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MINISTRY OF HEALTH - ETHIOPIA
የዜጎች ጤና ለሃገር ብልጽግና!
HEALTHIER CITIZENS FOR PROSPEROUS NATION!

GLOBAL FINANCING FACILITY

WORLD BANK GROUP
Health, Nutrition & Population

ETHIOPIA HEALTH PRIVATE SECTOR ASSESSMENT

October 2019

TABLE OF CONTENTS

ACRONYMS

AFDB	African Development Bank
ANC	Antenatal Care
CHAI	Clinton Health Access Initiative
EFDA	Ethiopian Food and Drug Agency
FP	Family Planning
MOH	Federal Ministry of Health
GDP	Gross Domestic Production
GFF	Global Financing Facility in Support of Every Woman Every Child
GFTAM	Global Funds to Fight AIDS, Tuberculosis and Malaria
GHE	Government Health Expenditures
GTP	Growth Transformation Plan
HA	Health Accounts
HEP	Health Extension Program
HERQA	Higher Education Relevance and Quality Agency
HIA	Health in Africa
HRH	Health Human Resources
HSDP-IV	Health Sector Development Plan IV
HSTP	Health Sector Transformation Plan
IBRD	International Bank of Reconstruction and Development
IDA	International Development Association
IFC	International Finance Corporation
MDGs	Millennium Development Goals
NCD	Non-communicable Disease
NGO	Non-governmental Organization
NHA	National Health Accounts
ORT	Oral Rehydration Therapy
OOP	Out-of-pocket
PFP	Private for Profit
PFSA	Procurement Fund and Supply Agency
PPD	Public private dialogue
Ppm	Public private mix
PPP	Public private partnership
RH	Reproductive Health
RHB	Regional Health Bureaus
RMNCAH-N	Reproductive, maternal, newborn, child, adolescent health and nutrition
PCV	Pneumococcal Conjugate Vaccine
PSA	Private Sector Assessment
SSA	Sub-Saharan African
TFR	Total Fertility Rate
THE	Total Health Expenditures
UHC	Universal Health Coverage
USAID	United States Agency for International Development
USD	United States Dollar
VAT	Value Added Tax
WBG	World Bank Group
WHO	World Health Organization
WDI	World Development Indicators

EXECUTIVE SUMMARY

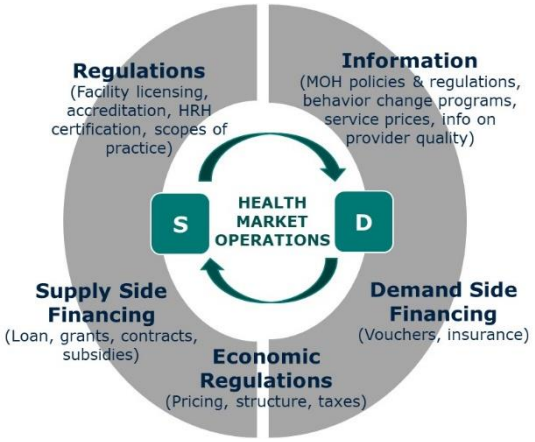
Background

The Global Financing Facility (GFF) in Support of Every Woman Every Child is a country driven partnership that aims to accelerate efforts to end preventable maternal, newborn, child and adolescent deaths and improve the health and quality of life of women, adolescents and children. The GFF is supporting the Ethiopian Federal Ministry of Health (MOH)'s efforts to collaborate with the private sector as a strategy to address health priorities and system gaps confronting the Ethiopian health sector. GFF agreed to support the MOH to conduct a private sector assessment (PSA) as a first step in a longer process to engage the private health sector. A PSA can play an instrumental role in generating sound data on the private health sector to guide MOH policy and planning and create a "road map" to harness private sector resources.

Methodology

The PSA team used a three-step process to carry out the assessment: **Plan => Analyze => Recommend**. In the plan phase, the PSA team engaged in a series of conversations with MOH to help shape the direction of the PSA according to national priorities and gaps and identify key public and private stakeholders as key informants. During the analyze phase, the team reviewed published and gray literature; conducted secondary analysis of past surveys including the past Ethiopia Demographic and Health surveys and Ethiopia Health Accounts; and supplemented them with stakeholder interviews. The team used an iterative process to triangulate the data from the three sources and vet the findings with MOH leadership. Moreover, the team used a health market systems approach (see box) to interpret the data and shape the recommendations. In the recommend phase, the PSA team presented actionable strategies to be vetted with MOH and private sector leaders, eventually creating the foundation for private sector engagement strategy and action plan. Key limitations of the PSA include: the time constraint, the inability to interview larger number of stakeholders such as those outside of Addis Ababa; and data gaps and challenges related to private sector data that must be interpreted with caution.

Health Market Systems Approach



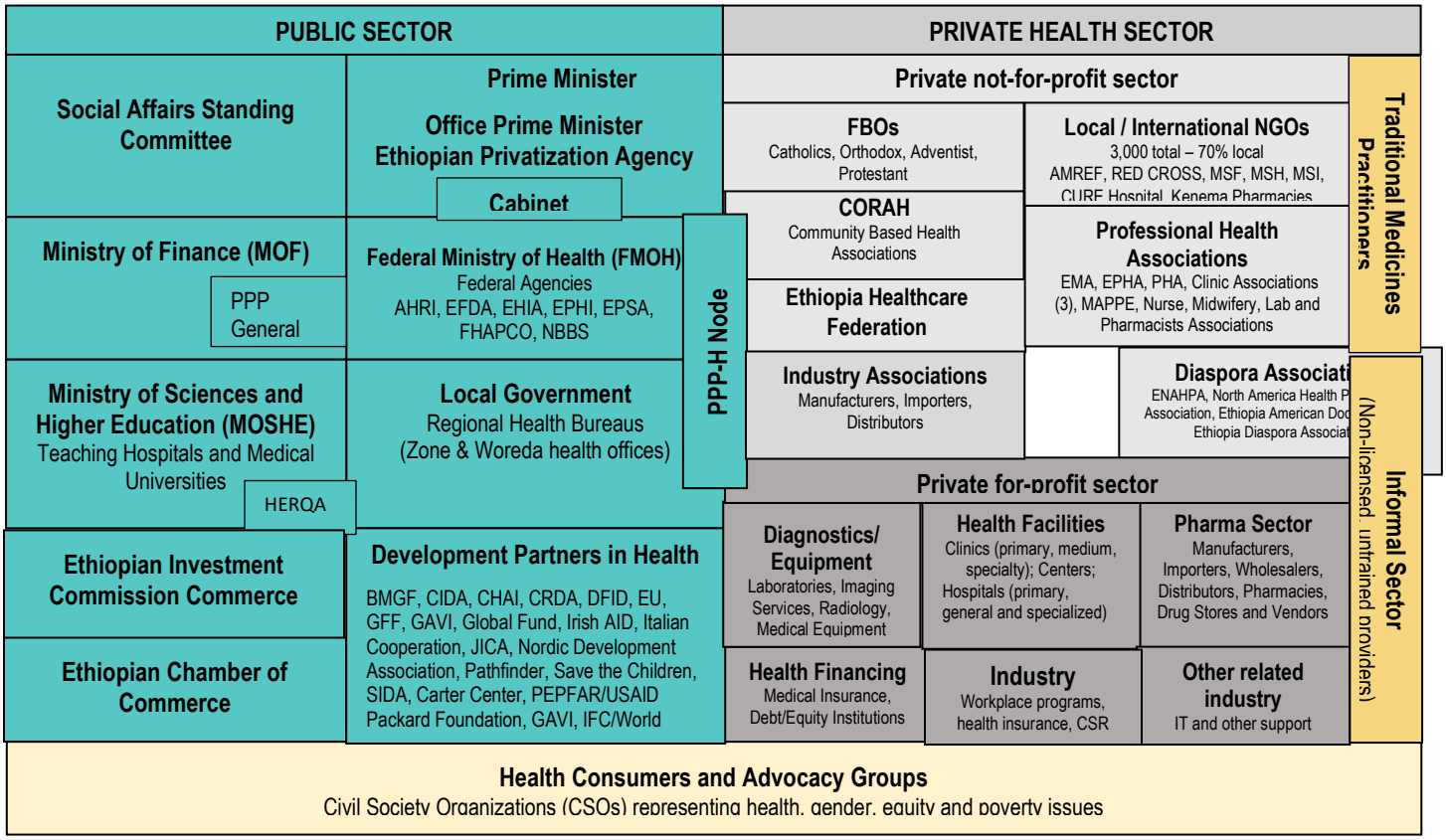
Ethiopian Health Sector Landscape

The PSA offers a new landscape of the health sector to demonstrate the wide range of actors – both domestic and international as well as state and non-state – that play an active role in health. Although not exhaustive, the new health sector landscape offers a more complex and nuanced perspective of the full range of actors that need to be involved when designing policies and plans to improve health. Key discoveries include:

- Although the MOH is the lead government agency responsible for health policies and regulation, there are other government entities, like the Ministry of Finance and the Prime Minister's Office that play an important role in health.
- Development Partners are a key player in health contributing an estimated 33% of total health expenditures.
- The private sector goes beyond health services and is engaged in a wide range of activities including medical training, commodity manufacturing and distribution, etc. that can be leveraged to complement MOH's initiatives in health.

- Health consumers are an important stakeholder in health and are engaged during strategic and annual planning processes.

Ethiopian Health Sector Landscape



Ethiopian Private Health Sector at a Glance

- The private health sector *owns and manages a wide range of health facilities* offering diverse health services and products.
- The private health sector *is present across all levels of care* in Ethiopia, ranging from primary level facilities such as private pharmacies and drug stores, non-government health facilities and civil society organizations, and primary clinics/medium clinics; to secondary level facilities including private for profit specialty clinics; to tertiary level facilities like non-government and private for profit hospitals and specialty centers.
- The Ethiopian private for-profit sector *serves mostly the high- and middle-income groups* in both urban and rural areas while the non-government organizations and charities, together with MOH, serve the working poor and poorer income groups mainly in rural areas.
- The private sector also serves the poor while the MOH heavily subsidizes the middle-and upper-income groups who can afford to pay for healthcare in the private sector.
- The Ethiopian private sector *is relatively small and fragmented* (approximately 20% of total market share) compared to other countries in the region (e.g. 46% in DRC and about 65% of all health facilities in Kenya are managed by Private sector).

Ethiopian Mixed Health Delivery System

The Ethiopia health sector is a mixed delivery health system composed of a diverse range of actors across the public and private sectors. A mixed health system is defined as a system in which publicly financed government health delivery co-exists with privately financed (mostly through out-of-pocket payments) market delivery (Nishtar, 2002). Below are key statistics on the public-private mix of key components of the Ethiopian health sector.

The public sector owns and manages most health facilities in Ethiopia – 3 out of 4.

Public-Private Mix of Health Infrastructure. The total number of public health facilities in Ethiopia has increased significantly between 2008 to 2017. Most the growth has been mainly in public health facilities. During the same time period, the private health sector expanded its health infrastructure but not at the same rate as the public sector.

- Of the more than 28,000 health facilities in Ethiopia, the public sector owns 3 out of 4 (MOH 73% compared to private for-profit and not-for-profit facilities combined- 27%).
- Growth in private sector health infrastructure has concentrated in primary clinics, medium clinics as well as retail pharmacies, drug stores and drug vendors.
- Distribution of both public and private health facilities is inequitable – the majority of public and private health facilities are concentrated in Oromia, South and Amhara regions.

Distribution of both public and private health facilities is inequitable, concentrated in Oromia, South and Amhara regions.

Ethiopia has a nascent pharmaceutical and manufacturing industry with growing private sector capacity.

- In 2016/17, the private sector owned all (75) manufacturing companies of which 11 are large scale.
- There is a growing – albeit small – number of private importers and wholesalers (384 and 489, respectively).
- Compared to potential demand given the population size and growth in income, Ethiopia has a small retail pharmacy market – only 3,327 retail pharmacies and 4,476 drug shops.

The private health sector plays a significant role in the pharmaceutical sector and owns most pharmacies and labs. Yet the retail pharmacy sector is small compared to potential demand.

Public-Private Mix of Human Resources in Health (HRH). There is limited data on HRH across both sectors. The data gap is more acute in the private sector - the MOH has not produced a report on private sector HRH since 2009 but is now trying to address this gap with new initiatives to include private sector HRH in a revised HRH development strategy. Moreover, there is a high percentage of under-reporting of private sector HRH due to the uncertain policy on dual practice and private wings as well as an important number of unlicensed health professionals produced largely by their reluctance to do the mandatory service time when assigned to rural areas that are not well-equipped. In many instances, these young professionals work informally in the private sector. Regulatory barriers also exist in absorption of privately trained HRH into public sector. Nevertheless, a staffing pattern between the sector has emerged from past data that is also confirmed with stakeholder interviews:

- The public sector employs the largest portion of HRH – almost 94%.

Private sector plays a major role in training of health professionals but there are challenges in licensing these institutes and certifying their

- The public sector employs the majority of all health cadres, particularly general practitioners and nurses.
- The private sector employs many specialists.

Public-Private Mix of Medical Training. The number and scope of private medical training institutes is unknown; few are licensed, and data collected is incomplete. The national regulatory body – Higher Education Relevance and Quality Agency – has struggled to keep pace with the recent and rapid expansion of privately-owned private medical training institutes in Ethiopia. Recent data shows:

- The private sector operates and manages nearly half of all medical training institutions although HERQA struggles to monitor the institutes' curriculum quality and graduate levels.
- The private medical training institutes focused mainly on training nurses, midwifes and allied health professionals.

The public sector in Ethiopia is the most important health care provider: 3 out 4 outpatient visits and 4 out of 5 inpatient visits take place in a public facility.

Public-Private Mix of Health Services. Examining health consumers' health seeking behavior is an approach to estimate demand for private health sector. Despite the extraordinary amount of data available on the Ethiopian health sector, there are inconsistent definitions of the private health sector nor do MOH reports disaggregate the data by source (between public and private and within private, private for profit, non-government organizations and faith-based organizations), making it difficult to estimate use of private health services. Despite the data limitations, demand for health services is on the rise - from 45% in 2008/09 to 62% in the 2014. The rapidly growing demand for health services underscores the challenges the MOH confronts and will continue to confront in trying to deliver accessible and quality health services without making an active effort in engaging the private health sector.

The private health sector serves all income groups – including the poor. A higher (27%) portion of wealthy consumers seek an outpatient consult compared to the poor (21%).

- Outpatient and inpatient services: The public sector is the most important health care provider in Ethiopia: 3 out 4 outpatient visits and 4 out of 5 inpatient visits take place in a public facility. When examining the type of private facility visited for inpatient services, private and non-government clinics are the main type of facility (86%) followed by hospital (9%) and pharmacies (5%).

  As expected, the highest income groups (Q4 and Q5) uses private and non-government healthcare providers at a higher rate (27% and 3%, respectively) compared to lowest income group (Q1 - 21% and Q2-2%) for out-patient services. Nevertheless, use of private healthcare and non-government providers is at comparable levels across all income groups,

Approximately the same level of wealthy and poor (1 out of 5) seek inpatient care in a private facility.

The government subsidizes a significant portion of health consumers who can afford to pay for healthcare in the private sector.

varying between 20% to 30%. Government health facilities heavily subsidize the highest income groups (Q3-80% and Q4-68%).

There is the same health seeking pattern for inpatient services. Most Ethiopians seek inpatient services at a government facility (71%) compared to a private one (for-profit 21% and non-government 5%). Of the 26% of health consumers who seek inpatient services with a private healthcare provider, most are admitted at a private (for-profit and non-government organization) clinic (64%) and hospital (36%).

When analyzing select maternal and child health services, the public sector is still the most significant healthcare provider.

When examining use of private sector facilities for inpatient care, the highest income group uses for-profit and non-government health facilities at a similar rate as the poorest income group (21% and 18%, respectively). Indeed, use of private facilities for inpatient services is at comparable rate for all income groups, varying between 16% to 27%. Government health facilities heavily subsidize the higher and highest income groups (Q3-71% and Q4-63%), almost at the same rate as the poorest (77%), even though higher income groups can afford to seek and pay for care for hospital care in the private sector.

On average, one out of four receive their maternal and child health care in a private facility. The rate is higher for diarrhea and/or fever: one out of three children are treated by a private provider

- Family Planning Services: Most Ethiopian women (84%) obtain their FP method in government facility while only 14% get their method in a private one. Of the women who obtained their modern FP method in a private facility, most (61%) attained the FP method in a clinic, followed by pharmacy (20%) and non-government facility (14%).

  The family planning market is appropriately segmented: more than one quarter (26%) of married women from the wealthiest income group (Q5) obtain their family planning method at a private facility while the public sector predominately serves lower income groups (Q1 and Q2 at approximately 92%). It is interesting to note that the private health sector also serves the poor– albeit at much lower rates that higher income groups (Q1 at 7%, Q2 at 4% and Q3 at 9%). Of note is the level of government subsidization of the wealthier income groups (Q4 at 91% and Q5 at 71%) who can afford to obtain their family planning services with a private health care provider.

Of those who see a private provider, pregnant women seek maternal care mostly at private hospitals while mothers with sick children seek treatment from frontline providers – pharmacists and drug sellers.

- Maternal health services: The private health sector delivers the full range of maternal health services: ante-natal care (ANC), delivery and post-partum.

  ANC: A low percentage (32%) of pregnant women completed the required four or more ANC visits yet this is a marked improvement from earlier rates (19%). One of out of ten women received their ANC with a private provider. These women visited a private hospital (36%), non-government facility (28%) or private clinic (36%).

The private sector serves all income groups including the poor. The poor rely more on public services compared to the wealthy.

As to be expected, more wealthy women seek care in a private facility approximately compared to poorer women. Approximately 15% of women from the wealthiest income group (Q5) obtain their ANC care at a private facility while the public sector predominately serves lower income groups (Q1 and Q2 at approximately 95%). It is interesting to note that the private health sector also serves the poor– albeit at much lower rates that higher income groups (Q1 Q2 and Q3 at around 3%).

But the FMOH subsidizes a significant proportion of wealthier households who can afford to pay for services in the private sector.

Delivery: According to the DHS 2016 data, only 26% of live births in Ethiopia were delivered by a skilled provider. This low portion of skilled deliveries explains why maternal mortality persists at 421 deaths per 100,000 live birth. Of the 26% of women who delivered in a facility, the majority delivered in a public one no matter the income group. The one out of five pregnant women who in a private facility went to a private hospital (68%), non-government facility (24%) and private clinic (12%).

Lower income mothers relied more on a public facility (Q1-75%, Q2-81% and Q3-78%). A much smaller percentage of women from these income groups delivered in a private one (less than 5%). A larger percentage of wealthier mothers (Q4-12% and Q5-14%) delivered in a private facility. The private health sector is an untapped resource to increase the number of skilled deliveries.

Moving wealthier income households to a private provider could free up scarce public resources to increase access for the poor.

- Child health services: Ethiopia has made major strides in reducing the infant and childhood mortality rates. Indeed, Ethiopia has achieved its Millennium Development Goal (MDG) to reduce the mortality rate for children under the age of five.

Diarrhea: Compared to other priority health services, there is greater use of the private sector to treat a child's diarrhea. Approximately one third (30%) of children received treatment at a private facility. Still, the public sector is the most important provider for diarrhea.

All income groups seek treatment for a child's diarrhea in a private facility, ranging from 25% in the lower income groups to as high as 40% in the highest. Treatment of diarrhea is an area in which the private sector can play a major role through local manufacturing of and expanded access ORT through private channels.

Fever/cough: Among children with fever, more than one third (33%) sought care with a private provider while the other two almost thirds (63%) visited a public provider. Once again, all income groups seek treatment of a child with fever. Moreover, the higher income groups treated their sick child with fever at a private facility (approximately 43%) as those with a sick child with diarrhea. The MOH could save resources by encouraging those who can afford to pay to seek treatment with a private provider.

Examples of Public Private Partnerships in Ethiopia. The MOH has a growing – albeit limited – experience in partnerships with the private health sector. The partnerships range from health service delivery, to management contracts, to outsourcing of non-clinical services. Stakeholder interviews show that:

- *Most of the partnerships are ad hoc, informal and often based on personal relationships* between the public and private sector partners. Faith-based organizations have long-standing service delivery partnerships with the MOH, but it is still mostly informal with a majority having no contract or MOU in place. And several non-government and civil society organizations have partnerships with the MOH to implement projects through informal agreements.
- *There is an increasing number of partnerships with the for-profit sector* to deliver TB, HIV and FP and more recently laboratory services. It is important to note that these recent partnerships are donor driven through specific health projects.
- There are barriers to expanding the number and type of public-private partnerships. *MOH lacks the tools and capacity to execute partnerships,* compounded by scarce and incomplete data on private sector size and capacity, insufficient number of MOH staff with the skills to design and manage complex PPPs, and no strategy linking partnership to HSTP priorities.
- *It is difficult to partner with private health sector.* Although increasingly organizing into professional and trade associations, the private sector is still fragmented and does not speak with "a common voice"; quality is inconsistent in private health sector; and negative perceptions and lack of trust linger between the two sectors.

