANGEMENTS

Selecting providers to deliver quality health services at the lowest possible cost is an integral part of contracting.[29] By relying on loose agreements, which are not well enforced, CBHI schemes miss an opportunity to select providers, communicate expectations for service delivery, and use contracting as a basis for performance monitoring and greater accountability. In Ethiopia, all public providers are automatically included in order to enhance access to services, especially in rural areas where public facilities predominate. However, minimum quality standards are still needed, as well as a robust system to monitor provider performance.[30] Ethiopia lacks a strategy and guidelines to contract with private providers, and private providers have been excluded from public health financing schemes. Engaging private providers could help enhance choice and access to services.[31–34]

PROVIDER PAYMENT

Line-item budgeting and open-ended fee-for-service payment methods lack incentives for providers to be more efficient and provide good-quality services.[2] While line-item budgets constrain flexibility of resource allocation, fee-for-service can result in cost escalation, as seen in Nigeria and South Africa.[28,35]

All payment methods, when used alone, have both positive and negative consequences. Country experience has shown that carefully designing provider payment methods to allow for uniform incentives across different levels of care (PHC and hospital care) and blending provider payment methods (using one method to reduce the negative consequences of another) can help create incentives that improve provider efficiency and quality.[36-38] Reforming provider payment for CBHI schemes may also help address the deficits caused by the current fee-for-service payment method.

Along with small, fragmented risk pools, use of fee-for-service is a likely key contributor to the weak financial viability of CBHI schemes. Changing to one or more other payment methods will require stakeholder consultation to determine what mix works best while considering the experience of ongoing provider payment pilots and how the different funding streams from the MOH, RHBs, CBHI schemes, and other sources can be better aligned to ensure that all services are adequately resourced. The Lancet Global Health Commission on financing PHC advocates for capitation as a resource allocation tool to ensure equitable distribution of resources.[14] Although bundled payment mechanisms such as diagnosis-related groups (DRGs) have become more common in low- and middle-income countries, DRGs require sophisticated information systems and disaggregated claims data to develop effective DRG classifications. Ethiopia could start developing systems to collect data on patient demographics, diagnosis, and treatment at the facility level to inform future payment reforms.

PERFORMANCE MONITORING

Health purchasing is strategic when information is generated routinely through integrated health information systems and used for monitoring at both the provider and system levels to inform purchasing policies.[2] Although various platforms exist to monitor performance across the schemes, the information generated is rarely used to inform purchasing decisions due to the lack of consistent and integrated monitoring systems across levels of care and low data quality. Routine data collection systems through the DHIS2 exist, but the other processes are ad hoc and are dependent on available resources. CBHI schemes use readiness assessments and clinical audits, but information from these processes is not used to reward or disqualify poorly performing facilities or support them in

improving their performance because all public facilities are automatically included as providers in the scheme. Ethiopia could benefit from streamlining the multiple provider monitoring processes and strengthening the culture of data use, to create a virtuous cycle that leads to better-quality data to inform purchasing decisions. Lessons can be learned from countries that have introduced e-claims management, including Ghana,[39,40] where the electronic claims system reduced errors in claims processing and payment and minimized abuses of the system by detecting fraud. It has been found to be cost-effective and has helped Ghana's national health insurance service contain costs by enforcing prescription and dispensing levels and linking treatment and diagnosis procedures.[40,41]

Study Limitations

This study used a participatory process to determine the study design, data collection and analysis, and validation of the findings. However, the process was limited in that it considered the perspectives of purchasers and providers but not communities and how they interact with health purchasing functions. Due to limitations in funding, the study team selected a few schemes to represent the various schemes in Ethiopia and provide a broad view of purchasing arrangements. These schemes cover the largest segments of the population and can therefore make the greatest progress toward UHC. Because the literature on strategic health purchasing is sparse, the team relied heavily on key informant interviews to fill in gaps in data after reviewing key documents and policies. Provider payment is a new topic to many stakeholders in Ethiopia, and key informants struggled with the abstract nature of the discussion, particularly in identifying the positive and negative consequences of the different provider payment mechanisms in use.

