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Welcome to the third volume of the International Institute for Primary Health Care-Ethiopia's (IPHC-E) Primary Health Care Digest! The purpose of the Digest is to share the latest news and research on primary health care from Ethiopia.

The Digest covers reviews on primary health care financing, digital primary health care, community-based health insurance, and an assessment finding on the Impact of the Leadership Incubation Program for Health (LIP-H) in Ethiopia.

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Financing Primary Health Care: A Review

Filmon Melaku , Helina Mesele , Getnet Mitike

Understanding core concepts and issues of health care financing (HF) is essential for health leaders and public health professionals. Health financing affects the entire health system including the primary health care (PHC). Its performance relates to quality, access, and efficiency of services. Since its declaration at Alma-Ata in 1978, PHC has faced numerous difficulties in its implementation and remains underfunded in majority of low-income nations. Experts' differing opinions on Comprehensive Primary Health Care (CPHC) and Selective Primary Health Care (SPHC) have hindered PHC from achieving its envisioned impact, making it more enticing to donors to fund vertical initiatives that yield quick investment returns (1). It is important to note that HF has been found to be crucial for the successful implementation of policies and programs in several nations that have centered their policies on PHC. In this brief review, we provide a working definition of health financing in primary health care and discuss the major differences in health care financing systems between developed and low-to-middle income countries (LMICs). We also indicate major obstacles health financing faces in regard to political, socio-cultural, and economic factors and provide a summary of its implication at the end.

Primary Health Care (PHC) is a whole-of-society approach to health that focuses on meeting people's needs as early as possible along the continuum. From health promotion and disease prevention to treatment, rehabilitation and palliative care, PHC attempts to be as near to people's daily environments and with the aim of ensuring the highest level of health and well-being through equitable distribution(2). Primary health care is the key component of all high-performing health systems and it is the essential foundation for universal health coverage (UHC), and a prerequisite for meeting the sustainable development goals, in addition to helping achieve good health at a low cost through cost effective health interventions(3).

A smooth functioning health system requires well designed health care financing systems that continuously supports its implementation. Reducing people’s out-of-pocket expenses and improving access to health services is fundamental for moving towards achieving UHC. Furthermore, meeting the health targets of UHC without properly instituting health care financing mechanisms is unthinkable.

The objective of this review is therefore to provide key concepts and practices related to health care financing with special emphasis on primary health care including challenges, sources and modalities for health care financing.

Methods

We searched and reviewed up-to-date and key literatures on health care financing with a special emphasis on primary health care that remained a cornerstone for the Ethiopian Health Policy and major strategies.

Key findings from the review

Generally, there are four main healthcare financing modalities that are currently in play. These are:

- General Tax Revenue
- Insurance (Mandatory social insurance [mandatory insurance [government/public], Voluntary insurance [market/private])
- User fees (including out of pocket payments), and
- Donor-based funds

General tax revenue

General tax revenue which is thought to be the most equitable healthcare financing modality faces challenges in low and lower middle-income countries (LLMICS) due to a combination of narrow tax bases and poor tax collection capacities. This is due to lower allocation of funds to healthcare because of competing demands from other pressing priorities(4). Even though African countries have committed themselves to allocating at least 15% of the government's budgets to the public health sector in the Abuja Declaration of 2001, no sub-Saharan Africa country has achieved the commitment yet(5) and Ethiopia stands at the lower side.

The practice from Ethiopia shows that despite implementation of several reforms in the healthcare system to achieve universal health coverage by 2030, the system keeps struggling with low healthcare funding, high out-of-pocket expenditure and allocation of only 7.8% of the GDP, which is short of the Abuja Declaration(15%)(6).

Health Insurance (Voluntary insurance and Mandatory social insurance)

Voluntary insurance: these insurance schemes are financed through private premiums. The scheme includes a third party - insurer who is the primary contact for a policy holder (insured person) and health service provider or an employer may insure its workers without involving an insurer. Hence playing all the roles and facing risks of an insurer. In this scheme, the finances are operated through a non-governmental system. The coverage may be full or partial. This type of health insurance scheme is commonly practiced in developed nations.