FMOH has a growing – albeit limited – experience in partnerships with the private health sector to address these health priorities.

The general policy framework shows a growing government and FMOH interest in working with the private health sector.

The FMOH's attitude towards the private for-profit sector, has changed in the last five years.

The overall policy environment supports private sector engagement and public private partnerships.

Enabling Environment for the Private Sector

Opportunities

A review of the general policy framework shows a growing government as well as MOH interest in working with the private health sector. The first national health policy in 1993 mentioned the role of the private health sector. HSDP I-II Plans did not recognize a private sector role in health. HSDP IV and the HSTP 2015-2020, however, increasingly acknowledged the private health sector. Moreover, the 2015 Health Financing Strategy initiated private wings in public hospitals and other private sector projects. Subsequently, all plans - HSDP IV and HSTP - plans referenced the need to engage the private sector in health.

The MOH's attitude towards the private sector, mostly private for-profit sector, has changed in the last five years. The MOH aligned itself with the GOE's perspective on private sector after the 2015 Growth and Transformation Plan. The 2015 HSTP identified specific opportunities to partner with the private health sector. Moreover, the MOH develop a PPP Strategic Framework

aligned to the 2017 MOFEC PPP Proclamation that paved the way for more coordinated efforts and initiatives in engaging the private sector in health.

Challenges

Despite the favorable policy environment, there are several barriers preventing the private health sector from playing a larger, positive role in the Ethiopian health sector. Fortunately, there are several MOH initiatives underway to address several of them.

Market conditions present the biggest constraint to private sector growth and limits their ability to partner with the FMOH.

- *No overarching private sector engagement strategy.* Instead, there are ad hoc, diverse and at times, overlapping strategies to engage the private sector across the different MOH departments. Moreover, these strategies recommend engaging the private health sector but offer few details or implementation plans to operationalize the sector engagement.

There are limited economic and financial incentives to attract and retain private health businesses.

- *No common vision of key challenges in the health sector.* The public sector focused on challenges related to population's interests – access, quality, equity – while the private sector focused on the barriers as a healthcare business. The one area that both sectors agreed on is human resources for health (HRH) stating there is a shortage of trained and skilled health professionals in the sector.

There is still distrust between the public and private health sectors, but the suspicion is breaking down.

- *Data on the private sector data is highly unreliable.* Factors contributing to poor data quality include: i) inconsistent definition of "private" across ministry reports and across reporting time periods, ii) Challenges in implementation and interpretation of the 2012 facility standards; iii) data is not centralized with uneven reporting from the regional health bureaus and woreda health offices; iv) data is incomplete on key segments of the private sector – particularly the private supply chain actors; and iv) data is out-of-date with gaps on private sector HRH since 2009. Moreover, the private sector routinely underreports because of various reasons that are mostly to do with building trust and dialogue. MOH.

Both sectors have limited experience in public private dialogue but a strong commitment to strengthen communication and improve relations.

- *Weak (but improving) regulatory framework and implementation.* The overall regulatory framework is out-of-date and contains many barriers to growing and harnessing the private health sector. Contributing factors include challenges in political commitment and decision-making as well as policy gaps in the areas of facility licensing, HRH certification and licensing, dual practice, private medical training institutes accreditation, and PPP authority and capacity. There are, however, several regulatory review processes underway to address some but not all barriers.

The FMOH has several initiatives underway to address the policy constraints and market conditions as well as improve public private engagement

- *Poor market conditions limit private health sector opportunities*. In addition to delivering health services, private providers are also businesses. They face the same challenges that other businesses do when operating in the Ethiopian economy. The key

market barriers health businesses confront include: i) limited access to capital creates barrier to market entry, dampens growth and limits expansion of existing businesses; ii) high cost to purchase key inputs to comply with quality standards; iii) no tax "relief" for private healthcare businesses delivering healthcare to the poor; iv) land and rent costs are significant barriers to entry to market as well as expansion; vi) unlevel playing field and competition with public health sector, and vii) lack of trained and skilled health professionals as well as the salaries representing an expensive input cost.

- *Limited government incentives to attract more private sector providers.* The MOH has limited financial and economic incentives in place, such as services contracts, voucher payments for priority health services and national health insurance to name a few. The MOH, however, is slowly rolling out these types of incentives but the private sector would like government to scale up and expand them.
- *Lack of trust due to limited engagement but promising initiatives.* Both public and private stakeholders interviewed expressed a strong desire to move beyond mistrust and suspicion and to improve the relations but there are several barriers: i) limited capacity of existing mechanism(s) as a platform for public private dialogue; ii) private sector consultation is irregular, infrequent and ad hoc; iii) private health is fragmented representing diverse perspectives; and iv) prejudicial perceptions of each other.

Recommendations to Engage the Private Health Sector

The PSA team drafted potential recommendations based on the preliminary PSA findings with several caveats. More time is needed to: i) further develop the proposed strategies and create comparable detail; ii) to link health financing strategy to private sector initiatives; iii) better integrate many of the "stand-alone" strategies; and iv) fully vet and prioritize the strategies with MOH and private sector stakeholders. As a result, the current draft recommendations are a work in progress and should not be interpreted as "setting the course". The recommendations center on the six strategic directions.

Strategy #1: Strengthen data collection, analysis and reporting on private health sector

There are four initiatives to strengthen data and reporting on the private health sector: 1) Assess MOH reports to integrate private sector data in decision-making; 2) Identify and conduct additional research as needed; 3) Incentivize private sector to report; and 4) Include the private sector in data analysis and dissemination of MOH reports.

Strategy #2: Improve the regulatory systems governing to private health sector

The MOH has an opportunity to modernize its systems and "leapfrog" into the 21st system by creating a web-based platform with interoperability between different regulatory functions by: i) creating a state-of-the-art

web-based platform, ii) introducing and rolling out the licensing platform to all health facilities and health professionals, and iii) building MOH's capacity to use the licensing platform as a management tool. In addition to the licensing platform, the MOH should invest in its capacity (e.g. staffing, transport, etc.) to implement the minimum quality requirements, streamline the processes by which to certify minimum safety and quality and follow through with joint supervision of private health facilities (including retail pharmacies, drug shops, diagnostic centers),. Once again, the MOH can create a web-based platform to introduce the quality standards and tool.

Strategy #3: Foster dialogue between the public and private health sectors

Establishing trust between the public and private sectors is a precondition for successful partnerships. Steps to foster public private dialogue (PPD) include: 1) establishing a platform to provide the structure for the public-private dialogue; 2) carrying out one to two joint activities together to establish the "practice" of collaboration; 3) building public and private members' capacity to effectively dialogue; 4) strengthening public and private stakeholders' capacity to carry out policy analysis to inform dialogue process / activities; and 5) supporting the private sector to organize itself so they can "speak with one voice".

Strategy #4: Integrate private health sector representatives in policy and planning processes

Experience shows that integrating different stakeholder perspectives into the policy and planning processes fosters buy-in and increases the likelihood of successful implementation. The MOH can take several steps to gradually integrate key private sector stakeholders into its routine policy and planning process: 1) MOH maps full range of planning exercises at national and woreda levels to identify strategic opportunities to integrate private health sector in policy and planning processes; 2) strengthen the PCD's capacity to lead public-private coordination and collaboration; 3) identify "PPP coordination" focal person in key districts with a significant percentage of private sector to implement the coordination guidelines; 4) coordinate and involve the private sector in dissemination of policy reforms and strategic plans.

Strategy #5: Support the PCD to become the "hub" for all MOH private sector activities

The MOH currently has the Partnership and Coordination Directorate (PCD) that leads most PPP and private sector activities work for the ministry. The proposed strategies will require MOH to: 1) hire more staff and building their capacity to carry out their roles and responsibilities; 2) invest in building the Unit's organization and operating systems; 3) build other MOH staff knowledge on private sector and capacity in private sector engagement; and 4) mentor the Unit's staff to design/implement first generation of H/PPPs.

Strategy #6: Grow and harness the private sector role in health sector

The PSA identified several barriers to private sector growth which the MOH needs to address if they want to grow and harness the private sector. Actions include: 1) establishing a working group comprised of public and private sector leaders to co-develop a private sector engagement strategy that will inform the next five-year HSTP; 2) establishing another working group to identify and prioritize economic and other regulatory constraints to private sector growth and develop an action plan to address these barriers; and 3) identifying, in collaboration with private sector umbrella organization, one to two realistic partnerships one to two feasible projects to demonstrate the benefits partnerships.

The PSA team proposed an ambitious agenda for the MOH and private health sector and suggests sequencing and timing their implementation over the next five years. The recommendations are organized by "quick wins" in the next six months, "low hanging fruit" requiring more time two to three years and "long-term gains" building on the foundation created by the reforms and new capacity developed in the prior years. Once again, the prioritization and sequencing need to be vetted with the MOH and private sector stakeholders.

1. Background to Ethiopia Private Sector Assessment

1.1. Global Finance Facility and the Private Health Sector

The Global Financing Facility (GFF) in Support of Every Woman Every Child is a country driven partnership that aims to accelerate efforts to end preventable maternal, newborn, child and adolescent deaths and improve the health and quality of life of women, adolescents and children, and thereby prevent up to 3.8 million maternal deaths, 101 million child deaths, and 21 million stillbirths in high burden countries by 2030. The GFF seeks to support countries with an integrated health system approach that looks for the best solutions for better reproductive, maternal, newborn, child, adolescent health and nutrition (RMNCAH-N) outcomes.

The GFF acts as a pathfinder in a new era of financing for development by pioneering a model that shifts away from focusing solely on official development assistance to an approach that combines external support, domestic financing, and innovative sources for resource mobilization and delivery (including the private sector) in a synergistic way. To do this, the GFF aims to reduce inefficiency in health spending through smarter financing, resulting in a reduction in the resource needs for RMNCAH-N by 2030. The GFF also aims to mobilize additional funding through the combination of grants from a dedicated multi-donor trust fund (the GFF Trust Fund), financing from International Development Association (IDA) and International Bank of Reconstruction and Development (IBRD), and crowding-in of additional domestic and external resources. The GFF also leverages the private sector expertise of the International Finance Corporation (IFC), the World Bank Group's (WBG) private sector arm, to attract private sector resources to priority investment areas.

The current situation in Ethiopia provides an opportunity for the GFF, together with the World Bank Group, to support the government with private sector analytics and capacity building to enable greater engagement with private sector to deliver RMNCAH-N services and products. Discussions between the World Bank Group and the Federal Ministry of Health (MOH) have agreed that the GFF will support two main areas of private sector work:

1) Analysis of the private sector's current role in Ethiopia's health system and exploration of possible partnership opportunities to strengthen RMNCAH-N services and products; and,
2) Capacity building of MOH to engage the private health sector, including strengthening the Public Private Partnership (PPP) Unit's capacity to engage and partner with the private health sector in line with best practices.

GFF's work complements other World Bank initiatives supporting the private health sector's ability to support national health objectives including the Health in Africa (HIA) team's current public-private dialogue (PPD) work to create the Ethiopia Private Sector umbrella association as well as World Bank Health Population Nutrition's efforts to strengthen and build the Ethiopian pharmaceutical regulatory agency, the Ethiopian Food and Drug Agency's (EFDA) capacity.

1.2. Rationale for PSA

A PSA team conducted interviews with public and private stakeholders that revealed several challenges preventing effective dialogue and collaboration with the private health sector. Key among them are:

- *Limited government understanding of who the private health sector is in Ethiopia.* Several factors contributing to lack of knowledge on the size and scope of the private sector included: inconsistent or incomplete data collection; underreporting by the private sector; and limited capacity to interpret and apply data to policy and planning.
- *Limited private sector understanding of government priorities.* The private sector representatives interviewed stressed that they have little access to information from the MOH. They struggle to learn about updates and/or revisions on regulations, MOH strategic plans and policies. In fact, very few private and government stakeholders, until recently, had heard of the formed Partnership and Coordination Directorate (PCD).

- *Limited interactions between sectors.* A common theme is the lack of "institutionalized" dialogue or absent mechanisms to bring together the sectors in a representative way. Few private sector representatives have consistent and regular access to the MOH except through personal contacts. Few MOH officials interact with the private sector because it remains diverse, fragmented and difficult to know who represent the private sector perspective.
- *Policy barriers to private sector growth.* Aside from the common policy issues found in Sub-Saharan African (SSA) health sector (e.g. unleveled playing field, high Value Added Tax (VAT) taxes on medical equipment, blame game and misunderstanding of profit), the private sector representatives mentioned the recent revisions in facility standards and licensing of health professional categories has created challenges (e.g. difficult for private sector owners to compare their facility categories with those in the public sector; difficult for MOH to implement fairly and consistently between public and private sectors).

Subsequently, the GFF in partnership with the MOH, agreed to conduct a private sector assessment (PSA) as a first step in a longer process to address some of the challenges revealed during the stakeholder interviews. As Table 1.1 indicates, the PSA can play an instrumental role in generating sound data on the private health sector to inform government and donor programming, guide MOH policy and planning, and design a "blue print" to harness private sector resources and potential to help Ethiopia overcome challenges confronting RMNCAH-N.

Table 1.1 Rationale of Conducting a Private Sector Assessment in Ethiopia

- To generate and consolidate data on private sector activities into a single document facilitate government planning
- To develop a comprehensive understanding of the private sector contribution throughout the entire Ethiopian health system
- To provide evidence on the private sector to inform public-private dialogue efforts
- To propose a road map to harness the private sector potential to address RMNCAH-N challenges

1.3. Target Audience and Use of PSA

The Ethiopian PSA is designed to address the information gaps that both public and private health stakeholder groups face when analyzing the health sector, attempting to overcome many of the myths and misunderstandings perpetuated by the lack of evidence. Moreover, the PSA will provide data on private sector capacity and interest in forming partnerships that will accelerate access to RMNCAH-N challenges. The PSA provides a "snapshot" in time and should, over time, be conducted on a regular basis to inform policy dialogue and reforms and to measure the evolving role of the private health sector and their contribution to the Ethiopian health sector.

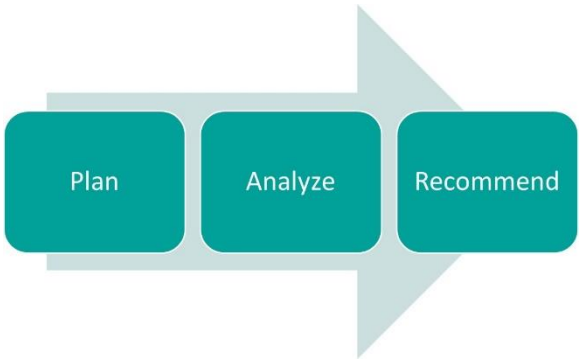
1.4. Methodology

Due to time and resource constraints, the PSA team modified the comprehensive, lengthy approach developed by the United States Agency for International Development (USAID) called "Assessment to Action" (Source: http ://assessment-action.net/). Instead, the PSA team carried out a three-step process described below (see Figure 1.2) covering the time period of September 2018 to February 2019.

Step 1: Plan

The first task of the planning process entailed ***defining the parameters*** of the PSA. The PSA team conducted a series of conversations with the MOH to shape the direction of the PSA. The PSA scope covers: i) Ethiopia health priorities and health system gaps, ii) size and range of private sector actor and activities in the Ethiopia health sector, iii) policy environment and market conditions supporting/ challenging the private health sector, and iv) policy reforms and partnership opportunities.

Figure 1.2 Private Sector Assessment Process



The second task involved working with the WBG team and MOH staff to ***identify key private and public stakeholders influential in the health sector*** to become key informants for the PSA. In addition, this group identified and ***collected key documents and literature*** to be considered during the analysis phase.
These stakeholders played a critical role in the analysis by sharing their perspective, insights, and concerns about the private health sector, market conditions and potential partnership and investment areas.

Step 2: Analyze

There are two processes by which to ***collect data***: 1) desk review and 2) key informant interviews. To better understand the current political, economic, and social landscape in Ethiopia, the PSA team began with a literature review of gray literature (i.e. unpublished reports and government materials), published key policy documents, and previous studies on the private health sector and public-private partnership (PPP) arrangements in Ethiopia. In addition, the PSA team conducted a secondary analysis of past surveys – including the past Ethiopia Demographic and Health Surveys (EDHS, 2016), Health Service Provision Assessment (SPA 2015) and Ethiopia Health Accounts (HA I, II, III, IV, V and VI) report.

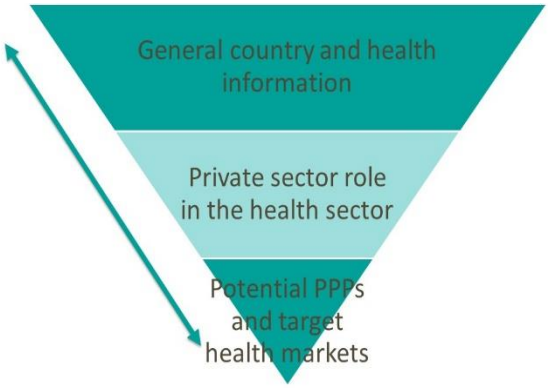
While reviewing the literature, the PSA team also conducted stakeholder interviews to fill in the information gaps and to gauge stakeholders' interest in and willingness to engage in public-private dialogue (PPD). The PSA team developed interview guides targeted to each stakeholder group (see Annex 1 for an overview of the interview objectives) interviewed over 20 public and private stakeholders as well development partners engaged in the Ethiopian health sector (see Table 1.2).

Table 1.2 Overview of Key Informant Interviews

Government Stakeholders	Private Sector Stakeholders	Donor Stakeholders
MOH ▪ Policy and Planning Directorate ▪ Ethiopian Health Insurance Agency ▪ Coordination and Partnership Directorate ▪ Medical Services General Directorate ▪ Health infrastructure Directorate ▪ Health and Health Related Institution Regulation Directorate ▪ Health professional Licensing and Competency Assessment Directorate ▪ Human Resource Development Directorate ▪ Pharmaceutical and Medical Equipment Directorate ▪ Health Information Technology Directorate	Private Sector Facility Associations ▪ Private Hospital Association ▪ Clinics Association ▪ Pharmacies ▪ Diagnostic and Lab Services ▪ Pharmaceutical manufacturers ▪ Wholesalers/Importers ▪ Non-government/faith-based organizations Professional Providers and Professional Health Associations ▪ Nurses ▪ Doctors ▪ Midwives ▪ Pharmacists	▪ AFDB ▪ CHAI ▪ GFF ▪ UNFPA ▪ USAID ▪ World Bank Group ▪ WHO

The PSA team ***analyzed the data and validated the findings*** concurrently with data collection. As Figure 1.3 shows, the process by which to collect and analyze the data is iterative and layered that drills down from general information on Ethiopia to more specific information on partnership opportunities in target health markets. The PSA team also shared preliminary analysis with MOH leadership in a Senior Staff Meeting in December 2018 and vetted the initial findings with the public and private sectors at the January 2019 workshop.

Figure 1.3 Iterative Data Collection and Analysis Process



Step 3: Recommend

The PSA team also formed actionable recommendations based on the PSA findings and used the consultative meetings with the MOH leadership, public and private sector stakeholders to vet and prioritize the recommendations. After the consultative phase, the GFF finalized the PSA report which was approved by the MOH in 2019.

Table 1.3 provides an overview of the time frame and steps to finalize the PSA report.

Table 1.3 PSA time frame

2018				2019	
Sept	Oct 2018	Nov	Dec	Jan	Feb
▪ Finalized SOW ▪ Identified stakeholders	▪ Collected data ▪ Conducted secondary analysis	▪ Reviewed literature ▪ Conducted stake-holder interviews	▪ Conducted stake-holder interviews ▪ Shared findings with MOH ▪ Drafted PSA report	▪ Vetted findings with public and private stakeholders	▪ Vetted policy recommendations and partnership ideas ▪ Finalized PSA report

1.5. Limitations

Due to the time constraint, the PSA team was unable to interview a larger number of public and private sector holders, including gathering the perspective of regional stakeholders outside of Addis. The attitude and perspective, therefore, only reflect those of public and private stakeholders at the federal level.

Also, the PSA analysis uncovered key data gaps and challenges, especially on the data related to the private health sector, thus the data presented in the PSA must be interpreted with some caution. Data challenges stem from the fact that there was no consistent definition of "private sector" across ministry reports and the implementation of the 2012 facility standards has been arduous, especially in the initial years of its introduction facing significant resistance from both public and private sector facilities, but today showing significant improvement in ease of licensing and regulatory oversight In addition, Regional Health Bureaus (RHB) and Woreda Health Offices continue to differently interpret the 2012 facility standards, creating inconsistencies in the private sector facility data).