The two frameworks used in the assessment helped to provide both a broad and detailed view of the purchasing arrangements in Ethiopia, but the result is only a cross-section that will require updating to reflect future progress and changes in purchasing arrangements.

Recommendations

The TWG leading this assessment identified key challenges and gaps to address and developed a set of strategic actions to improve strategic health purchasing in Ethiopia. This process involved three validation workshops in 2022. The last workshop, in September 2022, included representatives of all agencies that provided data for the assessment. Table 2 summarizes the challenges and recommendations.

Table 2. Key Challenges and Recommendations for Policymakers

		Challenges	Recommendations
Governance arrangements	**Institutional home**	• CBHI governance not implemented as intended because administration of the CBHI scheme within the WoHO removes the purchaser-provider split; this may compromise quality assurance and accountability for use of resources • Duplicative and overlapping purchasing functions among MOH, RHBs, WoHOs, CBHI management, and EHIS (such as in setting user fee schedules and designing benefit packages) • Weak capacity at the woreda level to carry out purchasing functions • Lack of mechanisms for stakeholder participation or engagement • Lack of an adaptive and evidence-based governance mechanism that includes all stakeholders	• Clearly demarcate roles and responsibilities among all purchasing agencies and strengthen purchasing capacity at the regional and woreda levels • Include mechanisms for stakeholder engagement across all schemes
	Financial management	• Weak financial viability of CBHI schemes due to accumulated CBHI deficits • Lack of cross-subsidization across CBHI schemes • Fragmented CBHI pools • Insufficient resources for exempted interventions • Insufficient evidence base for setting insurance premiums/contributions • Weak financial management, documentation, and archiving systems at different levels of the health system • Weak financial accountability and governance system	• Adequately resource CBHI schemes by increasing CBHI subsidies (targeted and general) and other resources • Enforce minimum reserve of 5% of CBHI contributions • Cross-subsidize by pooling at a higher level (e.g., regional) • Ring-fence or earmark resources for exempted health interventions at all levels • Strengthen the financial management and accountability system at the provider level • Strengthen the fund management and accountability system at the purchaser level
	Provider autonomy	• Multiple funding flows with different accounting systems • PFM rigidities in how funds can be spent by providers, due to strict line items • Limited number of suppliers for providers to procure medicines and supplies • Rigid procurement regulations for medicines and supplies	• Build capacity of PHC facilities for planning, budgeting, and PFM so they can better manage the resources they receive • Improve system-level integration of funding flows and accounting systems and avoid duplication

		Challenges	Recommendations
Purchasing functions	**Benefits specification**	• Lack of standardization in exempted interventions across regions and facilities • Benefit packages in CBHI schemes not explicitly defined • Significant variation across the country in provider capacity to deliver the EHSP and CBHI benefit packages • Low adherence to standard treatment guidelines • Schemes relying on MOH standards at public facilities and not defining their own service delivery standards	• Harmonize and standardize lists of exempted health interventions and their financing sources across regions • Develop a capital and human resource investment strategy to improve provider capacity • Develop and implement an explicit benefit package
	Contracting arrangements	• Lack of clear selection and contracting criteria • Loose agreements between purchasers and providers • Weak quality assurance and poor implementation of strategies to improve service quality, with no consequences for poor-quality service delivery • Lack of legal frameworks and mechanisms to engage and contract with private providers	• Develop accreditation guidelines to guide contracting of providers and quality improvement • Include standard treatment guidelines in contracts, and build capacity of MOH and RHBs for quality assurance to increase adherence to treatment guidelines • Scale up contracting arrangements between purchasers and providers, beginning with CBHI, and link to quality assurance mechanisms to improve provider capacity to deliver the benefit package • Develop platforms to engage private providers for inclusion in the schemes, including accreditation and contracting frameworks
	Provider payment	• Line-item budgets based on historical expenditure and favoring urban facilities, which have better infrastructure and staffing • Line-item budgets not motivating cost-effective service delivery • Cost escalation due to fee-for-service payment and user fee schedules set by multiple agencies • Administrative burdens related to generating, tracking, and reconciling claims • Inadequate mix of provider payment mechanisms, which are not linked to incentives • Low awareness of provider payment mechanisms • Low automation of claims management	• Consider alternatives to line-item budgets based on inputs (e.g., a formula based on population size and health needs) to reduce focus on infrastructure and staff • Consider alternative mix of provider payment mechanisms for CBHI that considers level of care and incentivizes good-quality care and efficient service delivery • Harmonize responsibilities and processes for setting fee schedules for each level of the health system • Assess ongoing capitation and PBF pilots to draw lessons for designing the next generation of provider payment systems • Strengthen automation of claims management