Mandatory insurance: these insurance schemes are owned and usually managed by a government/public system. For instance, governments may apply mandatory health insurance for employed people – formal sector. This is sometimes called Social Health Insurance. In Ethiopia, the government is about to approve a bill to implement social health insurance.

Community-based health insurance (CBHI) schemes are a type of health insurance plan that are operated by and for communities. These schemes are implemented to provide affordable and accessible health care to members of the community who are not covered by the traditional health insurance plans.

CBHI schemes vary in terms of benefits they offer, the premiums they charge, and the populations they serve. Ethiopia and a number of developing countries started practicing a community based health insurance schemes which target a set of population (workers in the formal and rural sectors)(7). Thirty seven studies from 14 countries reported CBHI schemes increased utilization of health care services, reduced the burden of healthcare costs on households, and improved health outcomes(8). CBHI also has positive impact on health outcomes and contributed to improving equity in health care financing(9). Success of CBHI schemes depend on the design of the scheme, the availability of high-quality health care services, and the level of community involvement in the scheme(10).

Out-of-pocket costs are expenses for medical care that are not reimbursed by insurance, which include deductibles, coinsurance and copayments for covered services plus all costs for services that are not covered. The World Health Report demonstrated a significant increment in the health spending of LICs and an estimated 60% increment attributed to out-of-pocket payments, much of it for episodic, unregulated care from private providers(11). The Ethiopian out-of-pocket expenditure stands at 30.6% as of the 2016/17 reports and the share of the proportion of the Gross Domestic Product (GDP) has decreased over a period of time from 5.2% (2010/11) to 4.2% (2016/17)(6).

User fees

User fees (including out-of-pocket payments) are thought to be the most regressive methods of financing health care which contribute to the unaffordable cost of burdens which they impose on poor households and they also represent one facet of the social exclusion experiences. These payments capture higher proportion of income among poor households than wealthier ones. Based on the equity principle they remain the least desirable way of financing health services. It is advised that those with the greatest ability to pay should make the larger contributions(4). There are current calls for removal of user fees due to their regressive impacts and their role in enhancing social exclusion(5).

Even though, the virtues of PHC are well established there are still huge fundamental literature gaps which show the levels, trends and allocation of donor and governmental resources to PHC(11).

Donor-based funds

Donor-based funds are those funds that are released by donor communities both domestic and international which usually prioritize disease specific programs (like Tuberculosis, HIV/AIDs, malaria etc.) rendering little resource for basic healthcare and health systems strengthening. Furthermore, donor based funding has been in the decline though out years(3).
In principle health financing for PHC should dominantly come from domestic sources with cost-sharing by beneficiaries. Unfortunately, most PHC in low-income countries depend on donors' contributions affecting their sustainability.

Implications

Healthcare systems are fueled by their financing arrangements. These arrangements include the amount of funding the system receives, the way funds are moved through the system to frontline providers, and the incentives created by the mechanisms used to pay providers. The right financing arrangements are crucial to support the development of people centered PHC. It can drive how PHC is delivered and equips the system to respond effectively to evolving population health needs(3).

In summary, political, socio-cultural, and economic conditions are important for efficient and equitable financing of PHC. These factors represent both constraints and opportunities towards proper financing of the PHC(3).