Another factor contributing to the data challenges is the decentralized nature of data collection, resulting in incomplete and inaccurate data on number of private sector facilities and human resources in health (HRH). Data, especially on private facilities (but also to some extent on public facilities), is incomplete and out-of-date because RHB and Woreda Offices do not aggregate and regularly report this information to the Federal level. Data on lower level facilities such as clinics and pharmacies and public labs and pharmacies is incomplete.

To address these data gaps, the PSA team worked with the relevant MOH departments but was unable to rectify the problems to create a "clean" baseline of data on the private health sector that can be used going forward. The MOH acknowledges the challenges and discrepancies related to private sector and has initiated strategies to address some of the data gaps. More importantly, however, the MOH departments worked with the PSA team to shape the PSA recommendations aimed at improving data collection and use in government policy and planning.

1.6. PSA Framework – A Health Market Systems Approach

A health market is the interaction between a healthcare provider and a health consumer.

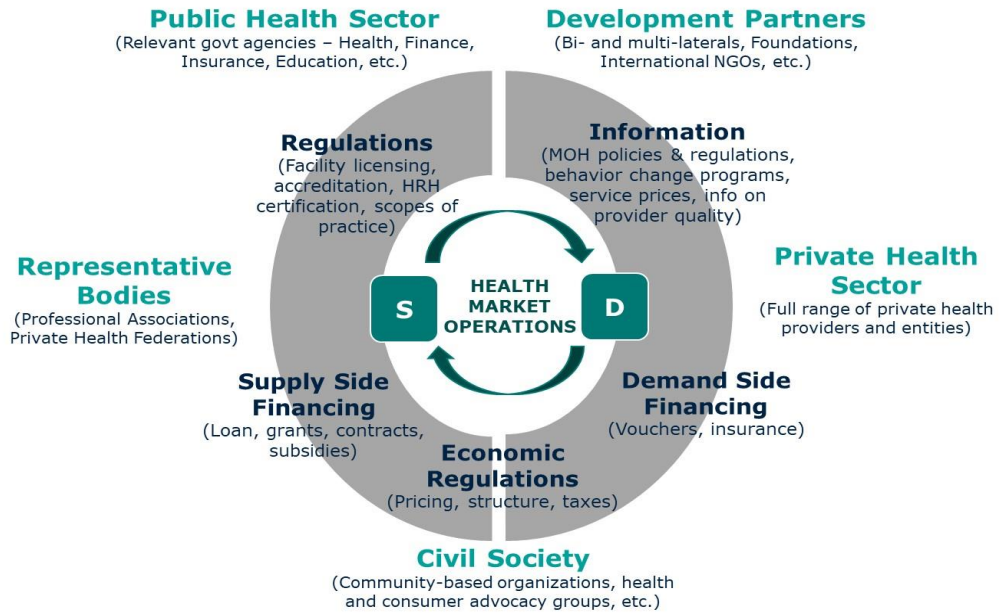
The PSA team applied a health market systems framework to analyze the data collected and present the PSA findings. This approach focuses on market systems that support a specific health market. As Figure 1.4 illustrates, there is an entire system that support the interaction between buyers and sellers of health. A market system is comprised of multiple actors (government agencies, development partners, private sector and representative organizations as well civil society) who carry out numerous functions and use different "policy levers" or "tools of government" (both formal and informal) to shape market operations. The market-based analytical framework defines the specific health market and its corresponding market actors, and examines the systems – policies, market conditions, institutional arrangements – that influence a market's operations.

Supply and demand: At the core of a health market systems is a health market. A health market provides a space for consumers and suppliers to come together to carry out a transaction – referred to as market operations. As the text box illustrates, there are different "buyers" and "sellers" depending on the type of health

market. There are, however, several types of health markets in the health sector, e.g. retail pharmacy market, acute care market, etc.

Market actors: In each health market, the buyers and suppliers change as do the market actors supporting the

Figure 1.4: Health Market System Analytical Framework



market system. In a health market systems approach, the main categories of actors in health are government, the private sector and their representative bodies, and civil society representing consumer and marginal populations. A health market system analysis examines the full range of actors related to the specific market under consideration.

- In a health market system, the government – particularly a Ministry of Health (MOH) – plays a central role in "setting the rules" (stewards) given the complexity of delivering health services and products. As Section 3.1 shows, there are also other government agencies, such as Finance, Education and Local Government, that play an important role in Ethiopia's health sector and depending on the health market, can also influence it. Moreover, a MOH not only sets the rules (regulate) but also delivers health services, making it difficult to create a level playing field for non-state healthcare providers and entities.
- International donor agencies working in health have become market players by contributing significant funds to MOHs to finance health. As Section 6.3 illustrates, development partners support more than a third (35.6%) of total health expenditures in Ethiopia. Heavy reliance on donor funds and grants can dampen competition and "crowded-out" the PFP health sector in specific health markets. For example, flooding markets with free condoms and other family methods can discourage importers and pharmacies from purchasing these health products and free ARVs through the public sector can deter private providers from delivering HIV/AIDS care and treatment.
- A hallmark – and complicating factor – of a health sector in a developing country is the diversity of private sector in both the private-for-profit (PFP) and private not-for-profit (PNFP) sectors, and the diverse range of private health operations (e.g., multiple levels of hospitals, diagnostics and laboratories, pharmaceutical production, supply and distribution, medical training, etc.). Ethiopia also has a diverse, albeit nascent private health sector as illustrated by the description of the private health sector in Section 3.2.

- Additional challenges arise when trying to organize the market, with a fragmented and disorganized private health sector, weak representative bodies, and nascent membership organizations. Section 5.2 describes the challenge facing Ethiopian private sector associations.
- Civil society organizations can play two functions in a health market system – delivery of support health services like health education and information and advocacy with the government on behalf of health consumers and under-represented group. In the case of Ethiopia, there are few health consumer advocacy groups but a growing number of community-based organizations.

Tools of Government: Governments play a critical role in ensuring access, affordability and quality of health services for their citizens. A MOH has several policy tools and instruments at their disposal to achieve these sector goals. Below is a description of the wide range of tools available to shape demand and supply. There are several global and regional examples in Sections 4, 5 and 6 of how other countries have applied specific tools of government to shape priority health markets.

Supply

- Information is another important tool government can use to influence supply. Information asymmetry is a common factor contributing to a health market failure and underperformance. Many developing country MOHs are still reluctant to share information with the private sector – particularly the PFP sector. Mistrust between the public and private sectors, as well as suspicion and misunderstanding of the profit motive, still linger among policymakers. Limited access to information on government health priorities, epidemiological trends and socioeconomic profiles of underserved population groups, restricts the PFP and PNFP sectors' ability to gauge market potential and prevents them from aligning their respective activities to help address public health goals. It is important to note that private health sector actors are also distrustful and reluctant to share information with government for fear that they will be subject to more taxes and fees or possibly closed due to non-compliance.
- Regulations governing who can deliver what service and products, under what conditions play a critical role in shaping supply. These social regulations (facility licensing and accreditation, professional certification, and continuing medical education and relicensing) greatly improve quality, but also influence supply in a health market. To comply with these rules requires a level of advanced training (medical/health-related), correctly setting a high barrier to entry into a health market. Moreover, poorly-enforced rules on quality disproportionately affects the private health sector as quality – aside from price – is the most important factor to distinguish formal, licensed private providers from the growing number of unlicensed health professionals.
- In recent years, developing country governments are implementing social health insurance and service contracts to deliver specific health services or specialty care, and to perform non-clinical (e.g. waste management, catering, security, etc.) functions. These supply-side financing tools help "crowd" in market actors like the private health sector that may have not supplied these services in this space before. Others supply-side financing tools include loans and grants.

  Several international agencies have pumped large amounts of money and resources (including free commodities, equipment and supporting staff) into specific health markets driven by their agendas (e.g. HIV/AIDS, malaria, child health). When applied with little regard for the market dynamics, this form of financing and subsidies – also supply-side financing - can distort the market and "crowd" out the private health sector.
- There are several economic regulations that influence market operations. These include pricing policies, tax policy, land access, etc. MOHs often "cap" or limit mark-up, profit margins and consultation fees with the goal of making healthcare services more affordable to the consumer, but these regulations may instead "crowd" out providers and suppliers from the marketplace. Similarly, governments provide tax relief for key economic sectors (e.g. technology, extractive) to encourage growth, but often overlook similar tax strategies to grow the

private health sector. Reducing import taxes on materials and inputs as well as drugs and medical devices are effective levers to stimulate new entrants into manufacturing and/or imports.

Demand

- Direct free provision of health goods and services, cash grants and subsidies are all common financing tools utilized in the health sector. These demand-side financing tools can stimulate demand in a specific health market – for example, vouchers for maternity services.

- Information asymmetry also affects demand. Few developing country MOHs publish data on qualifications of healthcare providers and/or rank quality of public and private health facilities so consumers can make informed choices. Moreover, there is limited public information on prices so that health consumers can compare cost with quality among different healthcare providers and medicines when selecting a provider.

- In addition to the tools of government, a health market systems analysis examines the government and other market actor's capacity to implement and/or comply with the rules and regulations. In many instances, MOHs in developing countries do not have the systems and capacity to enforce the social regulations. MOHs tend to underfund these departments and only have resources to haphazardly apply these regulations to private healthcare entities. As a result, the private health sector remains mostly unregulated with a sizeable informal, illegal health sector. Any market analysis needs to consider the impact of poor regulatory enforcement and how to address competition created by unlicensed health professionals.

- In other cases, few developing country MOHs have the data and skills needed to effectively regulate the PFP health sector. For example, most developing country MOHs do not collect data on the size and scope of private sector activities and are unaware of or do not acknowledge the private sector's contribution in health. Moreover, MOH staff are often selected for their medical background and may lack skills or training to understand how health markets operate and how to shape them. Economic and financing skills to introduce subsidies and/or grants to not distort health markets are also limited. Institutional arrangements and staff capacity to implement sophisticated government functions, such as strategic purchasing and contracting, are in short supply.

- Finally, the conditions may not be favorable. Few developing country MOHs have mechanisms and skills to engage and collaborate with non-state health actors. Private sector organizations, their representative bodies, and membership organizations are often excluded from health policy and planning due to persistent mistrust and suspicion between the public and private sectors. In many cases, developing countries' MOHs implement health reforms that directly affect the private sector without understanding a policy's potential negative impact. Governments do not actively engage the private sector on a regular basis to implement policies and reforms and miss strategic opportunities to harness private sector resources and expertise. Understanding the "state" of public-private relations and the strength of the mechanisms used to foster dialogue and collaboration are critical components in a market systems analysis.

1.7. Organization of PSA

The PSA report is organized into six sections.

- **Section 1** introduces the PSA, giving its scope, objectives, and methodology.
- **Section 2** gives a general description of Ethiopia's socio-economic indicators, health priorities and system gaps and health financing challenges.
- **Section 3** offers a new perspective on the landscape of public and private stakeholder in the Ethiopian health system and presents data on the overall size and scope of the private sector in key building blocks in health.
- **Section 4** presents data on the private sector's contribution to in- and out-patient service as well as delivering key RMNCAH-N services.

- **Section 5** analyzes the environment supporting, or some case, challenging the private health sector and covers Ethiopia's economic development policies, health sector policies and plans, market conditions and public-private sector working relations
- **Section 6** concludes with policy recommendations to reform critical policy barriers preventing the private health sector to play a greater role in RMNCAH-N services and products and proposed potential private sector partnerships to expand access and quality of RMNCAH-N through the private health sector.

2. Ethiopia Overview

Section two sets the stage for the PSA by presenting an overview of the socio-economic and health trends in Ethiopia and benchmarking them with Sub-Saharan Africa (SSA) to provide perspective. As the data shows, Ethiopia, with second largest population in the region, has experienced remarkable and sustained economic growth (highest in the region) that masks great income disparities in purchasing power (lower than regional average). The majority of Ethiopia's population (~80%) reside in rural areas compare to SSA (62%). Overall, Ethiopia's health and mortality indicators – except for maternal mortality – compare favorably with those in SSA but are still too high compared to the Government of Ethiopia (GOE)'s MDG targets.

The Ethiopian economy grew at a remarkable rate of 10.8%-one of the highest in the region.

2.1. Ethiopia Socio-Economic Indicators

The Ethiopian economy grew at a remarkable annual average rate of 10.8% in the past thirteen years- one of the highest in the region (See Table 2.1-Africa GDP growth average is ~3%). Ethiopia's location in the horn of Africa, with proximity to Middle East and other markets, offers the country economic opportunity for continued growth. Although landlocked for many years, recent peace with Eritrea gives Ethiopia strategic access to ports as alternative to Djibouti's main port. Much of Ethiopia's economic growth in the last decade can be attributed to agriculture, rural development, infrastructure and service industries on the supply-side while private consumption and public investment explain the demand-side growth.

Ethiopia's economic growth has not yet translated into prosperity for all.

The Ethiopian government's second growth transformation plan (GTPII-2015/16 – 2019/20) strives to accelerate and sustain economic growth to "*reach the level of lower middle-income countries by 2025 and middle-income by 2035".* GTP II continues to focus on expanding physical infrastructure through public investments and to transform the country into a manufacturing hub. To reach these ambitious goals, however, the government needs to strengthen its governance and the country's competitiveness by encouraging private sector participation (very underdeveloped currently and limits the country in many ways) through foreign investments and significant job creation to sustain growth (Ethiopia Growth and Transformation Plan II and Ministry of Health, Addis Ababa 2016: Investment Process in Ethiopia's Health Sector).

Rapidly growing and young population will stress the government's capacity to deliver needed services and to benefit from the demographic dividend.

Ethiopia's economic growth has not yet translated into prosperity for all. Ethiopian's per capita GDP increased from USD$794 in 2015/16. Although Ethiopia has a notably higher purchasing power compared to its regional neighbors (USD $456 for Tanzania or USD $435 for Uganda), it is still lower than the SSA average (USD $1,900). The higher GDP per capita masks great income inequities among the population:

in 2015, 36.8% of the population continue to live under $1 USD per day. Ethiopia's population remains very rural with one metropolitan and no secondary urban market.

Ethiopia's young and growing population will strain the government's ability to achieve its economic goals (See Table 2.1 for all the data in this section). Ethiopia is the second largest country in Africa, with a total population of 105 million 2017. At an annual growth rate of 2.5% annually, Ethiopia's population will double in less than 28 years. Ethiopia's population growth rate, although high, is comparable to the Sub-Sahara Africa (SSA) levels at 2.7%. Ethiopia is like most SSA countries with a young population – 40.6% of SSA population is under the age of 15 years. Approximately 40% of Ethiopia's population is under 15 years with a median age of 18.2 years, creating enormous demand on the government's ability to provide housing, education, health and meaningful employment for this population group. Although becoming more urban, globally connected and industrialized, Ethiopia remains a very rural population (~80%), with low literacy levels (49% total; gender gap of 42% women compared to 69% men).

To harmonize economic goals with those in social sector, the Ethiopian government has integrated the Sustainable Development Goals (SDG) into the national midterm plan (the Second Growth and Transformation Plan (GTP II)) and the SDG strategies are being implemented across the nation as of fiscal year 2015/16. Alignment between these two government policies will assure that economic growth will "not leave anyone behind" and encourage the government to invest in its people.

Table 2.1 Ethiopia and Sub-Saharan Africa Socio-Economic Indicators

Ethiopia	Number	Year of Data and Source	Average Value in Africa or Sub-Saharan Africa (SSA) and (Year of Data)
GDP growth (annual %)	10.2%	2017- WDI	SSA- 3.0% SSA (2019 Economic outlook) Africa - 3.1% (2015) *Ref: World Statistics Pocket book 2017*
GDP Per Capita ($US/per capita)	$767.6 USD	2017-World Bank and OECD National Accounts data.	Africa -$1,914.4 (2015) *Ref: World Statistics Pocket book 2017*
Total Population Size	104.96 Million	2017 – World Development Indicators (WDI)	Africa – 1,256,268,000 (est. 2017) SSA: 1,022,664,000 (est. 2017) *Ref: World Statistics Pocket book 2017*
Population Growth % (Annual)	2.5%	2017 – WDI	Africa: 2.6% (2015) SSA: 2.7% (2015) *Ref: World Statistics Pocket book 2017*
% population under 15 years % population above 65 years	40.6% under 15 years 3.5% above 65 years	2017 - World Bank estimates based on age/sex distributions of UN Population Division's World Population Prospects: 2017.	Africa (2017): 40.8% <15 yrs 5.5% > 65 yrs SSA (2017): 42.7% <15 yrs 4.0% >65 yrs *Ref: World Statistics Pocket book 2017*
Urban population (% of total)	20.31%	2017 - United Nations Population Division. World Urbanization Prospects: 2018 Revision.	Africa (2015): 40.4% SSA (2015):37.9% *Ref: World Statistics Pocket book 2017*
Literacy rate for men/women	49% total 42% of women and 69% of men ages 15-49 are literate	WDI, 2017 EDHS 2016	64% for all >15 years, 2007-2012 (WHO 2015)
% Population below poverty Level	24% living under $1.00 USD	WHO 2016	Africa (WHO 2015): 47% living under $1.00USD 2007-2013

2.2. Ethiopia Health Priorities and System Gaps

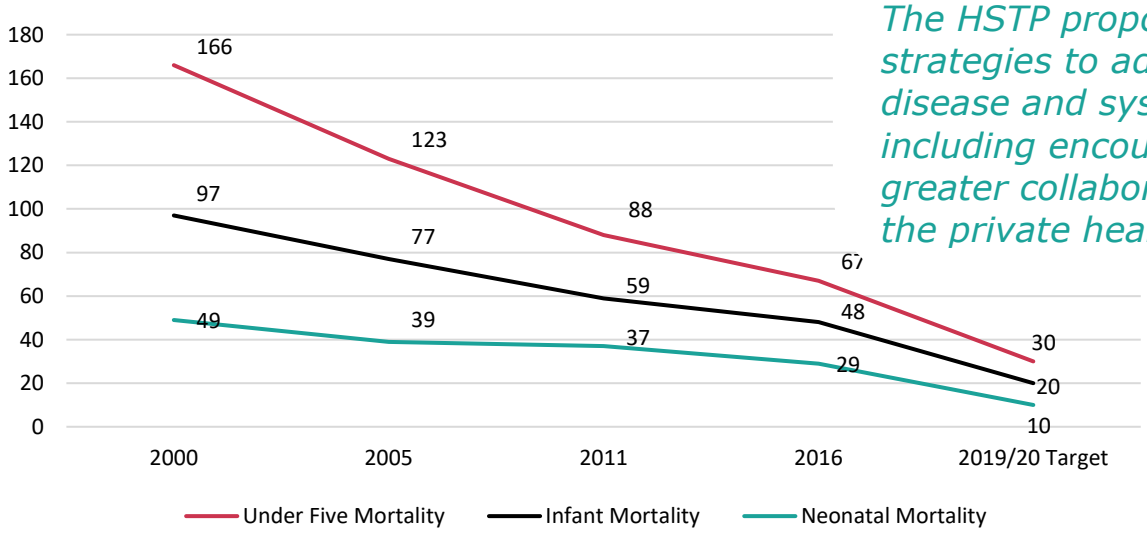
Ethiopia has made considerable progress in reaching its Millennium Development Goals (MDGs) targets (See Figure 2.1) ("Key Achievements 2015/16: Addressing the Gap"). Most notably, Ethiopia has experienced significant declines (67%) in under-five mortality rates from its 205 deaths per 1,000 live births to 67 in 2016 (See Table 2.2). The decline in childhood mortality contributed to the dramatic increase in average life expectancy at birth from 45 years in 1990 to 64 in 2014. Similarly, infant mortality has declined by 41% from 122 infant deaths per 1,000 live births in 1990 to 48 in 2016.

Ethiopia has made considerable progress in reaching its MDGs targets in health.

Maternal mortality has also experienced a significant decline from its 1990 level of 1,250 per 100,000 live births to its current level of 412 in 2016. Ethiopia's overall mortality and other health indicators compare favorably to those in SSA (see Table 2.2).

But more remains to be done to address the "double burden" of disease – a combination of infectious and NCDs.

Figure 2.1 Summary of Ethiopian Progress towards key child mortality MDGs



The HSTP proposes strategies to address the disease and system gaps including encouraging greater collaboration with the private health sector.