		Challenges	Recommendations
	Performance monitoring	• Use of multiple performance monitoring platforms and weak monitoring of exempted services in public and private facilities • Fragmentation of provider reports and reporting platforms, resulting in poor-quality data. • Limited use of data for purchasing decisions and inadequate feedback loops to providers • Low capacity for performance management • Inconsistent application of medical audit processes within CBHI schemes and claims payments made regardless of quality of care	• Develop a clear strategy for performance monitoring that integrates and builds on existing platforms to create an integrated national platform • Strengthen the system of data collection and develop feedback loops to providers • Invest in information systems that can support performance monitoring and inform design of more complicated provider payment mechanisms over the long term • Improve performance monitoring capacity within MOH, RHBs, EHIS, zonal health departments, and woredas • Develop implementation guidelines for the EHIS manual for medical auditing of claims, and apply the guidelines consistently

Strategic Actions for Improving Strategic Health Purchasing in Ethiopia

The TWG identified the most critical recommendations in Table 2 in order to propose a set of strategic actions for consideration by Ethiopian stakeholders—including the MOH, MOF, EHIS, RHBs, regional BOFs, and WoHOs. Table 3 presents the strategic actions in three phases:

Phase 1: Short-term actions – next 24 months

Phase 2: Medium-term actions – 25 to 60 months

Phase 3: Long-term actions – 60+ months

Key actions 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 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

These actions require a well-defined regulatory framework to support strategic purchasing. The sequence of actions listed in the table builds a foundation for future purchasing reforms, such as by setting up unified information systems that gather data for more complex provider payment mechanisms and support evidence-based purchasing decisions. Identifying the right mix of provider payment mechanisms is crucial and requires considering the incentives that need to be created and how to focus limited resources on priority interventions. Actions that create a culture of accountability through contracting are encouraged, and the building blocks for these processes are suggested for CBHI schemes, including strengthening quality assurance processes.

Table 3. Strategic Actions to Improve Strategic Health Purchasing in Ethiopia

(Responsible agencies are noted in parentheses)

	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)
Institutional home	• 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)
Institutional home	• 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)

Gaps and challenges	Short-term actions: next 24 months	Medium-term actions: 25 to 60 months	Long-term actions: 60+ months
• 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)	

	Gaps and challenges	Short-term actions: next 24 months	Medium-term actions: 25 to 60 months	Long-term actions: 60+ months
	• 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 PBF 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)	

	Gaps and challenges	Short-term actions: next 24 months	Medium-term actions: 25 to 60 months	Long-term actions: 60+ months
	• 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)		

Annex A. Technical Working Group Members

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* Based outside Ethiopia (Kenya)

** Based outside Ethiopia (Nigeria)

EPSS = Ethiopian Pharmaceuticals Supply Service
HFIP = Health Financing Improvement Program
HSQD = Health Services Quality Directorate
MAD = Member Affairs Directorate
PAQAD = Provider Affairs and Quality Assurance Directorate
PCP = Partnership and Cooperation Directorate
PRD = Planning and Research Directorate
SPARC = Strategic Purchasing Africa Resource Center

Annex B. Sampling Frame: Purchasers and Providers Included in the Study

PURCHASERS

Ministry of Health

Regional Health Bureau, Addis Ababa

Regional Health Bureau, Oromiya

Jinka Zonal Health Office

Ethiopian Health Insurance Service (community-based health insurance schemes)

Commercial Bank of Ethiopia (parastatal)

