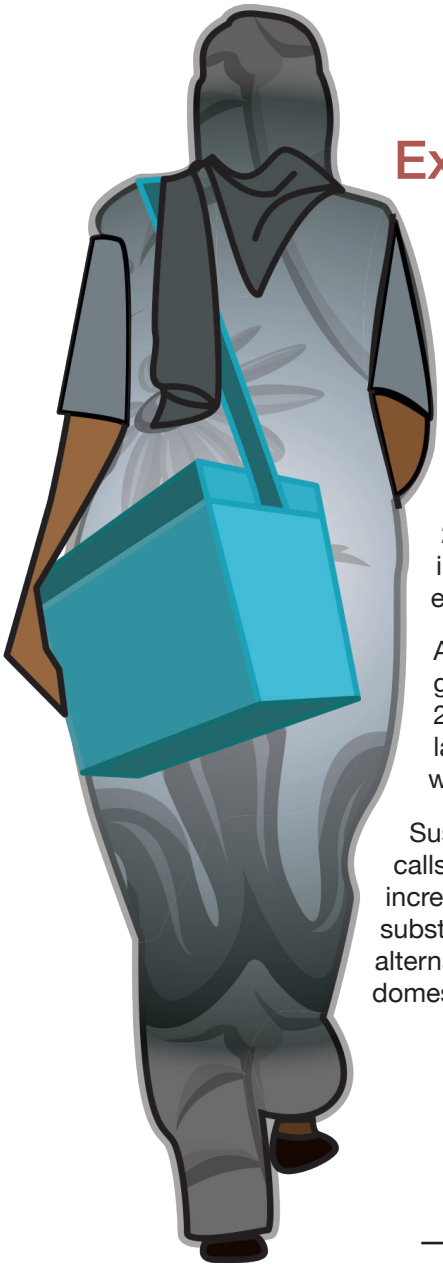
POLICY BRIEF 1

LOOKING INSIDE:
Envisioning Domestic Funding for Ethiopian Health Extension Program



Executive Summary

Since 2003, Ethiopia has been implementing the health extension program (HEP), one of the largest community health worker programs in the world, with the objective of providing improved access to basic health services.

Analysis of the trends and sources of funding for the HEP over the recent six years (2010/11-2016/17) shows that while the total HEP spending increased in nominal terms from 2.4 billion ETB (USD 0.52 billion in terms of PPP) in 2010/11 to 5.1 billion ETB (USD 0.58 billion in terms of PPP) in 2016/17, the share of HEP spending in the total health expenditure (THE) declined from 8.89% to 7.12%.

Analysis of the sources of funding reveals that the share of government spending on the HEP increased from 20.8% in 2010/11 to 40.3% in 2016/17. However, the program is still largely dependent on non-domestic sources for financing with an average share of 65.3% over the same period.

Sustaining the health and development benefits of the HEP calls for expanding government share in financing for HEP, increasing the rate at which domestic financing schemes can substitute non-domestic sources of funding and considering alternative sources of financing HEP packages to increase domestic resource mobilization.

Introduction

Primary Health Care (PHC) has been widely recognized as the center of health agenda to ensure effective, efficient, and equitable health care following the Alma-Ata declaration of 1978. However, financing primary health care in developing countries has been challenged by financial constraints. Especially, the low share of domestic funding endangers the sustainable implementation of PHC (1). The World Health Organization's review of 40 years PHC implementation indicates that limited financial resources remain a key challenge of primary health care following the economic down turns and biased budget allocation to secondary and tertiary level of care (2). The need to shift from donor-based financing to domestic funding is crucial as the global health actors have started to face challenges to keep their commitment (1,3). Increasing domestic funding has been cited as a long-term sustainable solution to increase domestic financing for health (4,5). Ethiopia has shown commitment to proactively increase access to and quality of PHC through HEP since 2003 and early reviews show that the program has been funded by government and donor (6,7). The current policy brief examines the national level trends and sources of funding for the HEP over the recent period of 2010/11 and 2016/17 with the focus of identifying how heavily reliant the HEP is on non-domestic sources. Based on review of the evidence, the policy brief advocates for local and domestic funding to keep health and development gains of the HEP.