PHC requires savvy political leadership, long-term commitment, proactive and adaptable strategies which engage stakeholders at all levels. Political commitment to primary healthcare implies more than formal support from the government and community leaders, rather a reorientation of national health development strategies, in particular the transfer of a greater share of health resources to the under-served majority of the population with the aim of meeting that targets of UHC through PHC. At the same time, increasing the national health budget until the total population has access to essential health care is crucial for strengthening PHC. Different stakeholder's (Governmental organizations, donors, private investors etc.) involved in financing healthcare should work in harmony towards achieving UHC by 2030. LICs should prioritize minimizing user fees including out-of-pocket payments, which place huge financial burden and diminish the health seeking behavior of poor households. Households with greater ability to pay should be encouraged to contribute higher amount to strengthen the financial health pooling system to achieve health equity. Donors should invest more in PHC, instead of focusing only on program-based projects that are usually implemented in LICs. Furthermore, in accordance with the pledge made in the Abuja Declaration debt remains a critical factor in determining priorities that influence resource allocation for the health sector in LICs. High-income nations should consider alternative ways of alleviating the burden debt upholds on LICs. Inter-nation collaboration should be an integral part of the efforts made to achieve UHC. Last but not least, CBHI should be implemented with strict and continuous monitoring and evaluation as the system is liable to mismanagement. The system should empower the community as they are the most crucial stakeholders who contribute the lion's share to the success or failure of the scheme. In addition, it should strengthen the engagement of responsible stakeholders at all levels and be open to adopt the best practices of countries with strong and exemplary work on CBHI.

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Digital Primary Health Care:
mHealth Role in Ethiopian Primary Health Care System

Robel Tezera & Mohammed Abdusemed

Introduction

Digital health can play a significant role in primary health care (PHC) by expanding access to healthcare services, enhancing client engagement, and improving the effectiveness and efficiency of healthcare delivery (1). Mobile health, also known as mHealth, is one element of digital health. mHealth can be defined as using mobile devices and multimedia technologies in the healthcare system (2). This paper aims to review the role of mHealth in the Ethiopian PHC system.

Methods

This paper examines the mHealth intervention focused on the PHC system through narrow scope narrative literature review of published and unpublished articles. The Articles were selected from search engines such as Google Scholar, PubMed, and Directory of Open Access Journals. In addition to using Boolean operators, the search terms used include "mHealth," "mobile-health," "telemedicine," "telehealth," "mobile phones," "primary health care," and "Ethiopia." The articles were assessed by reviewing the abstract and the conclusion to check their relevance for the review objectives. The review's findings are categorized into mHealth types and mHealth domains for PHC.

Findings
mHealth Types

This review identified two types of mHealth solutions: Basic and application-based solutions. The basic mHealth solutions include Short Message Service (SMS) and telephone calls interventions which require Basic (regular) mobile phones.

The applications-based solutions mostly consist of two components: mobile application, which captures data from user ends and transmits data to the second component, and the central system (web-based), which stores, analyses, and transmits information to the end-users. The application-based interventions also deliver SMS messages through customized software like FrontlineSMS and BulkSMS applications. For instance, a mHealth study conducted in Northwest Ethiopia used an SMS reminder application with a web-based component for patient registration and automatic appointment reminder scheduling and an SMS software component for transmitting the automatic reminder (3). The applications-based solutions usually require smartphones.

mHealth Domains for PHC

Despite there being no common consensus on categorization for the domain of mHealth initiatives for PHC, this review identified four domains based on the role/use of mHealth for PHC addressed in the articles.

The mHealth Domains for PHC include Patient Education, Communications and Reminders, Health Data management, and Decision support and consultation.

Reminders and Communication: Most articles included in this review use SMS for reminders and communication for MCH services. The use of SMS to transmit appointment schedules and a reminder to patients significantly improved the utilization of PHC services, including Antenatal care, delivery services (ANC) (4-6), postnatal care (PNC) (5, 6), immunization service (3-6). The SMS was also used to send appointment schedules and reminders for health care professionals (For example, ANC visits, expected date of delivery) to make appropriate arrangements for the provision of services and for HEWs to make home visits and create linkage with health facilities (4, 6-8). SMS reminders also used Reminder messages prompt HEWs to check up on cases with sputum examinations consistent with TB symptoms (8).

The mHealth application, mostly SMS, was also used to facilitate communication between healthcare professionals and HEWs to support service delivery, confirm HEW referrals for medical services, and facilitate supply management (4, 7, 8).