Table 2.2 Ethiopia and Sub-Saharan Africa Health Indicators

Indicators	Ethiopia Data and Sources		SSA/Africa Data and Sources
Life expectancy	▪ 65.5 years (63.7 for males and 67.3 for females)	WHO 2018	Africa (2018 WHO): 61 years for Males and 64 years for females. *Ref: Atlas of African Health Statistics 2018*
Maternal mortality ratio (per 100 000 live births)	▪ 412 maternal deaths per 100,000 live births ▪ 353 deaths per 100,000 live births in 2015 down from 1,250 in 1990	DHS 2016 WHO, 2015	Africa (2015 WHO): 542 deaths per 100,000
Neo-natal Mortality Rate	▪ 27.7 per 1000 live births	WHO 2016	27.2 per 1000 live births. Ref: WHO 2016

Infant Mortality Rate (between birth and age 1 per 1000 live births)	▪ 48 deaths per 1,000 live births ▪ 41 deaths per 1,000 live births in 2015 down from 122 in 1990	DHS 2016 WHO 2015	Africa (2015): 57.2 deaths down from 94 in 2000. SSA (2015): 62 deaths. *Ref: World Statistics Pocket book 2017*
Under- five mortality rate (per 1000 live births)	▪ 67 deaths per 1,000 live births 2016 ▪ 59 deaths per 1,000 live births 2015 ▪ 205 deaths per 1,000 live births 1990	DHS 2016[1] WHO, 2015	Africa (WHO 2015): 81 deaths per 1,000 live birth decreased from 153 in 2000
Total Fertility Rate (women age 15-49)	▪ 4.6 children per woman	DHS 2016	Africa: 4.72. SSA: 5.10. *Ref: UN World World Population Prospects 2010-2015*
Modern Contraceptive prevalence	▪ Has steadily increased from 6% of women using modern contraceptives in 2000 to 35% in 2016 ▪ 57.6% of women of reproductive age who have their need for FP satisfied with modern methods	DHS 2016 WHO 2011-2015	Africa: 28.5% using modern contraceptives. *Ref: United Nations, Department of Economic and Social Affairs, Population Division (2015)*
Non-communicable disease rates	NCDs estimated to account for 30% of total deaths	WHO – NCD Country Profile Ethiopia 2014	

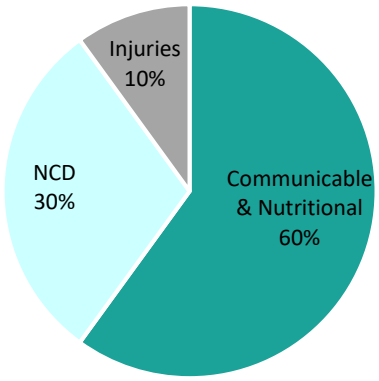
2.2.1. Health Challenges

2020 SDG Targets
- Maternal mortality:199 deaths per 100,000 live births)
- Under 5 mortality: 30 per 1,000 live births
- Infant mortality: 20 per 1,000 live births
- Neonate mortality: 10 per 1,000 live births
- Death rate from traffic accidents: 27%

Despite the government's remarkable achievements in the last decade, there is much work to be done. As Figure 2.1 illustrates, Ethiopia will struggle to reach its 2020 SDG targets in several areas (see box). According to the latest Ministry Health Annual Report, the top 10 causes of mortality are related to maternal, Infant and child health as well as communicable diseases. Figure 2.2 shows that 60% of the disease burden is related to communicable, maternal and nutritional disease which is slightly lower that the SSA average of 65%. Non-communicable disease (NCDs) are a growing factor in mortality; 30% of all deaths are caused by an NCD) which is above the SSA average of 25%. Injuries remain the third largest cause of death in Ethiopia at 10% which is the same level disease burden across most of the SSA region (~ 10%) (WHO Atlas of African Health Statistic 2016).

[1] The Mini-DHIS was not available at the time of the report analysis and writing. We have added WHO data to enable comparisons with SSA.

Figure 2.2 Ethiopia – Disease Burden



Source: WHO 2014 WHO NCD Country Health Profile

Table 2.3 Top 10 causes of mortality, 2016/2017

Rank	Diagnoses	Case (%)
1	Prematurity	7.4%
2	Birth Asphyxia	6.3%
3	Neonatal sepsis	5.8%
4	Pneumonia	5.6%
5	Other or unspecified diseases of circulatory system	4.3%
6	Cerebrovascular accident (stroke)	4.2%
7	Tuberculosis all forms	3.8%
8	Other or unspecified perinatal disease	3.4%
9	Trauma (injury, fracture, etc.)	3.0%
10	AIDS	3.0%
	Sum of all top 10 cases (N=11,866)	46.8%

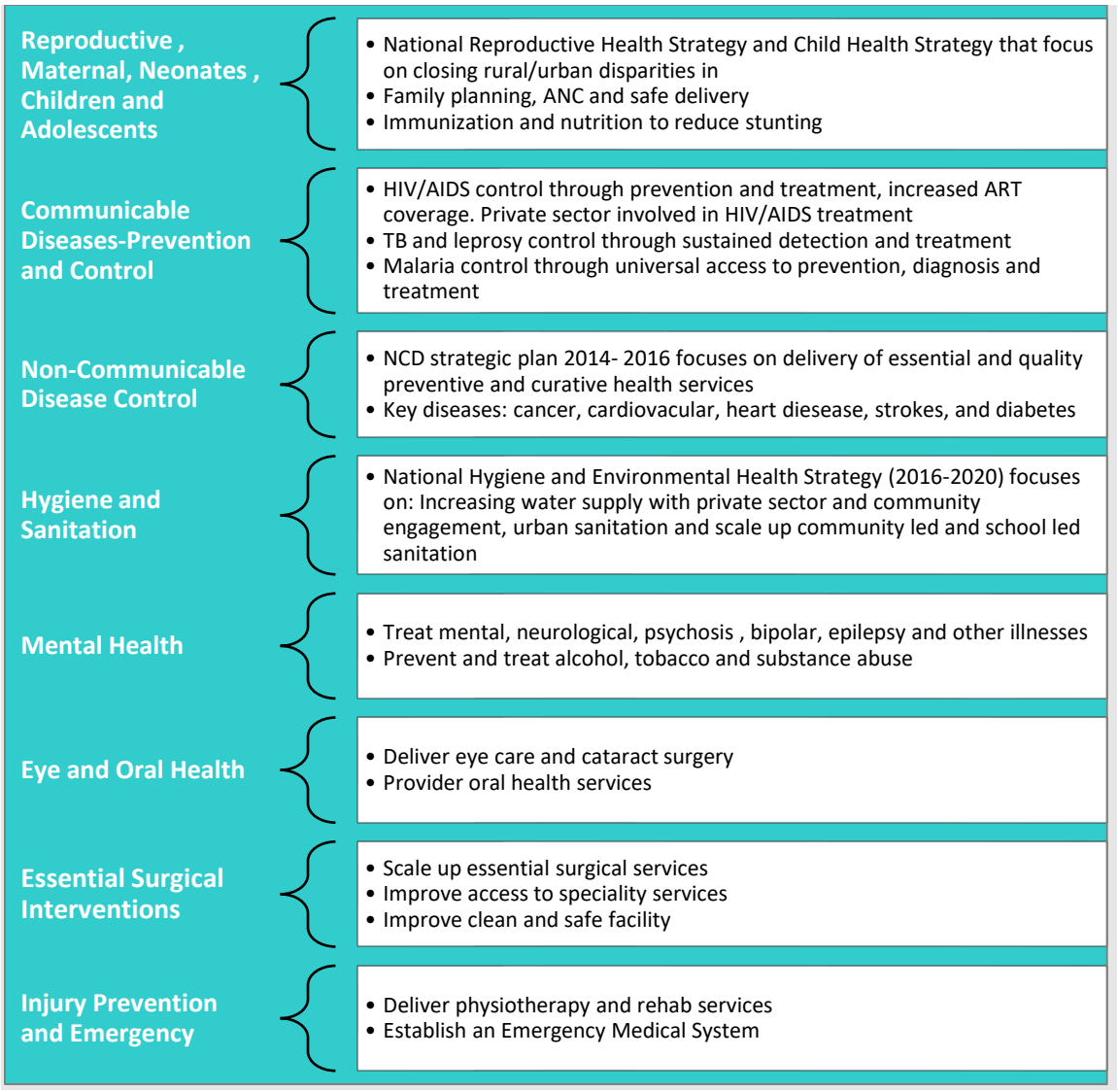
Source: MOH health and Health Indicators Report 2016-2017

2.3. Strategy to Address Health System Gaps

The GOE is committed to addressing the health challenges confronting the Ethiopian population. The current HSTP (2015-2020) lays out the GOE's health priorities and strategies (see Table 2.4). The HSTP sets out ambitious goals to: i) improve equity, coverage and use of and enhance quality of essential services while strengthen implementation capacity. The plan focuses on four pillars of excellence to operationalize these goals:

1) Increase access and equity of health services
2) Improve safety, responsiveness and quality of health services
3) Enhance leadership and governance of the health sector, and
4) Strengthen key health systems to deliver essential health services (e.g. infrastructure, supply chain, HRH, heath financing, resource mobilization)

Table 2.4 Overview of HSTP 2015-2020 Health Priorities


Reproductive , Maternal, Neonates , Children and Adolescents
• National Reproductive Health Strategy and Child Health Strategy that focus on closing rural/urban disparities in
• Family planning, ANC and safe delivery
• Immunization and nutrition to reduce stunting
Communicable Diseases-Prevention and Control
• HIV/AIDS control through prevention and treatment, increased ART coverage. Private sector involved in HIV/AIDS treatment
• TB and leprosy control through sustained detection and treatment
• Malaria control through universal access to prevention, diagnosis and treatment
Non-Communicable Disease Control
• NCD strategic plan 2014- 2016 focuses on delivery of essential and quality preventive and curative health services
• Key diseases: cancer, cardiovacular, heart diesease, strokes, and diabetes
Hygiene and Sanitation
• National Hygiene and Environmental Health Strategy (2016-2020) focuses on: Increasing water supply with private sector and community engagement, urban sanitation and scale up community led and school led sanitation
Mental Health
• Treat mental, neurological, psychosis , bipolar, epilepsy and other illnesses
• Prevent and treat alcohol, tobacco and substance abuse
Eye and Oral Health
• Deliver eye care and cataract surgery
• Provider oral health services
Essential Surgical Interventions
• Scale up essential surgical services
• Improve access to speciality services
• Improve clean and safe facility
Injury Prevention and Emergency
• Deliver physiotherapy and rehab services
• Establish an Emergency Medical System

3. Ethiopia Private Health Sector Overview

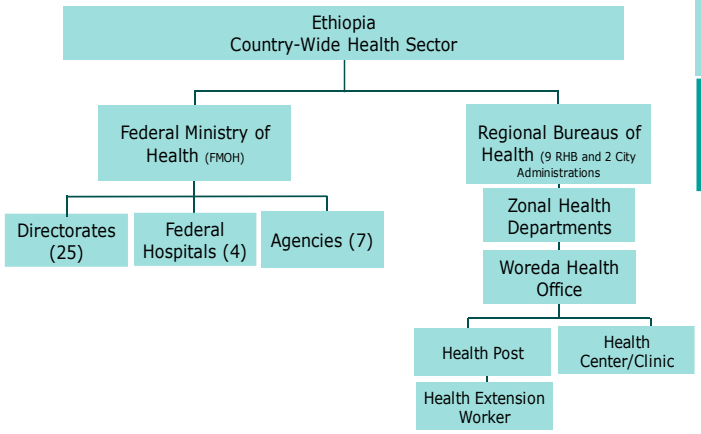
Increasingly, many low- and middle-income countries are exploring private sector engagement as a strategy to spur economic growth and development. Ethiopia has successfully engaged the private sector primarily in agriculture, manufacturing, construction and trade. Indeed, the private sector has become an engine for growth, increasing from virtually no private sector activity in 1980s to contributing 80% of gross domestic product (GDP) when including the informal sector.[2] Government recognition of the private sector in the early 1990s, followed by specific plans to harness the private sector like the Growth and Transformation Plan II have helped create an enabling environment for a productive role for the private sector.

The health sector has aligned its policies to the Growth and Transformation Plan II and promotes private sector engagement as a strategy to address several of the challenges found in the Ethiopian health sector. But as the data in this section will show, existing policies and plans have not successfully enabled a productive role for the private health sector, and it remains relatively small and fragmented.

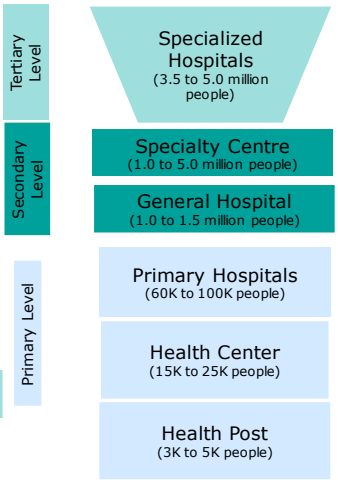
3.1. Ethiopian Health Sector – a New Landscape

All government documents illustrate the Ethiopian health sector as the Federal Ministry of Health (see Figure 3.1). Moreover, the health sector is organized along the lines of the federal system of government comprising of 9 regions and 2 administrative council, 62 zones and 523 districts or "*woredas*". The MOH at national level and the Regional Health Bureaus at regional level are responsible for health sector leadership. Health services are organized into a three-tiered delivery system comprised of primary, secondary and tertiary levels. As these figures show, there is no mention and/or acknowledgement of non-state actors' role in the health sector.

Figure 3.1 Organization of Federal Ministry of Health



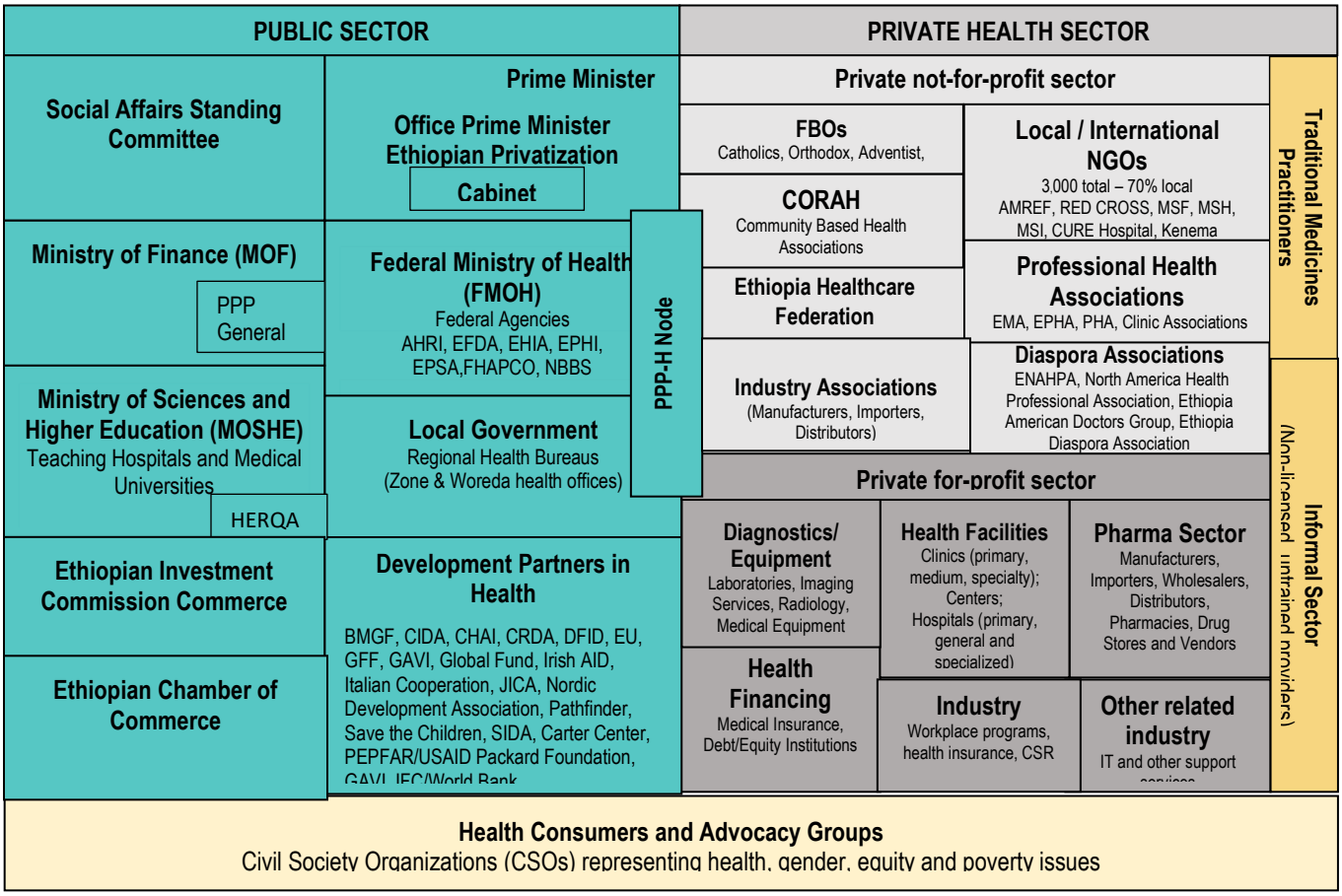
Ethiopia Health Delivery Tier -System



[2] Defere, E., 2015. Private Sector Landscape for WASH in Ethiopia: Bottlenecks and opportunities. OneWASH Plus Programme Report. IRC: The Hague.

One of the Private Sector Assessment's objective is to create a new landscape of a health sector to demonstrate the wide range of actors – both domestic and international – as well as state and non-state that play an active role in health. The Ethiopian health sector landscape, as depicted in Figure 3.2, is a ***mixed delivery health system*** composed of a diverse range of actors across both the public and private sectors and can be organized across the following broad segments:

Figure 3.2 Ethiopia Health Sector Landscape



LEGEND:

AMREF – African Medical Research and Education Foundation
CIDA – Canadian International Development Agency
CRDA – Christian Relief and Development Association
CSR-Corporate Social Responsibility
DFID – Department of Foreign and International Development
EMA – Ethiopian Medical Association
ENAHPA - Ethiopian North American Health Professionals Association
ESA – Ethiopian Statistical Agency
EFDA Ethiopia Federal Drug Agency
GP-General Practitioners
IFC- International Finance Corporation
JICA – Japan International Cooperation Agency
MSH –Management Sciences for Health
SIDA – Swedish International Development Cooperation Agency
USAID-United States Agency for International Development
BMGF-Bill and Melinda Gates Foundation
CHAI-Clinton Health Access Initiative
CSO-Civil Society Organizations
CURE – Catholics United for Racial Equality
EU-European Union
EHNRI – Ethiopian Health and Nutrition Research Institute
EPHA – Ethiopian Private Hospital Association
FBOs-Faith based organizations
GAVI-Global Vaccine Alliance
HERQA- Higher Education Relevance and Quality Agency
IT-Internet Technology
MAPPE –Medical Association of Physicians in Private Practice
MSI – Management Sciences International
PEPFAR – President's Emergency Plan for AIDS Relief

- **The public/government sector**: Includes various ministries and government agencies but also the development partners in health and their implementing agencies that play a key role funding health as providing technical support.
- **The private health sector** is diverse and includes private-for-profit (PFP) entities engaged in a wide range of health activities, the private-not-for-profit (PNFP) comprised of faith-based organizations delivering health services and products and non-governmental organizations also providing health but also community health promotion. Other private entities are industry whose core business is not health, but they provide health services to their employees through workplace programs, health insurance and corporate social responsibility and the finance sector offering health insurance and commercial financing to private health businesses.
- **The informal health sector,** is part of a country's economy that is not recognized as normal income sources. In Ethiopia, this includes some of the unlicensed traditional practitioners in most of the urban areas, complementary medicine practitioners and overall other un-licensed private practitioners.
- **Health consumers** are organized and represented through civil society organizations, advocacy groups, community-based organizations representing health, gender, equity and poverty issues important to health.

The Ethiopian health sector is mixed delivery system.

The health sector is complex and diverse comprised of multiple government agencies as well private entities engaged in a wide range of health-related activities.

Although not entirely exhaustive, one can see that the new health sector landscape offers a more complex and nuanced perspective of the full range of actors that need to be involved when designing policies and plans to improve health. Key messages include:

- Although the MOH is the lead government agency responsible for health policies and regulation, there are other government entities, like the Ministry of Finance and the Prime Minister's Office that play an important role in health.
- As the health finance section reveals, Development Partners are key players in health contributing an estimated 33% of total health expenditures (THE).
- The private sector goes beyond health services and is engaged in a wide range of activities including medical training, commodity manufacturing and distribution, etc. that can be leveraged to complement MOH's initiatives in health.
- Health consumers are an important stakeholder in health but are often excluded from policy and planning although they are the end beneficiaries.

Development Partners play are influential in the health sector.