Ethiopian Federal Police (parastatal)

Ethio Life and General Insurance (private insurance)

Ethiopian Insurance Corporation (private insurance)

MIDROC (private insurance)

Cordaid (nongovernmental organization)

PROVIDERS

Public health facilities

- Arada Health Center
- Beletshachew Health Center
- Bishoftu Hospital
- Black Lion Hospital
- Dimeka Health Center
- Jinka Hospital
- Koyibe Hospital
- Olanciti Hospital
- Seka Chekorsa Hospital
- Serbo Health Center
- St. Paul's Hospital Millennium Medical College
- Tarre Health Center

Private health facilities

- Bishoftu Private Pharmacy
- Ethio Tebib Hospital
- Hallelujah General Hospital

Parastatal health facilities

- Commercial Bank of Ethiopia Clinic
- Police Hospital

Annex C. Summary of Findings

The following tables list the purchaser(s) under each type of scheme and the governance arrangements and purchasing functions for the purchasers, respectively.

Schemes and Purchasers

Type of scheme	Purchaser(s)
MOH	• MOH
RHBs	• Regional Health Bureau, Addis Ababa • Regional Health Bureau, Oromiya • Jinka Zonal Health Office
CBHI	• EHIS
Parastatals	• Commercial Bank of Ethiopia • Ethiopian Federal Police
Private insurance	• MIDROC • Ethio Life and General Insurance • Cordaid (nongovernmental organization) • Ethiopian Insurance Corporation

Purchaser Governance Arrangements and Purchasing Functions

	Indicators	MOH	CBHI schemes	RHBs	Parastatals	Private insurance
	% 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	~2.5 million	~2% of Ethiopian population (2.24 million)
	% 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)	0.2% (256,500,000 birr)	0.1% (67,252,909 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.	Parastatal organizations are responsible for carrying out most or all purchasing functions. Mechanisms are in place for stakeholder engagement.	Private insurers are responsible for carrying out all purchasing functions, capacity is strong, and no overlaps or gaps in responsibilities exist. Stakeholder engagement is inclusive and meaningful.
	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 MOF or the 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.	Public providers have no autonomy or extremely limited autonomy to carry out financial and managerial functions, and they have limited ability to respond to financial incentives created by provider payment systems.	Providers have autonomy to carry out financial and managerial functions, and they are able to respond to financial incentives created by provider payment systems.

	Indicators	MOH	CBHI schemes	RHBs	Parastatals	Private insurance
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.	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, and budget overruns rarely occur.	A process is in place to determine the purchaser budget based on collected premiums.
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.	Commercial Bank of Ethiopia uses a negative list, while the Ethiopian Federal Police have an explicit list that is expected to be revised.	A benefit or service package is defined, reflects health priorities, and is a commitment.
	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.	The purchaser defines some general service delivery standards and some specific service delivery standards that are enforced through contracts.	The purchaser defines some general service delivery standards and some specific service delivery standards that are enforced through contracts.
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.	Formal agreements are in place between the purchaser and public and private providers to help achieve specific objectives, and they are linked to performance.	Formal agreements are in place between the purchaser and public and private providers to help achieve specific objectives, and they are linked to performance.

	Indicators	MOH	CBHI schemes	RHBs	Parastatals	Private insurance
	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	The purchaser contracts at least somewhat selectively with public and private providers based on their definition of quality standards.	The purchaser contracts selectively with private providers based on uniformly applied quality standards.
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	Fee-for-service is the predominant payment system and is linked to specific services in the benefit package.	Fee-for-service is the predominant payment system and is linked to specific services in the benefit package.
	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.	Rates are based on the purchaser's available budget and negotiation.	Rates are based on the purchaser's available budget and negotiation.
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).	No data available	No data available
	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.	Some form of analysis is carried out at the system level (e.g., service utilization, medicines prescribed, total claims by service type).	Information and analysis are used for system-level monitoring and purchasing decisions.