Patient Education: Few studies are used mHealth for patient education. The mHealth interventions in PHC employed SMS for patient education and Behavioural changes communication (BCC) (7, 9, 10), and telephone call interventions could be used alternatively. One study used mobile video for community behavior change (11). The most commonly addressed area for patient education was maternal and child health services (MCH) (7, 9-11). According to a study conducted in 10 health centers in Amhara regions, educational SMS messages resulted in significant behavioral changes among clients and increased delivery and postnatal care services (9). The mHealth-based patient education is broadly applicable to a wide range of health behaviors and conditions, and the willingness of the user to receive an SMS message for clinical care could be considered an opportunity for implementation (12, 13).

Health Data Management: The health data management domain focused on using the mHealth application for data collection, storage, and monitoring in PHC services. The study conducted in HEWs reported the significant role of mHealth in collecting and transmitting community health data and making it easier for HEWs to access clients' data (4, 6, 10, 14-16). Using mHealth for health data management improved the quality of health data, including the accuracy, completeness, and timeliness of reports in PHC settings (6, 15). The features of mHealth could be a simple digital form (for example, Open Data Kit/ODK software) or an advanced mobile personal health record application. Shiferaw and his colleagues argue that local resources and an open-source platform could be used to create a mHealth for data management intervention in the PHC setting (10).

Decision Support and Consultation: The mHealth has a key role in supporting Health care professionals and HEWs to make effective decisions and provide quality service via a decision support system (DSS) and teleconsultation (4, 6, 17, 18). In PHC settings with a severe lack of skilled personnel, HEWs could benefit from mHealth DSS to design efficient services at the point of care through improved information access (18). The mHealth support system consists of senior professionals' and experts' teleconsultations and the provision of online resources like treatment guidelines (18, 19). The below figure summarises the mHealth domains, types, and implementation considerations.