3.2. Overview of Private Health Sector

Box 3.1 offers a quick overview of the type and range of private sector found in the Ethiopian health system demonstrating that the private health sector owns and manages a wide range of health facilities offering diverse health services products.

In addition, it is important to note that the private health sector is present across all levels of care in Ethiopia. Private health facilities range from:

- Primary level: private-for-profit retail pharmacies and drug shops, health non-government organizations and civil society organizations, and primary clinics /medium clinics
- Secondary level: to private-for-profit specialty clinics
- Tertiary level: to faith-based organizations and private-for-profit hospitals and specialty centers (See Figure 3.3).

Box 3.1 Ethiopia: Formal, Private Health Sector At a Glance

Primary Clinic

Primary clinic is the first level of care and refers to a health facility in the category of primary healthcare that providers curative, preventive and promotive services at ambulatory basis only as indicated in the national standards requirements. The primary clinic shall provide medical services that can be handled under the scope of the professional assigned to the clinic. It offers emergency services as First Aid, primary level nursing services and consultation of healthy living. It shall provide MCH services under the scope of the professions such as pregnancy planning, antenatal care etc. It can also provide delivery service but shall not hold prescriptions

Medium Clinic

A medium clinic is also in primary care and is operated by a qualified, individual (e.g. GP or BSc nurse and upgrade health officer/nurse practitioner with minimum 5 years). The medium clinic provides outpatient care from diagnosis to treatment of acute conditions but also follow-up of chronic conditions such as TB, HIV. These solo practitioners manage all conditions ordinarily managed in a general practice, with referral to higher levels as required. A medium clinic provides preventive and curative services along with general medical services such as routine examinations, minor surgical services and nursing services.

Pharmacies, Drug Shops and Rural Drug Shops

These different types of retail outlets are also part of the primary care level. They offer medical preparations, dietetic, products and other articles as approved by the Ministry for sale to the public. A licensed pharmacist own/operate a pharmacy and perform the pharma scope. An allied health pharmacist (diploma in pharmacy) owns/ manages a drug shop and does not compound drugs. Nurses, health assistants and pharmacy technicians own/manage a rural drug shop and perform the most restricted dispensing of medicine. This is one of the fastest growing segments in the private sector despite the market conditions (see section XX).

Specialty Clinic

A specialty clinic is a secondary level health facility. It is a group practices offering a full range of health services (promotive, curative and rehabilitative) assisted by specialist in various fields as well as ancillary clinical services such as diagnostics. A practicing physician - or jointly with a business partner(s) – owns the group practice. The scope of services is limited to the stated specialty services available.

General Hospital

A general hospital is also secondary level facility that provides in- and out-patient healthcare. A general hospital covers all basic specialties, emergency room services, surgical suites, intensive care units and laboratory and radiology services among others.

Specialty Center

A specialty center provides secondary or is the first level in tertiary level care (equivalent to center/polyclinic elsewhere) but normally has a focus on a certain specialty, such as women's health, pediatrics or other. A specialty center differs from a specialty clinic as these have inpatient admissions and offer 24 hours emergency services. A specialty center differs from a hospital in that they do not offer the full spectrum of specialties required for a general hospital.

Comprehensive Specialized Hospital/ Multi -Specialty Hospital

A comprehensive specialized Hospital is a tertiary level facility that provides curative and rehabilitative services with a minimum capacity of 110 beds. It can also be a multi-specialty hospital depending on the specialties it chooses to offer. They offer the following services: gynecology and obstetrics, pediatrics, internal medicine, surgery, orthopedics, psychiatry, ophthalmology, ENT, dentistry, dermatology specialty services and emergency services and require advanced diagnostic facilities and therapeutic interventions. As of today, there are **no private comprehensive specialized hospitals** although they can be licensed as such. The tertiary facilities are licensed as general private hospitals or specialized centers.

Diagnostics

Secondary and tertiary level facilities are required to have a basic laboratory and some relevant diagnostic service scopes. There are also a growing number of advanced standalone medical diagnostic facilities. Nevertheless, given the population size of Ethiopia and it demand, the numbers of advanced medical laboratories and diagnostics center are quite limited.

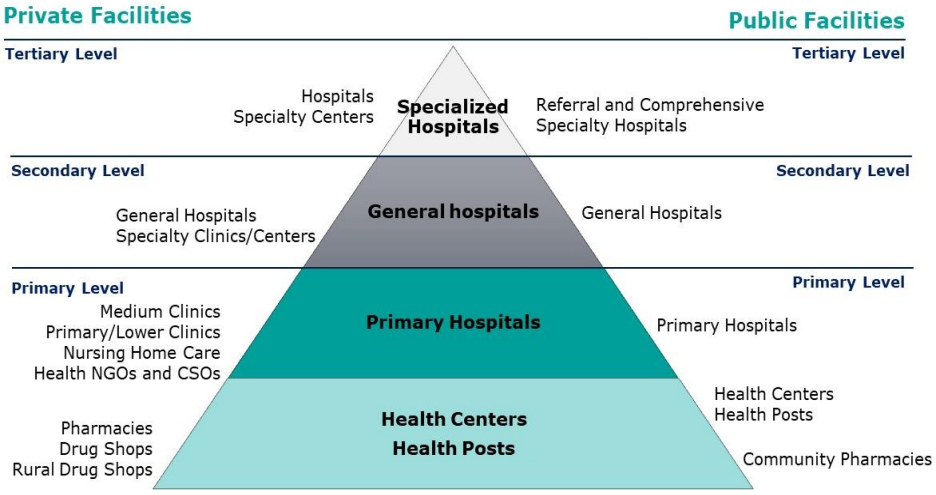
Industry

A few big corporations such as the beer and textile companies (e.g. Heineken, Unilever) provide health services with agreements with local and international insurers such a Cigna or Bupa. Depending on their size and capacity, several private companies provide health services to their employees and, in some cases, the communities where the business operates. Services vary, ranging from workplace programs on education and prevention, to nurse-managed primary care, to comprehensive health services including tertiary care.

Health Financing

Private health insurance is still very small in Ethiopia with a handful of insurers such as United Health Insurance as an example of a local insurer and a few but growing international private health insurance such as Cigna, Bupa and SOS.

Figure 3.3 Private Sector Operates at all Levels of the Ethiopian Health Pyramid



Source: Ethiopian Private Health Facilities Owners Association, 2017 (Private Hospital & Specialty centers data); Health & Health Related Indicators 2016/17 for Private Clinics & Public Hospitals, Health Centers & Health Posts; ESA Facility Standard & Master Plan for the Public Health lab system (2013) and also Public Sector Stakeholder Interviews to map the various levels '; MOH Indicators and Health Indicators 2014/15 and CSA for Pharmacy data

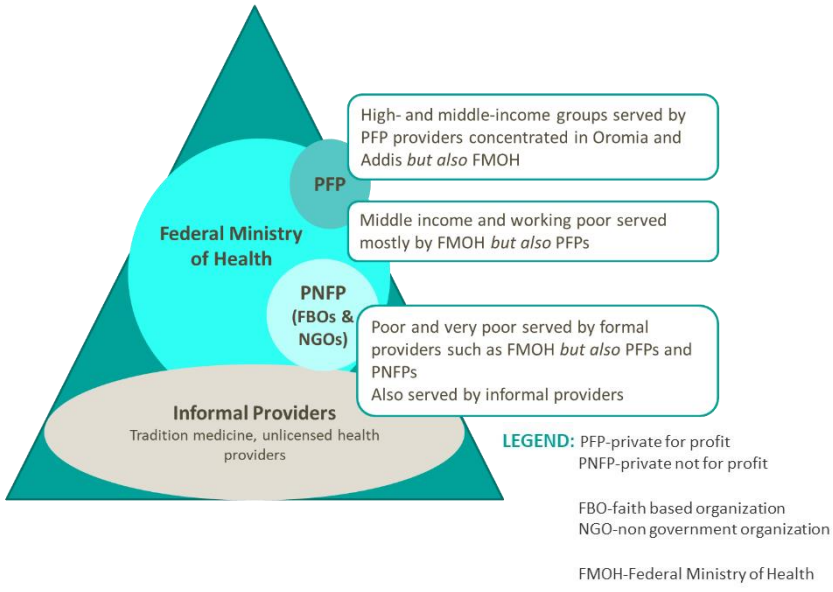
The private health sector owns and manages a wide range of health facilities offering diverse health services products.

The private health sector is present across all levels of care.

The Ethiopian private health sector serves the same market segments as other low-income countries. As Figure 3.4 shows, the private for-profit health sector serves the high- and middle-income groups in mostly Addis and Oromia while the private not-for-profit, together with MOH serve the working poor and poorer income groups. However, the data shows that the private for-profit sector also serve the poor and that the MOH heavily subsidize the middle-and upper-income groups who can afford to pay for healthcare in the private sector.

Private for-profit providers mostly serve high- and middle-income groups in urban areas…..but they also serve the poor.

Figure 3.4 Market Segmentation by Health Consumer Groups



The FMOH subsidize the middle-and upper-income groups who can afford to pay for healthcare in the private sector.

3.3. Public-Private Mix (PPM) of Health Facilities

The total number of public health facilities In Ethiopia has increased significantly between 2008 to 2017 (See Table 3.1). The MOH has invested a significant amount of capital to build and/or upgrade its health infrastructure at the primary care level-health posts, health centers and primary hospitals. Although most of the expansion has occurred at the health post and health centre levels (64% increase 500% increase, respectively), the number of hospitals has also increased significantly (300% increase).

Table 3.1 Growth in Public Health Facilities by Level (2008-2017)

Level	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017
Hospital	93	105	116	122	125	127	156	234	241	266
Health Centre	732	1,362	2,142	2,660	2,999	3,245	3,335	3,586	3,562	3,622
Health Post	10,621	12,488	14,192	15,095	15,688	16,048	16,251	16,447	16,480	16,660

Source: Mid-Term HSTP

During the same time period, the private health sector has expanded its health infrastructure but not at the same rate as the public sector. Growth in private health sector infrastructure has concentrated in primary clinics, medium clinics as well as retail pharmacies and drug stores.

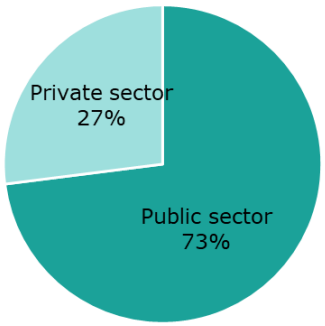
3.3.1. Total Number of Health Facilities by Ownership

MOH data indicates there are approximately 28,236 health facilities across Ethiopia; a small number considering the size of the Ethiopian population. For the more than 28,000 health facilities in Ethiopia, the public sector owns a majority (73%) while the private sector – both PNFP and PFP – owns / manages 27% (See Table 3.2). The private health sector infrastructure is concentrated in specialty centres and clinics (100%) with important portion of hospitals (17%) and health centres and health posts (26% and 24% respectively.

Table 3.2 Total Number of Health Facilities by Level and Ownership (2016/17)

Facility Level	Public	Private	Subtotal	% Private
Hospitals (including specialty, referral, general)	302	62	364	17%
Specialty centres / Specialty clinics	0	867	867	100%
Health centres / Medium clinics	3,724	1,308	5,032	26%
Health posts / primary and lower clinics	17,187	5,401	22,588	24%
Subtotal	**20,598**	**7,638**	**28,236**	**27%**

Source for public data: MOH Health and Health Related Indicators 2016/17. Data refer to public functional facilities (a subset of "available")
Source for private data: private specialty center and clinics - Ethiopian Private Health Facilities Owners Association 2017. Data does not include private pharmacies, drugs shops and diagnostic centers. Data for health centers and posts are from MOH Health Indicators report 2016/17.



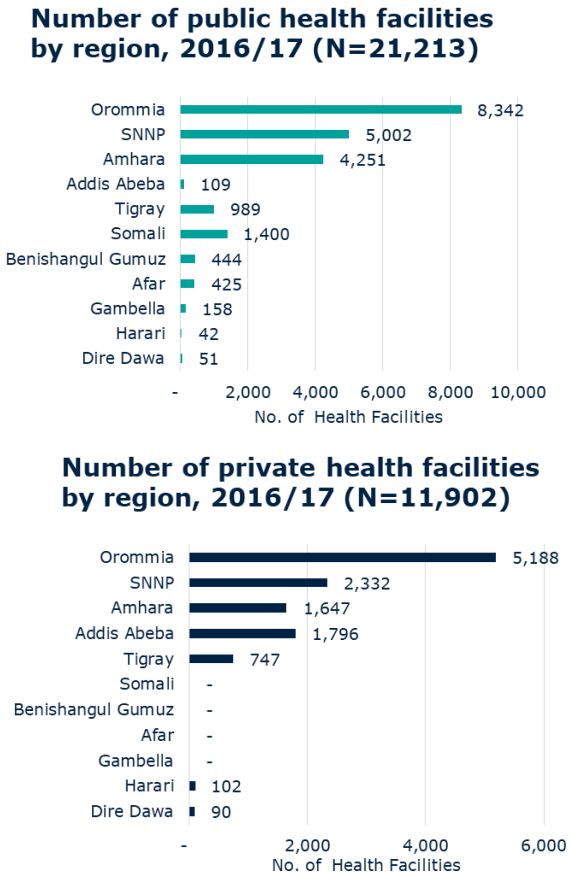
3.3.2. Distribution of Health Facilities by Region

The distribution of health infrastructure – no matter public or private health facilities – is inequitable and are concentrated in the most populous and urban areas. In 2016/17, MOH report indicates that about two out five

(41%) of *all* health facilities in Ethiopia's are in the in the Oromia regions of which 62% are public and are 38% private facilities. South (22%) and Amhara (18%) have the second and third highest number of health facilities. Approximately 6% of all health facilities are in Addis Ababa, of which 6% are public facilities and 94% are private. It is interesting to note that the private health sector is absent in some of the most challenged regions in terms of resource, geography and climate – Somali, Benishanguil Gumuz, Afar and Gambella.

The public owns and manages most health facilities – 3 out of 4 – in Ethiopia. Most public and private facilities are concentrated in Oromia, South and Amhara regions.

Figure 3.6 Total Number of Health Facilities by Ownership and by Region (2016/17)



Source public data: MOH Indicators Report 2016/2017
Source private data: Ethiopian Private Health Facilities Owners Association 2017 (Missing Afar, Benishangul, Somali and Gambella). Note: the total number of facilities (33,115) in this figure is different than the one in Table 3.1 above (28,236) because 1) the private sector data includes pharmacies, drug stores and diagnostic labs in the count while public facilities refer to ALL public facilities available whether functional or not.

The private health sector plays a significant role in the pharmaceutical sector and owns most pharmacies and labs.

Although most HRH work in the public sector, the private sector employs most specialists.

There are issues of both availability and reliability of data on the private health sector. The FMOH has several initiatives to address the data challenges.

Data on private health facilities must be interpreted with some caution for several reasons:

- There is ***no consistent definition of "private":*** Ministry reports define private inconsistently across reporting time periods. Earlier MOH annual reports would define private health sector as PNFP and PFP while more recent years only reported on PNFP.
- ***The 2012 Facility Standards*** - the implementation of the 2012 facility standards has been arduous, especially in the initial years of its introduction facing significant resistance from both public and private sector

facilities, but today showing significant improvement in ease of licensing and regulatory oversight Furthermore, the MOH applied the facility standards more stringently with private health facilities and as a result, many private health facilities were "downgraded" into a lower category. The MOH now recognized the variance in interpretations of the 2012 facility standards as well as the "double standards" in its application and is moving to rectify these issues.

- ***Data is not centralized:*** Private facility licensing is the responsibility of Regional Health Bureaus and Woreda Health Offices. This data is not routinely collected and reported to the federal level and is therefore incomplete and out-of-date.

The MOH acknowledges the data collection challenges and discrepancies in data and has several initiatives in place to address them. Key among them is the Master Facility List which has currently surveyed and collected GIS coordinates for all public health facilities. In phase two, the MOH will also survey and map all private health facilities by the end of 2019. In addition, the Policy and Planning Directorate has developed a dialogue mechanism to encourage increased private health sector reporting and data submission to the HMIS as a strategy to better reflect all sector activities as well as private sector contribution to health.

3.3.3. Total Number of Pharmaceutical Entities by Ownership

Ethiopia has a nascent but growing pharmaceutical and manufacturing industry (see Table 3.3). In 2016/17, the private sector owned all (75)[3] manufacturing companies of which 11 are large scale. There was a growing – albeit small – number of private importers and wholesalers (384 and 489, respectively). As compared to potential demand, Ethiopia has a small retail pharmacy market – only 3,327 retail pharmacies and 4,476 drug shops. There was incomplete data on diagnostic centres both in public and private sectors.

Table 3.3 Total Number of Pharmaceutical Facilities by Level and Ownership (2016/17)

Facility Level	Public	Private	Subtotal	% Private
Manufacturers (11 large scale)	0	75	75	100%
Importers/Distributors	1	383	384	99%
Wholesalers	0	489	489	100%
Laboratories	247	125	372	34%
Pharmacies	2,249	1,078	3,327	32%
Drug shops	1,257	2,799	4,056	69%
Rural drug shops	10	608	618	98%
Subtotal	**3,764**	**5,557**	**9,321**	**60%**

Source public data: EFDA progress report; drug shops and pharmacies are extrapolated from total number of health centers and health posts and some assumption as to proportion that are functional. Since licensing for retail drug stores are done at regional level, the data is inaccurate and fluctuates due to lack of resources to gather data from each region.

Source private data: Ethiopian Private Health Facilities Owners Association 2017 (missing Afar, Benishangul, Somali and Gambella) and EFDA progress report and stakeholder interviews for data on manufacturer, importers/distributers and wholesalers. Source public and private data: Diagnostic master plan for public laboratories 2013

Stakeholder interviews indicated that private businesses in this segment of the private health sector are critically challenged due to forex shortages (e.g. estimated 25% of ~300 importers imported only once in the last year; rural pharmacies and drug shops experience stock-outs due to limited cash flow and inventory). Due to these challenges, there is considerable "churning" with high rate of turnovers in wholesalers, pharmacies and drug shops.

There are several data challenges and gaps related to the pharma sector as well.

[3] FMHACA provided this number; number includes medical devices as well as non-functioning manufacturers.

- Data is not centralized: Different departments and Regional Health Bureaus collect different segments of the data which is not routinely consolidated and reported at the federal level. While manufacturers, importers/distributors and wholesalers are licensed at the federal level under the newly reformed EFDA (Ethiopian Federal Drug Agency), pharmacies and drug shops are licensed at the different regional health bureaus. The data is even scarcer for public pharmacies as until very recently with the community pharmacy projects, the publicly owned pharmacies are embedded within the hospitals and health centers according to the National facilities standards.
- Data is incomplete: EFDA does not have a comprehensive and current list of licensed manufacturers, importers and wholesalers as licensing is fully decentralized. Additionally, data on public pharmacies, drug shops and labs are incomplete (e.g. does not report number of inoperable facilities) and therefore cannot be compared across public and private sectors.

Recently, there have been extensive efforts to bridge this data gap and the newly reformed EFDA has modernized its licensing system through a digital registry for importers and wholesalers to streamline the process and improve accuracy of the data.

3.4. Public-Private Mix of Human Resources for Health

The MOH introduced HRIS in 2009 to facilitate HRH data collection and management but the system was not fully functional at various levels for many years and was and is still a challenge to produce comprehensive data, including HRH working in the private health sector at national level. With all the limitations, the MOH was able to produce, in January 2019, a 2nd edition of the report on Human resources for health in an effort to create a common understanding of the current human resource information in Ethiopia. In 2017/2018, most recent data reported under this update of HRH in Ethiopia reported that more than 170,000 Human resources for health workforce are working in public sector in Ethiopia, of which more than 9,000 (~5%) are Physicians and specialists and ~45% are nurses and midwifery professionals and the remaining all categories of allied health professionals including pharmacists, laboratory personnel among others.

But data on health human resource – particularly HRH working in the private health sector – remains the most inaccurate among all the data collected by the FMOH. The FMOH has not produced a report on private sector HRH since 2009. Nevertheless, the 2008/09 data in Table 3.4 shows a staffing pattern that still holds true today and was validated through stakeholder interviews from the relevant FMOH departments. As to be expected, the public sector employs the largest portion of HRH – almost 94%. The, arguably outdated data, indicates that private sector employs an important percentage of specialists; of the total specialists in Ethiopia, 41% work in the private sector. Although this was validated by the interviews, the number of stakeholders interviewed, due to limitations of time, may not be a representative sample and thus needs to be interpreted with caution.