Annex D. Design Features and Implementation Arrangements for Provider Payment Systems in Ethiopia

Payment system	Design features			Implementation arrangements		
	Basis for payment	Services	Cost items	How payments are disbursed, used, and accounted for	Caps	Unused funds and deficits
Capitation	• Capitation is implemented at the health center (HC) level, where households are assigned to the HC in their woreda and payment to the HC is based on calculated rate per household. • Payment rates are based on utilization, drug availability, comprehensive audit results, and historical data (after accounting for inflation and the ranking of the HC).	• Outpatient services • Diagnostic services • Inpatient services (3 days max) • Pharmaceuticals	• Medicines, supplies, lab/imaging, and consultation • Minor surgery	• Only HCs are paid using capitation • Payment is a calculated lump sum to the health facility, and providers can allocate expenditure across line items. • Payment is made to providers based on the estimated catchment / assigned population.	• A soft capped payment system is used. • Overruns due to unassigned households is allowed. (When households visit an HC out of their catchment area, the scheme pays for the visit and deducts the amount from the assigned HC.)	• HCs retain unused funds. • When HCs face deficits, payment rates are revised by the woreda scheme.
Fee-for-service	• The fee schedule is prepared by MOH for federal/tertiary hospitals and university hospitals and by RHBs for hospitals and HCs under their administration (with council approval). Some health facilities develop their own fee schedule.	• Outpatient services • Diagnostic services (laboratory, pathology, imaging) • Inpatient services • Medicines	**Public** • Medicines • Supplies • Equipment and human resources (HR) for federal and university hospitals **Private** • In addition to the above cost items,	• Fees are paid and accounted for by the health facility, either revenue from provision of health services or sales of drugs/supplies. • Revenue can be allocated flexibly up to the line item amount in the provider's budget.	• No cap is set because health facilities can request that all services be made available per clinical guidelines/ protocols.	• Unused funds from internally generated revenue can be used in the following fiscal year, except by federal and university hospitals.

Payment system	Design features			Implementation arrangements		
	Basis for payment	Services	Cost items	How payments are disbursed, used, and accounted for	Caps	Unused funds and deficits
	• Health facilities can mark up medicines by 15% to 25%. • Private facilities develop their own fee schedule. • There is no uniformity in how fees are calculated.		includes HR and facility infrastructure	• Expenditures are accounted for against budget line items.		
Line-item budget	• Budgets are based on historical expenditure, input norms, cost estimates, the priorities of the administrative level of government, etc. • Final budgets approved • Budgets have 49 line items	• Outpatient consultations • Diagnostic services • Inpatient services • Medicines and supplies	• Salaries and other personnel costs • Medicines • Supplies • Administrative costs • Repairs and equipment • Training	• Funds are disbursed, used, and accounted for according to 49 input-based line items. • The recurrent budget is usually paid monthly in equal installments, and the capital budget is paid according to cash flow requests submitted to WoFOs.	• Budget cap is available.	• Supplementary budget or transfer is requested by MOH or RHB for deficits. • Unused funds at all levels are returned to the treasury at the end of the fiscal year.
Performance-based financing	• Payment is based on the contract between the purchaser and the provider. • Rates are determined by indicators for quantity and quality of services. • The contract mainly contains unit costs for the services provided or the indicator and the targets to be achieved by the end of the fiscal year.	• Community-based health services (mainly targeting rural and pastoral communities—e.g., latrine construction) • Outpatient services • Inpatient services • Pharmaceuticals • Public health or vertical programs, (e.g., immunization,	• Basic preventive and curative services pertinent to the level of care.	• Payment is based on claims submitted by providers to the purchaser for services provided and is verified by the verifying entity. Payment for quality achievement is also made upon quality verification. • Payment is released upon submission of a health facility business plan that includes how and for which activities the	• No budget cap is set.	• Health facilities can keep unused funds to improve service quality.

Payment system	Design features			Implementation arrangements		
	Basis for payment	Services	Cost items	How payments are disbursed, used, and accounted for	Caps	Unused funds and deficits
	• The contract also indicates payments for quality scores. • Payment is based on performance as measured by agreed-upon indicators.	tuberculosis services, HIV/AIDS services)		incentive payment will be used (mainly to address challenges to providing quality services).		

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