Methods

National spending on the HEP was estimated through analyses of data from the 2016/17 National Health Accounts. Health expenditures at the health center (HC) and health post (HP) levels was apportioned to the HEP (at the HP level) and HC-level expenditure using data from different secondary sources, including Ethiopian Pharmaceuticals Supply Agency drug cost, supply and medical equipment, human resources data, health service coverage and use reports and the Health Sector Transformation Plan. The annual inflation rate from the Central Statistics Agency and purchasing power parity (PPP) from the World Bank were used to adjust the expenditure figures to standard units. Primary data on HP-level inputs were also used to supplement secondary sources in the estimation of the share of the HEP from the total primary health care unit (PHCU)-level expenditure.

Key Findings

The results show that there was an increase in PHCU expenditure (excluding primary hospitals) from 9.27 billion ETB (USD 2.04 billion in terms of PPP) in 2010/11 to 23.73 billion ETB (USD 2.67 billion in terms of PPP) in 2016/17. Over the same period, the total HEP spending has nominally increased from 2.4 billion ETB (USD 0.52 billion in terms of PPP) to 5.1 billion ETB (USD 0.58 billion in terms PPP).

Despite the increment in the expenditure in PHCU (HC & HP), the share of expenditure on HEP from the total PHCU-level spending has declined from 25% in 2010/11 to 23% in 2016/17. Similarly, the share of HEP spending from THE declined from 8.89% in 2010/11 to 7.12%.

Examination of the cost categories revels that recurrent expenditure (drug, supplies and others) account for 62% of the total HEP funding followed by human resource related (24%) and capital expenditures (14%). Analysis of the HEP spending on different HEP service packages shows that child health services accounted for the highest share of spending (46% on average) followed by nutrition (17%), hygiene and sanitation (16%), reproductive and maternal health (12%) and communicable disease control and prevention (9%).

Except for voluntary contributions of time and labor at the community level, government and donors are almost the only financing sources of the HEP. The share of government expenditure

from the total HEP spending increased from 20.8% in 2010/11 to 40.3% in 2016/17. Despite the increment in government funding, the HEP remains a highly donor-dependent program, with an average 65.3% of its spending still coming from donors.

Recommendations

The highly donor dependent HEP funding calls a shift to domestic funding. Shifting the main source of funding to domestic one can ensure sustainability of health extension program.

It is imperative to assess the feasibility and effectiveness of alternative financing for HP based services through mechanisms including revolving funding, community-based health insurance and incentivizing private sector involvement at the village level and pay-for-performance.

A move towards pay-for-performance interventions, which aimed to incentivize health workers by paying for agreed indicators of service quality might also be considered. Pay-for-performance is found to improve quality of care but even if it was found with no impact on coverage and equity (8). The pay-for-performance programs can be contextualized to the Ethiopian PHC as domestic funding scheme to enhance community participation contribution, to reduce out of pocket money from individual users, and reduce health extension workers' dissatisfaction related to poor incentives. A systematic review among Asian specific region revealed that pay-for performance improved quality (3).

Another domestic funding schemes like removal of fees and public insurance improved PHC utilization by reducing user's out-of-pocket expenditure, contracting out PHC services enhanced coverage, efficiency and equity. Contracting out PHC would be a special approach to involve the private sector in some primary health services with maximum yield of quality and coverage (9,10).

It is also recommended that the government maintain expanding its share of financing in the HEP. To maintain this in momentum, it should be backed by an overall efficiency in revenue collection, thus the total health expenditure in general and expenditure for PHC in particular could sustain. Government's subsidizing effort for domestic funding sources would also contribute to strengthen the extremely neglected and low share of the domestic expenditure. A systematic review on health financing mechanisms among Asian countries and China revealed that overall, the utilization of health care among the poor has increased as a consequence of the implementation of government subsidized health insurance schemes which target the poor in most of the studied countries. The higher the percentage of government expenditure on health, the greater the financial protection is (10).