Table 3.4 Total Number of Human Resources for Health by Select Cadre (2008/09)

Specialty	Public	Private	Subtotal	% Private
General practitioners	1,009	143	1,152	12%
Specialists	501	347	848	41%
Nurses (all)	20,506	982	21,488	5%
Allied professionals*	4,247	135	4,382	3%
Subtotal	**26,263**	**1,607**	**27,870**	**6%**

* Public health specialists and health officers, pharmacists and pharm tech
Source: MOH Health Indicators 2008/09 and WHO Report on HRH, 2009

In between The recently established HRH Development and the newly established Licensing Directorates acknowledge these challenges and is in the process of modernizing their operating systems to strengthen data

collection and reporting on HRH across both public and private sectors. The Human Resource directorate is revising the HRH Strategy to develop a more complete picture of the HRH working in both public and private health sectors.

3.5. Public Private Mix of Health Training Institutions

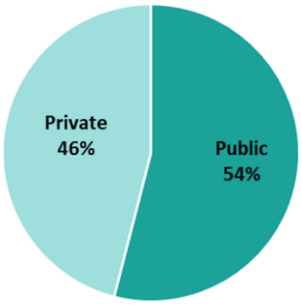
There are private medical training institutes operating without licenses; the number and size is unknown due to the lack of up-to-date information. The Higher Education Relevance and Quality Agency (HERQA)– the national regulatory body –has limited capacity to inspect, regulate and keep updated and accurate inventory of the private medical training institutes.

Nevertheless, the most recent data available from the MOH HRH Licensing Directorate in 2016/17 indicates that private sector operates and manages nearly half of all medical training institutions and plays an important role in producing nurses, midwifes and allied health professionals (see Table 3.5).

Table 3.5 Total Number of Medical Training Institutes by Type and Ownership (2016/17)

Type of MIT	Public	Private	Subtotal	% Private
Nurse/Midwifery	43	46	89	52%
Allied Health Professionals	43	39	82	48%
Medical University	17	4	21	19%
Subtotal	**103**	**89**	**192**	**46%**

Source: MOH, HR Licensing and Competency Assessment Directorate



4. Public Private Use of Key Health Services

Examining health consumers' health seeking behavior is an approach to estimate demand for private health sector. This section examines three important data sources to better understand when and where health consumers seek care with a private provider:

- National Health Accounts (NHA V) Household Health Service Utilization and Expenditures Survey, April 2014;
- Ethiopia Demographic Health Survey (EDHS), 2016; and
- Ethiopia Service Provision Assessment Plus (SPA+) Survey, 2015

Despite the extraordinary amount of data available on the Ethiopian health sector, there are limitations in these data sets when trying to examine the private sector contribution to health. Key among them is inconsistent definition of the private health sector across the data sets. The NHA V states that the private health sector is comprised of both private for-profit (PFP), non-government organizations delivering health services and traditional healers. The EDHS, in comparison, defines the private sector as mostly PFPs and non-government organizations. Neither report on faith-based organizations.

In addition, all three reports do not consistently disaggregate the data on all tables by public and private, therefore there is a limited analysis on public/private split unless one has access to the original data to conduct secondary analysis. For example, the NHA V shows use of outpatient services by gender and by region, but they do not show outpatient use by type (e.g. public, for-profit or non-government organizations) of health facility.

Despite the data limitations, one fact is irrefutable. Demand for health services is on the rise. The proportion of ill individuals who visited a health facility has increased from 45% in 2008/09 NHA to 62% in the 2014 NHA V study. The rapidly growing demand for health services underscores the challenges the MOH will confront in trying to deliver accessible and quality health services without engaging the private health sector.

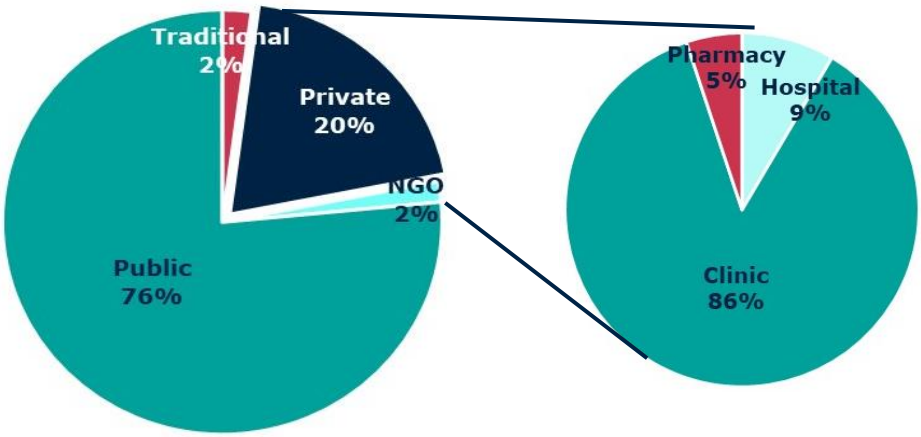
4.1. Public Private Mix of Outpatient Services[4]

A lower percentage – 12% – of the individuals surveyed stated that they made at least one outpatient visit in the four weeks preceding the survey. Most outpatient visits – 52.46% – delivered care to treat diseases considered government priority: as priority health programs. The largest number of outpatient visits were to treat malaria (15.17%), followed by child vaccination (13.95%) and family planning and reproductive health (FP/RH) (12.18%). Non-communicable diseases (hypertension, cancer, diabetes and mental illnesses) accounted for 4.79% of the total outpatient visits.

Figure 4.1 presents the types of health facilities individuals visited to obtain outpatient services. At the national level, government health facilities are the main provider of outpatient services (76%), followed by private health facilities (20%), non-government organizations (2%), and traditional and religious healers. When examining the type of private facility visited, private and non-government clinics are the main type of facility (86%) followed by hospital (9%) and pharmacies (5%). The health seeking pattern for private healthcare is different compared to other East African countries; health consumers seek care first in private pharmacies followed by private health facilities.

[4] Data for this section comes from the National Health Account Household Service Utilization and Expenditure Survey, 2014.

Figure 4.1 Outpatient Services by Source and by Private Provider Type



Source: NHA V Household Expenditure Review, 2014. Table 19

Rural health consumers seek care at a government health facility at a higher rate (78%) compared to individuals residing in urban areas (59%). As expected, urban health consumers use private (private 35% and non-government 3%) at a higher rate when compared to rural individuals (private 18% and non-government organization 2%). Urban consumers have greater choices in health care providers compared to rural households owing to the concentration and availability of private health services in Ethiopia's three urban centers.

Figure 4.2 presents outpatient services by type of provider and by income group. As expected, the highest income group uses private and non-government healthcare providers at a higher rate (27% and 3%, respectively) compared to lowest income group (21% and 2%, respectively). Nevertheless, use of private healthcare and non-government providers is at comparable levels, varying between 20% to 30%. Government health facilities

Figure 4.2 Outpatient Services by Source and Income Group

Source: NHA V Household Expenditure Review, 2014. Table 19

heavily subsidize the higher and highest income groups (80%, 68%, respectively), almost at the same rate as the poorest (76%), even though higher income groups can afford to seek and pay for care in the private sector. Redirecting the higher income groups to private healthcare providers could free up needed resources to deliver more care to the poor.

The NHA V presents the factors shaping health consumers preferred health service provider. Top three factors influencing choice included a health facility's proximity to their home (35%), lack of another alternative (18%), better supply of pharmaceuticals at the facility (18%). Consumers stated that perceived availability of qualified health professionals (6%), better counseling services (5%), availability of free services (5%) lower cost of service (2%), and shorter waiting time (2%) also influenced their choice. Unfortunately, the NHA V did not disaggregate the factors by type of healthcare providers. The NHA V also presented data on reasons for bypassing the closest facility, consumer satisfaction, and compliance with treatment but did not disaggregate the data by provider type.

The public sector in Ethiopia is the most important healthcare provider: 3 out 4 outpatient visits and 4 out of 5 inpatient visits take place in a public facility.

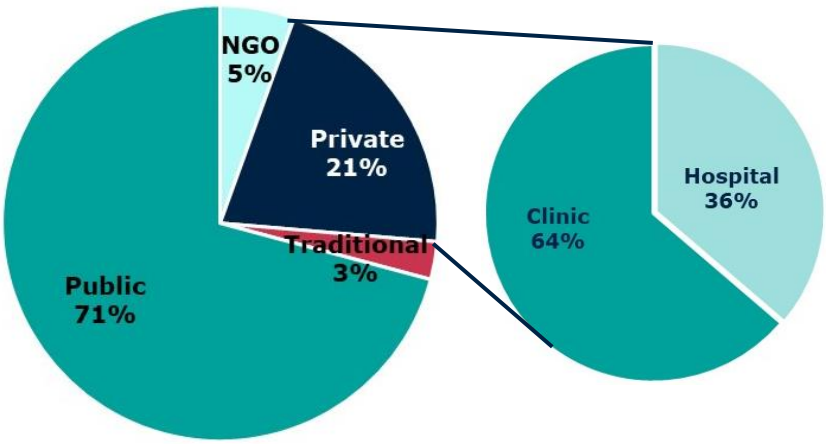
4.2. Public Private Mix of Inpatient Services

Main causes for inpatient admissions in the last 12 months include malaria (12%), followed by accident – (9%), diseases caused by intestinal worms and stomach-ache (8%) and delivery and pregnancy (4%). Non-communicable disease such as cancer, diabetes, hypertension and mental illness together accounted for 8% of all inpatient admissions.

Figure 4.3 presents inpatient services by provider type. Clearly, the majority of Ethiopians seek inpatient services at a government facility (71%) compared to a private one (for-profit 21% and non-government 5%). Of the 26% of health consumers who seek inpatient services with a private healthcare provider, most are admitted at a private (for-profit and non-government organization) clinic (64%) and hospital (36%).

The private health sector serves all income groups. A higher (27%) portion of wealthy consumers seek an outpatient consult compared to the poor (21%). Approximately the same level of wealthy and poor (1 out of 5) seek inpatient care in a private facility.

Figure 4.3 Inpatient Services by Source and by Private Provider Type



Source: NHA V Household Expenditure Review, 2014. Table 32

The government subsidizes a significant portion of health consumers who afford to pay for healthcare in the private sector.

Figure 4.4 presents inpatient admissions services by type of provider and by income group. Interestingly, the highest income group uses private for-profit and non-government healthcare providers at a similar rate as the poorest income group (21% and 18%, respectively). Indeed, use of private facilities for inpatient services is at comparable rate for all income groups, varying between 16% to 27%. Government health facilities heavily subsidize the higher and highest income groups (71%, 63%, respectively), almost at the same rate as the poorest (77%), even though higher income groups can afford to seek and pay for care for hospital care in the private sector. Once again, redirecting the higher income groups to private facilities could free up needed resources to deliver more care to the poor.

Figure 4.4 Inpatient Admission by Source and Income Group

Source: NHA V Household Expenditure Review, 2014. Table 32

The NHA V provides the main reasons individuals select a preferred provider for inpatient services. Referrals to a facility and proximity of the facility to one's home, were the dominant reasons for choosing that facility. The presence of qualified health professionals and a better supply of pharmaceuticals in the health facility, also played an important role. Waiting time and health professionals' approach tended to play only a limited role in the choice of inpatient health facility. Once again, the NHA V did not disaggregate the factors by type of healthcare providers.

4.3. Public Private Mix of Family Planning Services[5]

Ethiopia has one of the highest fertility rates in Africa, with 45% of its population under the age of 15. The 2016 EDHS measured the total fertility rate (TFR) for Ethiopia at 4.6 children per woman. The TFR in rural areas exceeds the TFR in urban areas by almost three children per woman: 5.2 and 2.3 children per woman, respectively (EDHS, 2016). The TFR has declined from 5.5 children per woman in 2000 to its current level at 4.6.

Knowledge of contraception is nearly universal in Ethiopia (EDHS, 2016). Yet it has not been translated to modern contraceptive use. The contraceptive prevalence rate for currently married women is 35%: a dramatic increase from 6% in 2002 and 14% in 2005. Several factors have contributed to this growth including:

- A conducive policy environment (1993 population policy, 2005/06 PASDEP and exempting taxes on contraceptives in 2007);

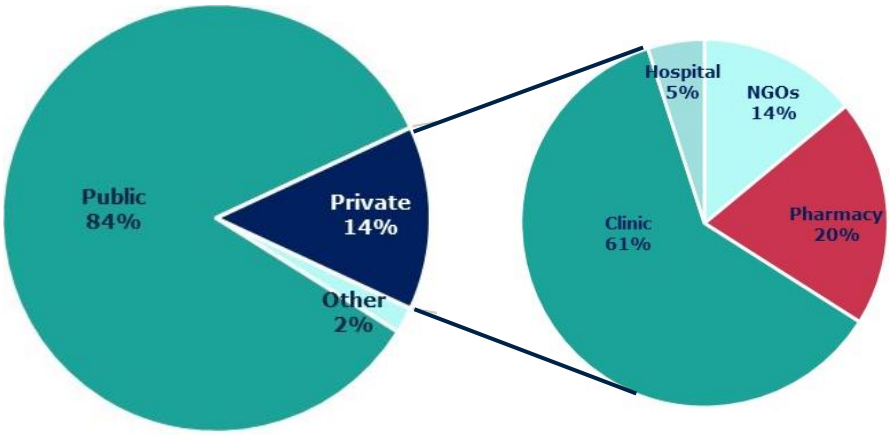
[5] Data used in this section is from EDHS, 2016, Chapter 5. The Mini-DHS was not available during the report analysis and writing.

- Rapid service expansions (provision of FP methods through Health Extension Workers and increased community support for FP use); and
- Continued development partner commitment to fund FP programs and methods.[6]

The increase is also due to increase use of injectables. In fact, HEWs are allowed to deliver injectables like Depo Provera and Implanon. Contraceptive use varies notably by region, ranging from 56% in Addis Ababa to 2% in the Somali region. Use of any modern contraceptive methods is highest in Addis Ababa (50%) and lowest in the Somali and Affar regions (1% and 12%, respectively). The most common modern method used by each group of women is injectables, followed by implants. Contraceptive discontinuitation rate for all methods is 35%; the highest is for the pill (70%) followed by injectables (38%).

The EDHS also shows the source of family planning (FP) methods (see Figure 4.5). Most Ethiopian women (84%) obtain their FP method in government facility while only 14% get their method in a private one. Of the women who obtained their modern FP method in a private facility (14%), most (61%) attained the FP method in a clinic, followed by pharmacy (20%) and non-government facility (14%). Use of a private pharmacy for a FP method is much lower than other countries in the region. Restrictions on injectables may be the reason for low use of private pharmacies. Clearly these non-state health facilities are an untapped resource to expand access to FP methods and to increase contraceptive use of a wide range of modern methods including injectables but also other methods.

Figure 4.5 Public Private Mix of Modern Contraceptives by Source and Private Provider Type



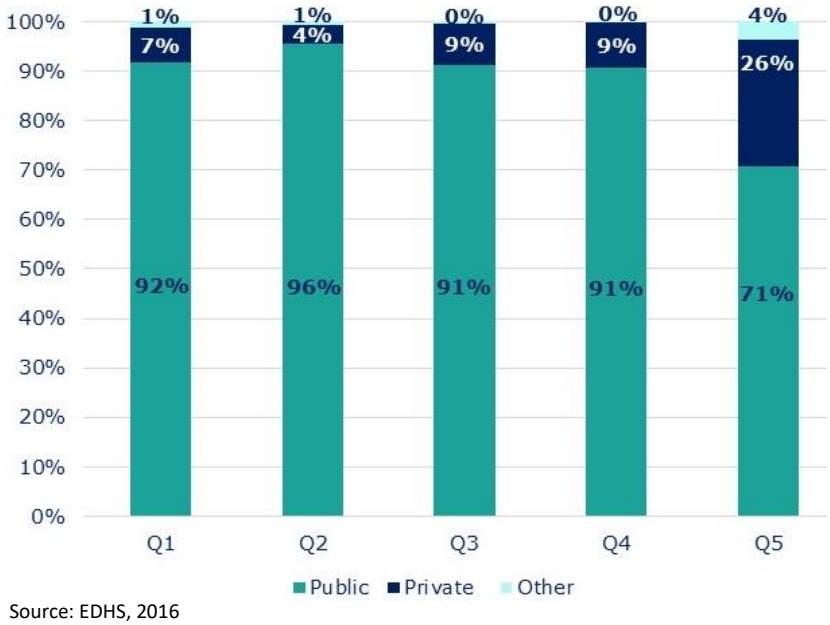
Source: EDHS, 2016

[6] USAID presentation on FP Program in Ethiopia: **Family Planning Program in Ethiopia - K4Health**

The family planning market is appropriately segmented (see Figure 4.6). More than one quarter (26%) of married women from the wealthiest income group (Q5) obtain their family planning method at a private facility while the public sector predominately serves lower income groups (Q1 and Q2 at approximately 92%). It is interesting to note that the private health sector also serves the poor– albeit at much lower rates that higher income groups (Q1 at 7%, Q2 at 4% and Q3 at 9%). Of note is the level of government subsidization of the wealthier income groups (Q4 at 91% and Q5 at 71%) who can afford to obtain their family planning services with a private health care provider. Moving these women to a private provider could free up scarce government resources so that the MOH can focus on reaching lower income groups as well as address many of the systemic problems associated with family planning services listed below.

The private health sector – mostly commercial and non-government clinics - plays a larger role in family planning compared to other health services.

Figure 4.6 Public Private Mix of Modern Contraceptives by Income Group and Provider Type



Source: EDHS, 2016

Private providers serve FP users from all income levels – mostly wealthier but also poorer groups.

The government subsidizes an important portion of FP users who can afford to pay for FP services in the private sector.

As noted in the FP 2020 policy brief - Family Planning 2020 Country Action: Opportunities, Challenges, and Priorities- quality of FP services including counseling and contraceptive security is suboptimal, possibly contributing to the low contraceptive prevalence rate. The brief lists the following challenges: sub-optimal service availability and readiness at government health facilities; missed opportunities to promote FP services due to limited focus on integrated service delivery; inequity of services for key population groups such as youth, pastoral community, minority groups, etc.; and persistent myths and misconceptions about contraceptive methods.

Moving wealthier FP users to a private provider could free up scarce public resources to increase access to FP methods and services for poorer beneficiaries.

Other challenges highlighted in the policy brief that have a direct relation to private provision of FP services included: weak coordination across sectors, such as among health, education, women affairs, youth, and sports as well as public and private sector; restrictive law that limits government engagement of non-government organizations who

advocate and deliver FP services; inadequate systems to assure quality of FP services in both public and private sectors; and managing stock outs in MOH facilities. [7]

In recognition of these challenges, the government of Ethiopia renewed its commitment to redouble its efforts in family planning at the Family Planning Summit in London.[8] The GOE proposed a three-pronged approach:

- Improve the health status of Ethiopian adolescents and youth by increasing modern contraceptive prevalence rate (mCPR) among and reducing unmet need for modern contraception;
- Improve the distribution of FP commodities and consumables by increasing the capacity of the Pharmaceuticals Fund and Supply Agency (PFSA) and strengthening the national supply chain; and
- Increase financing to family planning services by incrementally earmarking funds and using the National Health Account to track expenditures for FP.

Private health sector can assist the Gov't to achieve two out of its three FP2020 commitments by partnering with the FMOH to deliver FP services - particularly to youth – through private and non-government facilities and to perform key functions of the national supply

Partnerships to Deliver Contraceptives with a FP Voucher- Regional Examples of Tools of Government to HARNESS the Private Sector

FP Voucher

Multiple countries (Ghana, India, Senegal, Vietnam) have successful programs with private pharmacies and private drug shops to deliver modern FP methods for "free" to eligible clients. The Ministry establishes a "good prescribing practice" accreditation system for both public and private pharmacists, pharmacist assistants and drug dispensers. The Ministry accredits competent private providers and brands them as government approved providers. The Ministry offers training and supplies the FP methods. They also conduct IEC campaigns describing the benefits of FP, raising awareness of FP voucher program and informing who are the local accredited providers accepting FP vouchers. The Ministry issues the FP voucher to eligible women thereby removing the cost of FP consultation and methods. In exchange the private provider receives a "dispense" fee.

Establish/scale FP mobile services

Mobile FP/RH services is a proven approach (20 countries) based on MSI standardized model. The FP mobile outreach team has a clinician, counsellor and driver who work with community health workers and volunteers. The team offers IEC, temporary and LARC on-the-spot. The evidence shows the outreach has increased: # of new FP accepters, use of modern methods, and client satisfaction. The model is being expanded to offer other basic PHC services like ANC, high risk pregnancy referral, vaccination and well-baby care as well as HIV/AIDs

4.4. Public Private Mix of Maternal Health Services

The SDG target 3.1 aims to reduce the global maternal mortality ratio to less than 70 per 100,000 live births by 2030.