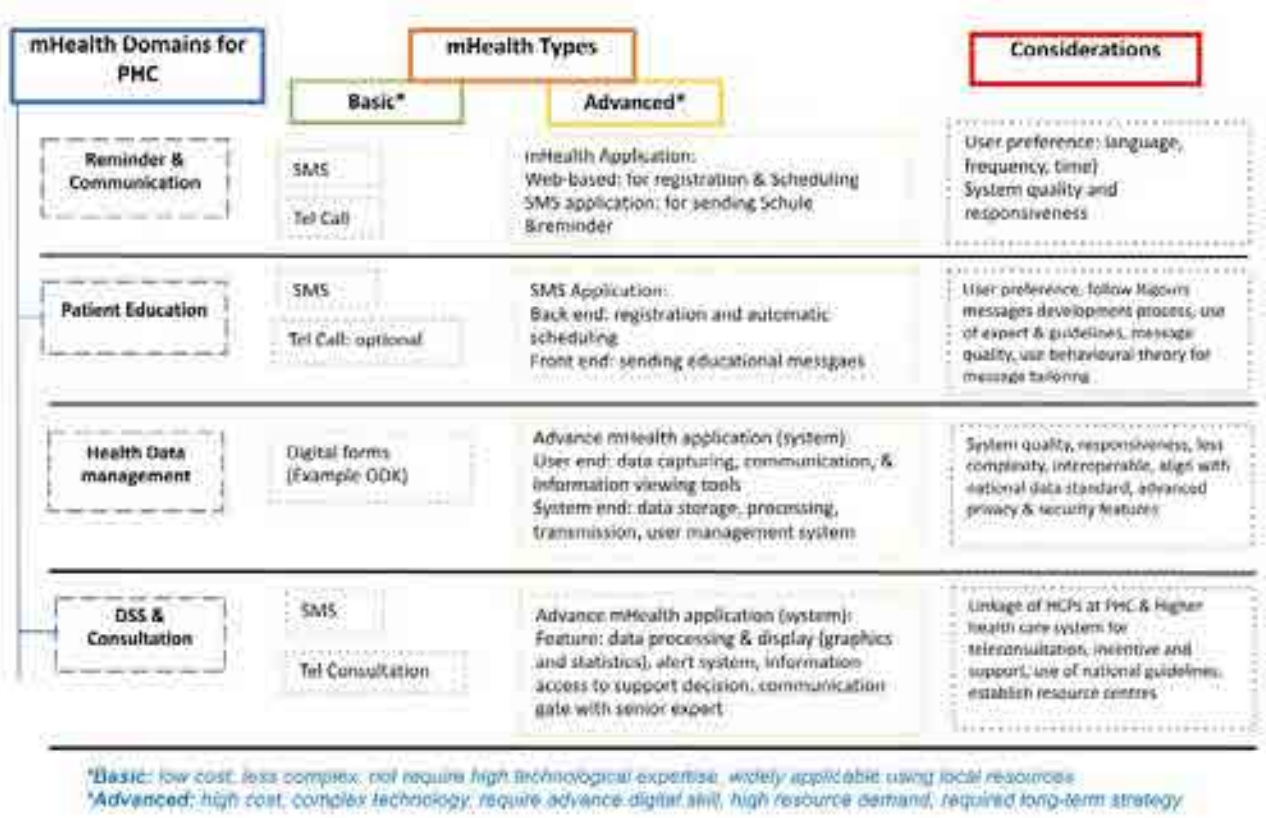

Figure: mHealth for PHC: domains, types and considerations

Conclusion

mHealth initiatives appeared to play a significant role in enhancing PHC services in Ethiopia. The successful outcomes of the intervention could be taken as a sign to use mHealth for patient education, decision support, communication and reminders, management of health data, and more. Government and stakeholder commitment were necessary, as was placing digital technologies at the forefront of their PHC vision, policy, and strategies.

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Community-based health insurance in Ethiopia
Challenges and way forward

Tigist Astale

Community-based health insurance (CBHI) is a voluntary prepayment mechanism with pooling of health risks and funds at a community level. It is promoted as a means to remove financial barriers at a point of care, a commonly reported barrier not to seek health care in the case of illness (1). In the past two decades CBHI has expanded in several Sub-Saharan African countries(2). The Ethiopian Government introduced CBHI scheme at household level to improve access to health care since 2011(3). Although the scheme showed promising positive results(4), the actual implementation of CBHI scheme faced challenges in terms of low enrollment and re-enrollment coverage, high member drop-out rates and heavy financial loses.

As of 2021, CBHI enrollment coverage in Ethiopia was 45%(5), which is far below the national target of 80%. A recent systematic review(6) in Ethiopia indicated that five factors positively influenced membership enrollment. These factors, ordered from largest to smallest based on their effect size are knowledge of respondents about CBHI, the presence of a person with a chronic disease in the household, perceived quality of service, affordability of premium payment, and trust in the scheme. In addition to low enrollment coverage, high rate of member drop-out is another challenge for the sustainability of the CBHI. As it was indicated in one recent study(7), 29% members dropped out of CBHI after their initial enrollment. In this study it was revealed that larger households, those with chronic illness, and those who have a trust in the scheme remained longer in the scheme and that time to drop out was not correlated with wealth index.

The CBHI scheme in Ethiopia is also not financially viable in that the scheme is facing a financial deficit and heavy losses(8). The reasons for this include adverse selection (people with chronic condition and elderly more inclined to join the scheme), moral hazard behaviors (negative practices both among patients and providers), stockout of medicines, delays in claims settlement for service providers, and low insurance premiums.

As a response to the above main challenges and based on lessons from other African countries, Ethiopia is currently looking for opportunities to improve the situation. With the hope of removing financial hardships for enrolment, sliding schemes are being investigated as an option as they allow citizens to contribute based on their ability to pay (9). However, although it is still important to ensure affordability of the premium payment, it appears more prominent to work on the management of a CBHI scheme. As it was indicated in recent studies(4, 10), weak health service delivery, whereby many health facilities provide low quality services to beneficiaries, constrained implementation capacity, poor institutional accountability and governance practices, were identified as major sustainability challenges.