[7] https:/ /www.familyplanning2020.org/sites/default/files/Country_Action_Opportunities-Challenges-and-Priorities_ETHIOPIA_FINAL_0.pdf
[8] http://www.familyplanning2020.org/ethiopia

With a maternal mortality ratio of 421 maternal deaths per 100,000 live births [9]and 19,000 maternal deaths annually, Ethiopia is a major contributor to the world-wide death toll of mothers.[10] Maternal deaths account for 30% of all deaths to women age 15-49.[11] As the 2016 EDHS as shown, this rate has not decreased substantially since the 2005 level at 673 maternal deaths indicating the need to invest not only greater access to healthcare but also interventions that address social determinants of health such as girl child education, job creation and women empowerment.[12]

The causes of maternal mortality are like other developing countries: unsafe abortion, obstructed labor, sepsis, eclampsia and hemorrhage. Indirect causes, such as malaria, HIV/AIDs, tuberculosis and poor nutrition also contribute to high levels of maternal mortality.[13] The 2016 EDHS also shows that low levels of reproductive and maternal health services also exacerbate the likelihood of maternal death: use of skill birth attendance (28%), cesarean section (2%), postnatal care (17%) and contraceptive prevalence (36%).[14] Behind these service statistics are barriers at all levels, particularly for rural women. There few essential services with a skilled provider for rural mothers.[15] Cultural beliefs, costs of care, lack of transportation/distance, low status of women all contribute to low use of ante-natal, delivery and post-natal services with a skilled provider. Of the 72% who were not assisted by a skilled birth attendant during delivery, traditional birth attendant (42%), nurse/midwife (20%) and relatives and neighbors (20%) and a attended these births.

Health Extension Program (HEP)

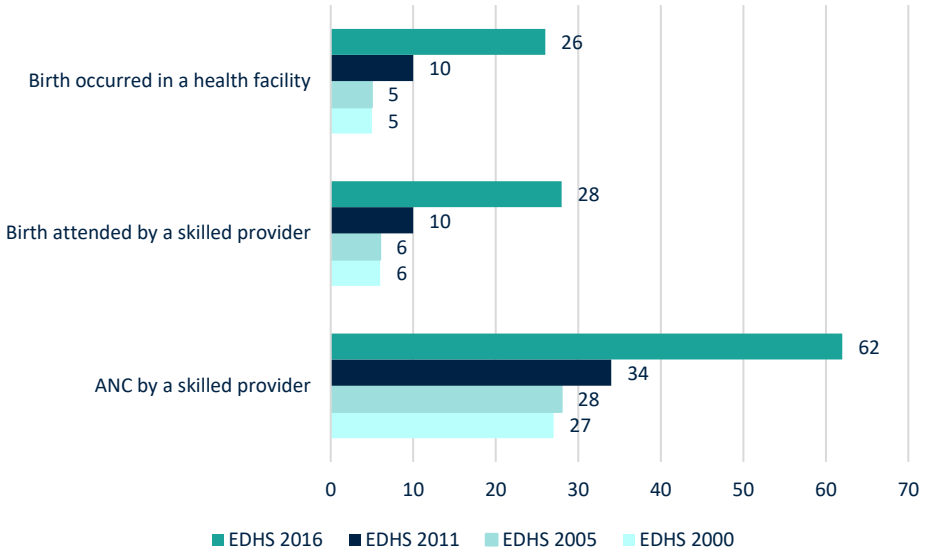
Ethiopia has made great strides in access to key health services through the Health Extension Program (HEP). HEP delivers a basic package of essential promotive, preventive and curative health services targeting households in a community through health extension workers (HEW) (FMOH 2007). HEP focuses on improving household behaviors and providing basic health services that have high impact and are cost-effective, such as improving sanitation and personal hygiene, childhood vaccinations, family planning, prevention and treatment of malaria, and treatment of diarrhea and pneumonia. HEP is one of the government's key strategies to achieve universal primary health care coverage of the rural population.

The Ethiopian Government is a strong advocate for improved maternal health as evidenced by its commitment to the MDGs, improvement of maternal health as a primary goal of the Health Sector Development Program (HSDP III), and increased funding to the Health Extension Program (HEP) introduced in 2003 (see text box). Also, as part of the government's national hospital reform, the MOH identified the quality of hospital-based delivery care as priority for improvement. To meet this objective, the MOH created a hospital alliance of 140 government hospitals assigned to a cluster with one lead hospital to work on priority improvements such as maternity care.[16]

The public health community agrees that specific health interventions, like access to a wide range of FP methods, completion of antenatal care (ANC)+4 visits, safe delivery with a skill attendant, postpartum visit for both the mother and newborn and access to quality Emergency Obstetric Care (EMOC), are critical to reduce maternal and newborn deaths. As the EDHS shows, the MOH has made progress – albeit slow - in many of these health programs. The following discussion discusses each of these areas the potential role private providers can play to help increase access to these life-saving interventions (see Figure 4.7).

[9] EDHS, 2016
[10] Koblinky et al, 2010. https://www.ajol.info/index.php/ejhd/article/viewFile/62951/50846
[11] EDHS, 2011. Table 15.3
[12] Ibid.
[13] Koblinsky et al.,2010.
[14] EDHS, 2016.
[15] Koblinsky el al., 2010.
[16] Koblinsky el al., 2010.

Figure 4.7 Trends in Coverage of Maternal Health Interventions (2000 to 2016)



Source: EDHS 2000, 2005, 2011, 2016

Public Private Mix of Ante Natal Care[17]

Of the women who gave birth in the five years preceding the survey, 62% received antenatal care from a skilled provider, that is, from a doctor, nurse, midwife, health officer and HEW. This is a marked improvement from 28% in 2005 and 34% in 2011. However, one woman in every three (32%) made four or more antenatal care visits during her pregnancy, up from 12% in 2005 and 19% in 2011. And women are starting their ANC late during their term: the median duration of pregnancy at the time of the first antenatal visit is 4.7 months.

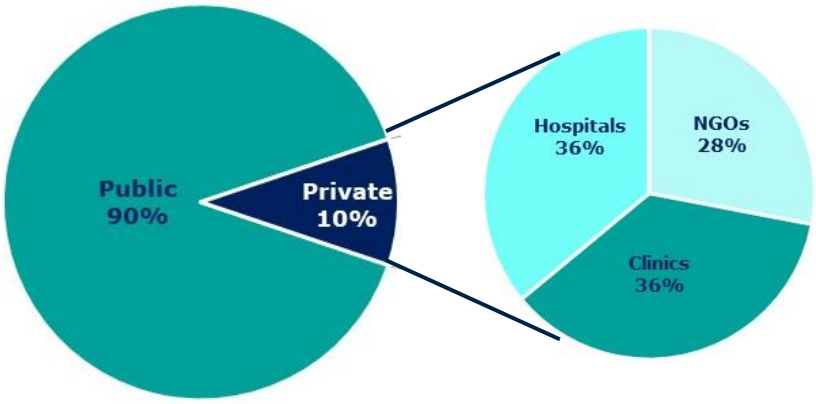
Urban women are more likely than rural women to receive ANC from a skilled provider: 90% of women residing in urban areas received ANC services from a skilled provider compared with 58% of women in rural areas. Urban women are eight times more likely (24%) than a rural woman (3%) to receive antenatal care from a doctor. A higher proportion of urban women (64%) received ANC from a nurse or midwife compared with rural women (39%). Finally, 15% of rural women received antenatal care from a HEW compared with less than 1% of urban woman.

A low percentage (32%) completed the required the four or more ANC visits; a marked improvement from 19% reported in the 2011 EDHS. Urban women are more likely than rural women to have made four or more visits (63% versus 27%). Moreover, the percentage of women receiving the full range of ANC services (e.g. iron tablets, intestinal parasite drugs, blood pressure check-up, urine and blood samples, tetanus toxide injections, complication detection) to maximize the effectiveness of the ANC visits was sub-optimal (e.g. did not complete 100% of care).

[17] All data for ANC is from 2016 EDHS Chapter 9, Tables 9.1, 9.2and 9.3. The Mini-DHS was not available during the report analysis and writing.

Figure 4.8 illustrated the source of ANC. The MOH is the largest provider of ANC services (90%) compared to the private sector (10%). Of the women who did receive their ANC care with a private provider, the distribution was even between a private hospital (36%), private clinic (36%) and non-government facility (28%).
Figure 4.9 shows the source of ANC visits by income group and provider type. As to be expected, more wealthy

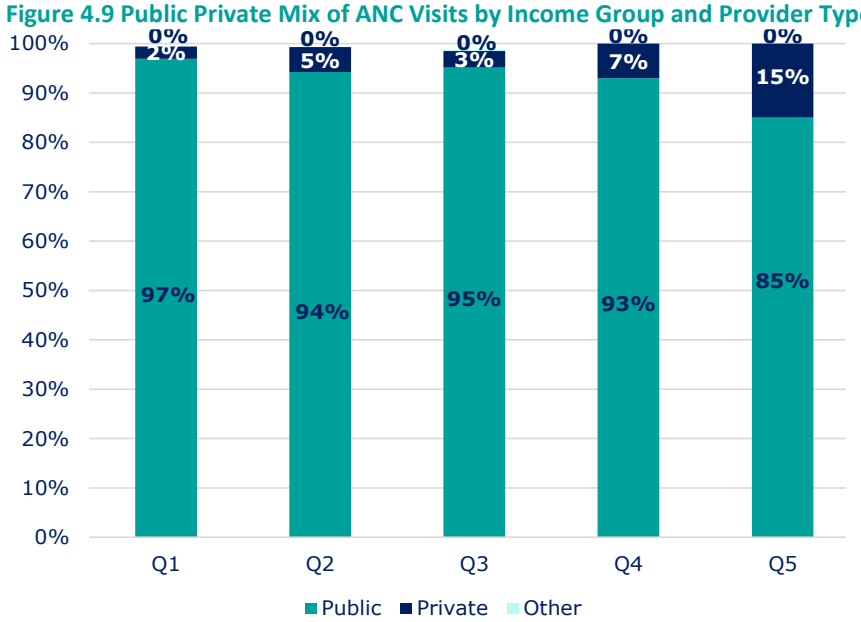
Figure 4.8 Public Private Mix of ANC Visits by Source and Private Provider Type



Source: EDHS, 2016

women seek care in a private facility approximately compared to poorer women. Approximately 15% of women from the wealthiest income group (Q5) obtain their ANC care at a private facility while the public sector predominately serves lower income groups (Q1 and Q2 at approximately 95%). It is interesting to note that the private health sector also serves the poor– albeit at much lower rates that higher income groups (Q1 Q2 and Q3 at around 3%). Like FP services, the government heavily susidizes women from wealthier income groups (Q4 at 93% and Q5 at 85%) who can afford to obtain their ANC care with a private health care provider. Moving these women to a private provider could free up scarce government resources so that the MOH can focus on reaching improving access and quality of ANC visits for lower income groups.

Figure 4.9 Public Private Mix of ANC Visits by Income Group and Provider Type



Source: EDHS 2016.

Public Private Mix of Delivery[18]

Only 26% of all births in Ethiopia are delivered at a health facility—22% of those delivered in a facility was in a public facility and 3% in a private facility. Seven women in every ten delivers at home. The percentage of deliveries in a health facility more than doubled from 10% in the 2011 EDHS while home deliveries decreased slightly from 90% to the current level of 74%.

The private sector delivers a full range of maternal health services.

Attendance at birth by a skilled health worker is one of the major interventions for reducing maternal deaths. According to the DHS 2016 data, only 28% of live births in Ethiopia were delivered by a skilled provider. This is low compared to average in SSA - 54% during the period of 2005-2016 in the African region (WHO, 2016). The percentage of live births delivered by a skilled provider remained virtually unchanged for a period of 5 years after 2000 but increased substantially after 2005; from 6% in 2005, to 10% in 2011, and 28% in 2016.

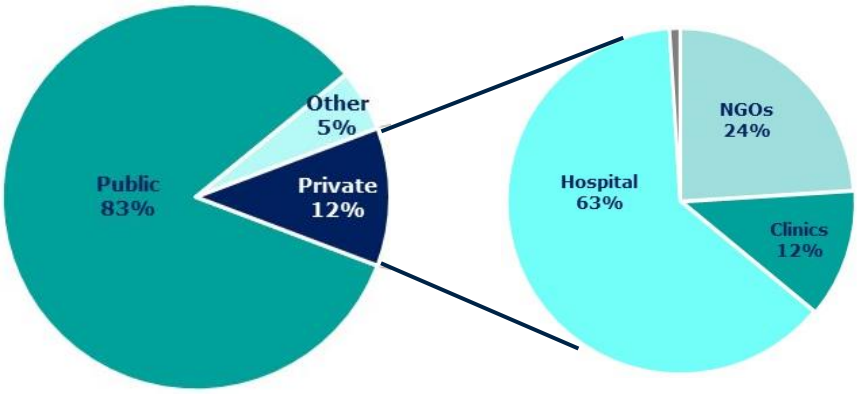
All income groups – including the poor – seek maternity care with a private provider.

First births are much more likely than higher birth orders of six or higher to be delivered in a health facility (48% percent versus 15%). Younger mothers age 20-34, with a higher education and who had a least 4 ANC visits tend to delivery in a health facility. Urban births that fit the above profile are notably more likely than rural births to be delivered in a health facility (79% versus 20%).

Of the 28% of births assisted by a skilled provider — 6% of the attendants were a doctor and 20% a nurse or midwife. HEWs attended to less than 2% of births. The remaining attendant birth were assisted by an unskilled individual: relative (14%) and a traditional birth attendant (42%).

The government subsidizes a significant portion of pregnant women who can afford to pay for maternity services in the private sector.

Figure 4.10 Public Private Mix of Delivery by Source and Private Provider Type



Source: EDHS, 2016

Moving wealthier pregnant women to a private provider could free up scarce public resources to increase

[18] All data for delivery is from 2016 EDHS Chapter 9, Tables 9.7; 9.8 and 9.9). The Mini-DHS want not available during the report analysis.

As Figure 4.10 shows, of the 26% of women who deliver in facility, 83% in a MOH facility compared to 12% in a private one. As to be expected, most women seeking delivery care receive it in a hospital (63%), and a non-government facility (24%) and private clinic (12%).

The EDHS uncovered the reasons why Ethiopians do not access healthcare that can possibly explain the factors contributing such a high percentage (74%) of women do not deliver in a health facility and barriers overall in seeking care during pregnancy and delivery. Seven women in ten (70%) stated having at least one problem or barrier accessing healthcare during pregnancy and delivery. 55% of women stated getting money for the treatment as the largest barrier followed by Access: 50% of women said that distance to a health facility was a problem. As expected, access was a greater barrier for rural woman (60%) compared to urban women (17%)).

The private sector delivers a full range of maternal health services.

Figure 4.11 shows the source of delivery services by income groups. Of the 26% of women who delivered in a facility, the majority delivered in a public one no matter the income group. Lower income mothers (Q1, Q2, Q3) relied more on a public facility (75%, 81% and 78%, respectively). A much smaller percentage of women from these income groups delivered in a private one (less than 5%). A larger percentage of wealthier mothers (Q4 at 12% and Q5 at 14%) delivered in a private facility.

All income groups – including the poor – seek maternity care with a private provider.

Figure 4.11 Public Private Mix of Delivery with a Skilled Attendant by Income Group and Provider Type

Source: EDHS, 2016.

The government subsidizes a significant portion of pregnant women who can afford to pay for maternity services in the private sector.

Once again, the public sector is subsidizing these mothers who can afford to pay for delivery services in a private facility and could move these women to a private provider and free up resources to bring in more women to deliver in a formal setting.

A large proportion of maternal and neonatal deaths occur during the 48 hours after delivery, and these first two days following delivery are critical for monitoring complications arising from the delivery. Post-natal care is a critical aspect of survival for both the mother and the infant. However, the level of postnatal care coverage is extremely low in Ethiopia. The majority of women (84%) did not receive a postnatal checkup. Of the 16% of women who received a postnatal checkup, 13% were examined within 4 hours of delivery, 3% within 4-23 hours, 1% within 1-2 days and 3% within 3-41 days of delivery. In total, 17% of women received postnatal care within two days, as recommended.

Freeing up scarce government resources to allocate more towards addressing maternal mortality is critical. The 2010 level study analyzing the HEW's capacity as a strategy to increase skilled births from its current 28% to the HDSP III stated goal of 32% seems to have been successful". "Expectations that HEWs will fill the void of skilled birthing care are optimistic" despite the increased government investment to have a HEW in each rural village.[19] The authors based this conclusion on the fact that the HEWs have minimal training and experience needed for normal birthing much less the skills need to stabilize a high-risk pregnancy for referral. Moreover, HEWS' perform a variety of other tasks for which they are likely better prepared. Finally, EmOC is still not yet available at all levels. Although not a panacea, partnering with the private health sector delivering the range of FP, ANC, delivery and PNC may be one of many strategies in the government's tool kit to confront this priority health challenge.

Partnerships to Offer Maternity Services – Global Examples of Tools of Government to HARNESS the Private Sector

Contracting private midwives

PhilHealth is the national health insurance program in in Philippines. To encourage more women to deliver in a facility with a skilled health professional, PhilHealth decided to contract private midwives. PhilHealth coordinates with the Department of Health (DOH) to train private midwives to become an eligible PhilHealth provider. The training is comprehensive and includes all FP methods, IUD insertion, pre-natal and delivery, and EmOC. The DOH also helps private midwives to establish basic QA and reporting systems and conducts regular supportive supervision. Expectant mothers and their families receive a predefined set of health services at no cost. In exchange, PhilHealth reimburses the private midwife. This is a very popular health service among women as evidenced by the update of mothers choosing to seek care among private midwives. The private services are convenient, the DOH ensures quality, and the provider delivers excellent customer care with no waiting time.

RH Voucher

Thirteen countries (Bangladesh, China, Cambodia, Kenya-2, Korea, India, Indonesia, Nicaragua-3, Taiwan, and Uganda-2) and growing have implemented Maternal/ Reproductive Health voucher programs to increase uptake of institutional deliveries. A Voucher Management Agency empanels eligible public / private facilities and contracts them for a specific maternity package. Ministry issues vouchers to eligible women who can select public or private provider. Research shows RH vouchers are successful in providing quality care, increasing use of institutional deliveries, greater acceptance of FP/RH and treatment of STDs.

4.5. Public Private Mix of Child Health Services[20]

[19] Koblinsky el al., 2010.

[20] The data on this section is from the 2016 EDHS, Chapter 10, Tables 10.9, 10 and 13. The Mini-DHS was not available during the report analysis and writing.

Unlike maternal mortality, Ethiopia has made major strides in reducing the infant and childhood mortality rates. Indeed, Ethiopia has achieved its Millennium Development Goal (MDG) to reduce the mortality rate for children under the age of five. Under five mortality dropped from 202 in1990 to 64 with 5% annual rate of reduction.[21] Sustained government commitment, matched with high levels of government investment, has successfully driven down deaths among children. Expansion of health facilities and the HEP as well as rapid increases in immunization have all played a significant part in this success story.

- 28% of infant deaths in Ethiopia occur during the first month of life (UNICEF 2018)
- Almost 1 in every 21 babies born does not survive to celebrate their first birthday

The 2016 EDHS states that 29% or 1 in every 3 infant deaths occur in the first month of life. Top reasons for infant deaths are intrapartum related events, pre-term birth complications and sepsis/meningitis/ tetanus.[22] Essential newborn care (drying, warming, immediate and exclusive breastfeeding, hygiene and cord care) as well as basic care for feeding support, infections and breathing difficulties can mean the difference between life and death for small babies. Reductions of early neonatal deaths depend on individualized clinical care and quality of services which is much more challenging to achieve.

Table 4.1 Overall Trends in Childhood Mortality (1990 to 2015)

Rate (per 1000 live births) / Year	1990	1995	2000	2005	2011	2016
Neo-natal Mortality (<1st month	63	68	49	39	37	29
Post Neo-natal Mortality (>2nd < 12th month)	70	62	48	38	22	19
Infant Mortality (< 1st year)	128.5*	111*	97	77	59	48
Child Mortality (>1st < 5th year)	96	94	77	50	31	20
U5MR (btwn birth and 5th year)	202*	173*	166	123	88	67

Sources: EDHS 2016, Figure 8.1 and Table 8.1 and *World Bank Indicators

Figure 4.12 shows, the three most common causes for under five mortality are pneumonia, diarrhea and malaria. Malaria has been consistently the number one killer for children across the years, followed by diarrhea and pneumonia. Post-neonatal deaths are amenable to public health interventions like immunization, breastfeeding, and improved hygiene.