Likewise, it is important to note that a CBHI scheme is a voluntary health insurance system, and that a change in the premium payment may not be accepted easily considering the current implementation constraints of CBHI. Rather, working on the quality of the services provided, and making the system easier to ensure member rights would attract more members and eventually improve the enrollment

coverage and decrease the drop-out rate with better risk-sharing. Once the management, and the service provision under CBHI schemes are improved and members are satisfied about the services they get, people may tend to easily accept the possible changes on membership premiums. As such, prioritizing the challenges and possible interventions accordingly would save resources.

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Developing the Next Generation of Leaders in Health: An Assessment of the Impact of the Leadership Incubation Program for Health (LIP-H) in Ethiopia

Nurhan Mawi, Kidest Hailu, Serkalem Moges

Introduction

Governance and leadership are crucial components of the health system building blocks, as identified by the World Health Organization (WHO, 2010), and are fundamental to the framework for high-quality health systems recently promoted (Kruk et al., 2018). In Ethiopia, health governance and leadership have been identified as key areas for health system strengthening in the national health policy (FDRE, 1993) and subsequently implemented the country's strategic plans (FDRE Ministry of Health, 1997; Federal Ministry of Health, 2015). To strengthen leadership and governance, the Ethiopian Ministry of Health has initiated various innovative and homegrown leadership capacity-building programs. One such initiative is the Leadership Incubation Program for Health (LIP-H), designed to incubate the next generation of leaders who can influence organizational culture, lead and manage transformational change in the health sector. The LIP-H launched on March 2019 by the ministry of health and regional health bureau heads. The program adopts a strategic approach involving targeted recruitment, leadership course delivery, coaching, reflective journaling, networking, shadowing, psychometric evaluation, and problem-solving projects over a period of six months.

Objective

The objective of this survey was to determine the whereabouts of LIP-H graduates, evaluate the impact of the program on their lives, and collect feedback on how to improve the training to better benefit the trainees and the health sector as a whole.

Methods:

An electronic survey questionnaire was developed, tested, and shared with 50 alums of the program.

Results: Out of 50 participants, 32 responded, of which 55.9% were male. All respondents agreed that the training program had a significant impact on their personal and self-leadership journey. 98% of respondents reported that the program improved their career/professional life, whereas 2% felt that the program did not influence their career growth because they did not receive any position change after completing the training. 81.3% of the respondents felt the program was highly effective in enhancing their knowledge, 48.3% of alums changed their positions after completing the training, whereas one respondent (1%) felt that the training program was not effective. The reason given was that they were in the same position and were unable to apply what they had learned. Other alumni replied that their organization did not understand the program, and that were underutilized. Further, trainees suggested having more face-to-face sessions rather than virtual ones.

Conclusion

The study showed that the training program positively impacted the trainees' self-leadership skills and performance in the workplace. However, the program also led to disappointment among some trainees who had high expectations of being promoted to a leadership position after completing the training. The implementation of the sustainability document and its follow up should be given due attention in order the program to sustain and produce as many pools of leaders as intended.

Recommendation

Program directors at the FMoH and its agencies (those holding positions) should join the program to bring visible and immediate change in the health sector. Institutionalizing the training program would ensure its sustainability.

EDITORS
(Prof. Getnet Mitike, Dr. Eskinder Wolka, Dr. Anteneh Zewdie, Tigist Astale)

PROOFREADERS
(Dr. Nahom Frew and Sarah-Louise Pasquino)

GRAPHIC DESIGN
(Dr. Nahom Frew)

IPHCE
International Institute for Primary Health Care - Ethiopia

Primary Health Care, With out exception.

International Institute for Primary Health Care- Ethiopia
Bole sub-city, Woreda 1, House number 2340
+251 - 703 88 74 28
info@iphce.org
www.iphce.org