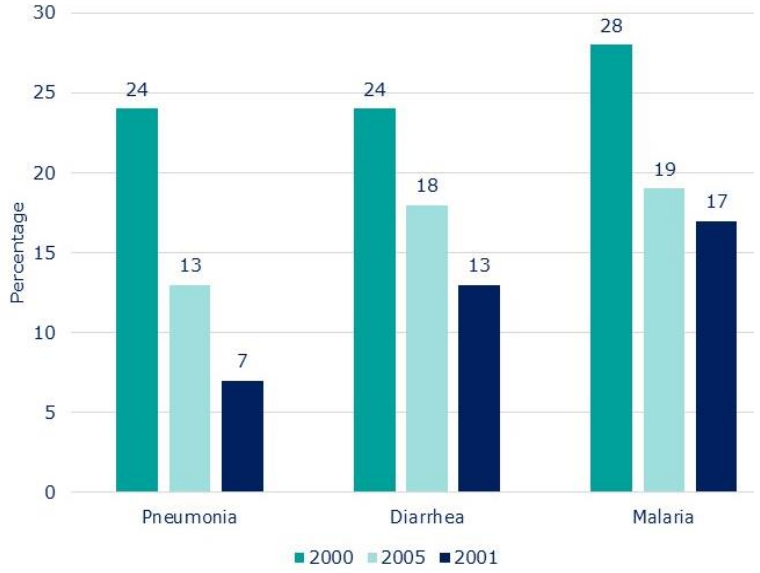
Research in Ethiopia has identified the key determinants that affect a child's survival: maternal education, maternal age at first birth and mothers' marital status, preceding birth interval, birth order, breastfeeding, infections, healthcare, family income, and hygiene practices. [23]

- Risk of dying for a child born to uneducated mother was 1.8 times higher compared to a child whose mother had primary and higher education[24]
- Births to teenage and older mothers face higher mortality risk than births to mothers in the age group of 25–29 or 30–34[25]

[21] Adinew et al. 2017
[22] Profile of Preterm and Low Birth Weight Prevention and Care. https://www.healthynewbornnetwork.org/hnn-content/uploads/Ethiopia20171.pdf
[23] Adinew et al. 2017
[24] EDHS, 2016
[25] Ibid.

- In general, children born after long birth intervals (lasting three years or more) appear to have better survival chances in all these age periods[26]
- Breastfeeding is the most important factor for reducing infant mortality and death rate was lower for neonates who were put to breast immediately upon birth[27]
- Mothers who did not use soap for hand washing had higher infant death than those who used soap[28]
- Children in poor families have relatively higher risks of infant mortality compared to those belonging to medium or rich families
- Higher levels of wealth score and income have shown a significant reduction in child mortality[29]

Figure 4.12 Trends of Common Causes of Under-5 Mortality (2000 to 2010)



Source: Adinew et al, 2017. Figure 8

Further research has demonstrated factors contributing to rapid decline in childhood mortality. One of the reasons behind the observed success has been the expansion of the coverage of health service. The MOH has expanded both health infrastructure and health extension programs significantly. As a result, primary health service coverage reached 93.4% of the population in 2012/13 and 94.0% in 2013/14.[30]

[26] Adinew et al. 2017
[27] Ibid.
[28] Adinew et al. 2107.
[29] Ibid.
[30] National Planning Commission, 2014.

Another important factor is increase coverage of childhood vaccines, particularly vaccines for measles and DPT3. In 2013/14, coverage for pentavalent 3 immunization was 91.1%, pneumococcal conjugate vaccine (PCV) immunization was 85.7%, and measles immunization was 86.5%. The percentage of fully immunized children was 82.9%.[31] Finally, residence is another factor contributing to reduced childhood mortality. [32] According to consecutive EDHS (2000, 2005, 2011, 2016) childhood mortality in urban areas is consistently lower than in rural areas. Infant mortality is 13% higher in rural areas (62 deaths per 1,000 live births) than in urban areas (54 deaths per 1,000 live births). Under-five mortality is higher in rural areas compared to urban (83 compared to 66deaths per 1,000 live birth, respectively). Finally, childhood mortality was 43% higher in rural areas than in urban areas.

The private health sector is an important source to treat childhood illnesses: out of three children with diarrhea and/or fever are treated by a private provider.

Diarrhea

Acute childhood diarrhea is one of the leading causes of death in children under five in Ethiopia, which is largely the result of lack of access to safe water, poor environmental condition, and crowded living conditions. The combination of high cause-specific mortality and the existence of effective treatment - oral rehydration therapy (ORT) - make diarrhea and its treatment a priority and area.

Mothers with sick children seek treatment from frontline providers – pharmacists and drug sellers.

Compared to other priority health services, there is greater use of the private sector to treat a child's diarrhea. Approximately one third (30%) of children received treatment at a private facility. Still, the public sector is the most important provider for diarrhea.

The private sector is also an important source of locally manufactured products needed for child health – bed nets, ORS, zinc, nutritional supplements.

As Figure 4.13 shows, all income groups seek treatment for a child's diarrhea in a private facility, ranging from 25% in the lower income groups to as high as 40% in the highest. Like maternal health, the government subsidizes the wealthier income groups who can afford to seek treatment in the private sector. Treatment of diarrhea is an area in which the private sector can play a major role through local manufacturing of and expanded access ORT through private channels.

The poor rely more on public services compared to the wealthy.

[31] Adinew et al. 2017
[32] EDHS, 2016

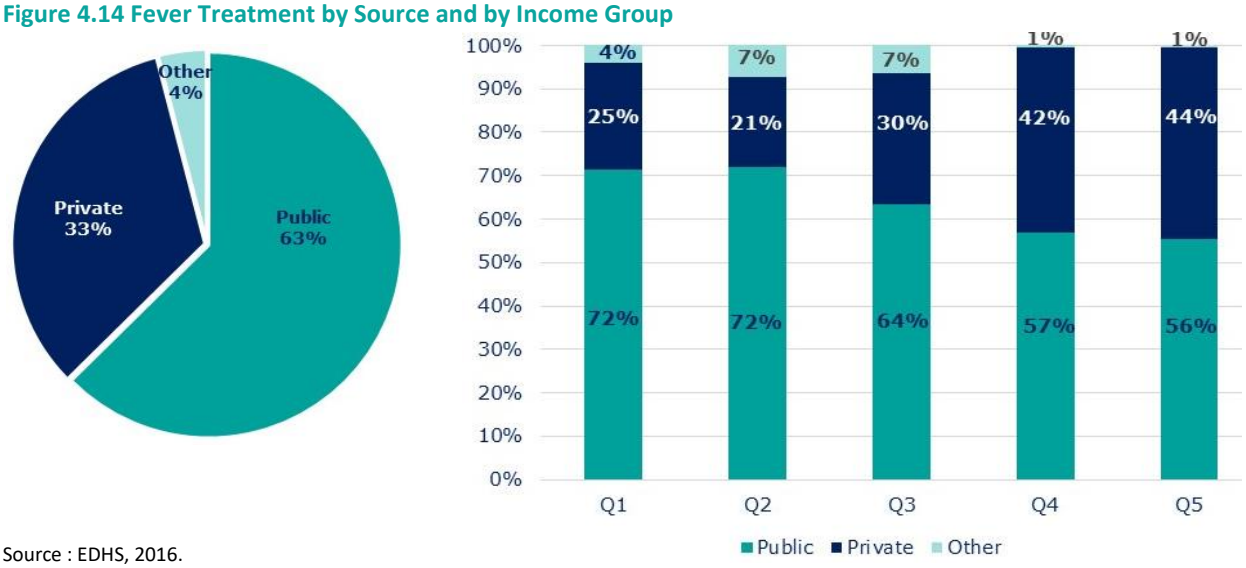
Figure 4.13 Diarrhea Treatment by Source and by Income Group

Source: EDHS, 2016.

Fever/cough

Fever is a major manifestation of malaria and other acute infections in children. Fourteen percent of mothers reported that of their children under five had had fever in the two weeks preceding the survey. The prevalence of fever varied by age of child and was highest in children age 6-11 months and 12-23 months (21% and 20%, respectively). Among children with fever, nearly one-third (35%)
sought advice or treatment for the fever at a health facility or health provider. Children age 6-11 months, male children, and children living in urban areas were more likely to have received advice or treatment than other children.[33]

Figure 4.14 Fever Treatment by Source and by Income Group



Source : EDHS, 2016.

Among children with fever, more than one third (33%) sought care with a private provider while the other two almost thirds (63%) visited a public provider (see Figure 4.14). Once again, all income groups seek treatment of a child with fever. Moreover, the higher income groups treated their sick child with fever at a private facility at

[33] EDHS, 2016.

about the same levels (approximately 43%) as those with a sick child with diarrhea. The MOH could save resources by encouraging those who can afford to pay to seek treatment with a private provider.

4.6. Examples of Public Private Partnerships in Ethiopia

Partnership to Improve Diarrhea Treatment – Ghana Example of Tool of Government to HARNESS the Private Sector

The government worked with the private sector to compliment Ministries efforts to treat acute pediatric diarrhea. The Ministry focused on front line providers in communities such as private pharmacists, drug retailers and over the counter medical sellers (OTCMS). With USAID's assistance, the Ministry, in partnership with the Ghana Pharmacy Council, trained the frontline providers in treatment guidelines for acute diarrhea. They also trained private providers such as doctors, nurses and midwives in the new diarrhea protocols. The Ministry reinforced knowledge through supportive supervision and text messaging. To ensure a sustained supply of quality, affordable ORS and Zinc, the Ministry partnered with M&G Pharmaceuticals to manufacture locally and distribute the zinc product - ZINTAB. Finally, the Ministry carried out extensive IEC campaigns to educate consumers about diarrhea treatment and ZINC.

The MOH has a growing – albeit limited – experience in partnerships with the private health sector. The partnerships range from health service delivery, to management contracts, to outsourcing of non-clinical services (see Table 4.x; note that each row has a definition of the type of health PPP and examples). Stakeholder interviews show that ***most of the partnerships are ad hoc, informal and often based on personal relationships*** between the public and private sector partners. Faith-based organizations have long-standing service delivery partnerships with the MOH, but it is still mostly informal with no contract or MOU in place. And several non-government and civil society organizational (e.g. AMREF, Red Cross, others) have partnerships with the MOH to implement projects but through informal agreements. Originally the partnerships were with mostly faith-based and non-government organizations but ***there are an increasing number of partnerships with the for-profit sector***. Examples include public-private projects to deliver TB, HIV and FP and more recently laboratory services. It is important to note that these recent partnerships are donor driven through specific health projects.

However, there are barriers to expanding the number and type of public-private partnerships. Stakeholder interviews also indicate the ***MOH lack sufficient tools and capacity to execute partnerships.*** For example, the MOH has scarce and incomplete data on private sector size and capacity. The MOH has insufficient number of staff with the skills needed to design and manage complex PPPs. And there is no strategy in place that links partnership to HSTP priorities, resulting in ad hoc and opportunistic projects that are smaller scale.

In addition, the MOH stated it is ***difficult to partner with private health sector.*** The private sector, although organizing into professional and trade associations, is still fragmented and does not speak with "a common voice" on key policy areas and partnership approaches. Quality is inconsistent in private health sector making it difficult to find competent private providers. And negative perceptions and lack of trust linger between the two sectors.

Table 4.2 Select Examples of Health PPPs in Ethiopia

	**Primary care: Public health, vaccinations, maternal and child health services, PHC** ▪ **Dubo St Mary Catholic Primary Hospital** serves as the referral hospital for nearby MOH public health centers and health posts ▪ **Wasera Catholic Health Centre** serves as referral health centre for nearby MOH health centres and health posts ▪ **St Luke Catholic Primary Hospital and School of Nursing** serves as referral hospital for nearby health centers and health posts ▪ **Red Cross, Marie Stoppes and Kenema:** Directorate of Drug & Pharma Administration partners with these entities to address stock-outs in MOH facilities ▪ **Bilal Primary Hospital** is a private provider that the govt has contracted to deliver ART, PMTCT, FP counseling and methods for patients in Dire Dawa city administration (patient pay for exam but not the drugs) ▪ **Gizaw Higher Clinic** is a private provider contracted by regional health bureau in Oromia region to deliver TB care and treatment, and Malaria diagnosis and treatment ▪ **Jimma Higher Clinic** is a private provider contracted by Regional health bureau to deliver TB diagnosis and treatment (DOTS)
	**Clinical support services: Lab analysis, diagnostic tests, managed equipment services, other** ▪ **ICL and ARSHO contracts:** Regional government hospitals have over 15 agreements with private labs to deliver specialized lab tests to MOHgovernment facilities that do not have lab equipment or lab staff to perform these specialized tests ▪ **GE or independent biomedical engineers:** MOH has multiple contracts across the country with a private company/individual to service MOH medical equipment ▪ **Julphar purchase agreement:** MOH purchases medicines, such as insulin, from a local manufacturer ▪ **Medicine and Drug Purchase Agreement:** MOH contracts private pharmacies to supply and services its public patients for an agreed purchase price in specific regions where drugs are not available or experiencing stock outs in public facilities
	**Specialized clinical services: Dialysis, radiotherapy, day surgery, other specialist services** ▪ **Mekelle University Hospital**: A privately established dialysis center (service and teaching) ▪ **Zewditu memorial hospital**: An eye Care Center established by private investors ▪ **Bahir Dar Health Center**: A private non-profit investor established Vision Maternity Care ▪ **MOH Hospitals partner with Sudanese and Egyptian** firms (both clinical and management expertise) to transplant kidneys and deliver dialysis in public facilities
	**Non-clinical services: IT equipment and services, equipment maintenance (MES), food, laundry, cleaning, building and equipment management** ▪ **Mizan Aman Public Hospital:** Outsources accounting services to a private vendor ▪ **Local private companies:** MOH has several contracts with a range of private companies to manage security, housekeeping, catering in public health facilities
	**Management contract: Management of entire facility or network of hospitals and/or clinics** ▪ **Gefersa Mental Health and Rehab:** Facility management is contracted to Catholic church
	**Emergency services: Fleet management and paramedic training** **Tebita and Red Cross:** The MOH is in initial discussions with Red Cross for collaboration

Source: Stakeholder interviews and MoH, HEPCAPS2 Project. 2015. Strengthening Public Private Partnerships for More and Better Health Outcomes in Ethiopia: Expert Reviews and Case Studies. Ethiopian Ministry of Health, Harvard T.H. Chan School of Public Health, JSI Research & Training Institute, Inc.: Addis Ababa, Ethiopia, Boston, Massachusetts

As the box denotes, countries with well-developed capacity and institutional arrangements to transact with the private sector use PPPs in the health sector to transfer infrastructure and service projects to the private health sector.

Transactional PPPs – Global Examples of Tool of Government to TRANSFER to the Private Sector

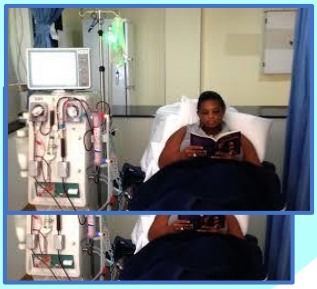
Infrastructure PPPs

- South Africa DOH issued **multiple facility PPPs** to rehabilitate Pelonomi hospital and the Universitas Hospital, operate private wings in each facility, and technology transfer between public/private staff.
- Indian State Govt. formed a PPP with GVK to create **emergency services.** GVK raised private capital funds to construct call center and EMT school, acquire and equip ambulances, establish infrastructure for dispatch technology, and train and hire staff including EMT/drivers.

Services PPP

There are several examples of services PPPs using **co-location** for lab, dialysis, and imaging services:

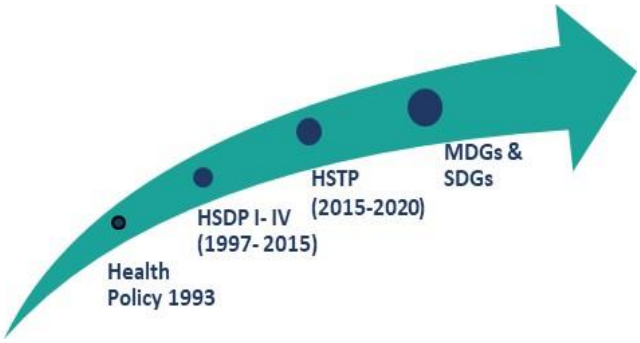
- Lancet and Kenya Moi Hospital formed a **co-location PPP for diagnostic services.** Moi Hospital offers space and lends its staff. Lancet remodelled and equipped lab, trained MDs and lab staff, operates lab and resupplies commodities. Patients pay below market price for tests.
- Uttar Pradesh MOH and Braun formed a **co-locations PPP for dialysis services.** Hospital offered space but also required Braun to open centres in rural areas. Braun remodelled and built new centres, purchased equipment, staffed and operates centres. Patient fees covered by RSBY (national health insurance).



5. Enabling Environment Supporting the Private Health Sector

This sector examines the general policy framework that shape and influence the MOH's policies and perspective in working with the private health sector. Figure 5.1 illustrates the principle policies that shape the Ethiopia health sector. The 1993 Health Policy - now being revised - created the foundation for current policies and regulations in health. The health sector aligned itself to the GOE's national development policies and planning cycle in the early 1990s. In 1996, the MOH developed its first Health Sector Development Plan (HSPD) which spanned a 20-year period starting in 1997. Every five years, the MOH updates the HSPD building on lessons learned in the previous phase. There were four HSDPs. In 2015, the MOH transitioned to the Health Sector Transformation Plan (HSTP) which cover the timeframe between 2015-2020. The MOH is in the process of organizing a planning process to draft the next five-year HSTP. This section discusses the MOH's growing

Figure 5.1 General Policy Framework



interest, as the HSDP and HSTP show, in working with the private health sector. In addition, the GOE has signed both MDGs and SDGs that have prioritized the national health goals and objectives.

5.1. Review of General Policy Framework

A review of the general policy framework shows a growing government as well as MOH interest in working with the private health sector (see Table 5.1). The earlier HSPD plans (HSDP I-II) did not recognize the private health sector role and there was no mention of the need to coordinate and dialogue with non-state health actors. Later plans (HSDP IV and the HSTP 2015-2020), however, increasingly acknowledged the private sector. The HSTP IV was the first plan to mention public private partnership (PPP) in health and the HSTP further defined and developed the health PPP concept. Rapid expansion of private training institutions accompanied by growth on both private for-profit and non-government organizations sectors inspired government interest. Moreover, the 2015 Health Financing Strategy initiated private wings in public hospitals and other private sector projects. Subsequently, all plans - HSDP IV and HSTP - plans referenced the need to engage the private sector in health.

The MOH's attitude towards the private sector, mostly private for-profit sector, has changed in the last five years. The MOH aligned itself with the GOE's perspective on private sector after the 2015 Growth and Transformation Plan acknowledged the private sector's role in economic growth and social development and recommended partnerships and dialogue with the private sector. The 2015 HSTP reflected this change in government position vis-à-vis the private sector and identified specific opportunities to engage and partner with the private health sector. Moreover, the MOH develop a PPP Strategic Framework aligned to the 2017 MOFEC PPP Proclamation that paved the way for more coordinated efforts and initiatives in engaging the private sector in health.

Table 5.1 National and Health Sector Development Policies

Policy / Plan	Private Sector References
Growth and Transformation Plan (2015-20)	▪ Recognizes multi-factorial challenges for private sector engagement ▪ Recommends supporting and strengthening partnership and dialogue particularly in the areas of manufacturing industry and foreign direct investment ▪ No clear mention of encouraging private sector in health but otherwise focused on private sector as it relates to road, electricity and telecommunications sectors
PPP Framework (2014) and Policy for the Use and Implementation of Public Private Partnerships (August 2017)	▪ Recognizes the use of PPPs to fill gap in infrastructure financing ▪ Acknowledges benefits of private sector involvement in: innovations; cost reductions; improved quality and efficiency; knowledge transfer and increased asset utilization ▪ Key objectives to develop a PPP framework and promote enabling environment for private sector engagement (mainly in investment) and facilitate project development ▪ Led to PPP definition, governance and implementation framework prior to more detailed PPP legal framework development.
Health Sector Development Plan (HSPD I-IV)	▪ 1997/8 Health Sector Development Plan I and HSDP II main focus was on decentralization and primary health care expansion ▪ Both plans had minimal reference to the private health sector ▪ HSDP IV and the HSTP 2015-2020 increasingly acknowledged the private sector: HSTP IV was the first to mention PPPs in health and the HSTP further defined and developed the health PPP concept ▪ 2015 Health Financing Strategy references health PPPs and establishes private wings, other PPPs and health insurance ▪ MOH seriously considers engaging the private health sector in HSDP IV 2010-2015 ▪ HSDP IV mentions need for inter-sectoral collaboration and PPP ▪ Specific areas for PPPs include HRH development; access to commodities, drugs and reagents and contracting private health facilities in prevention and treatment of TB and HIV/AIDS.
National Health Sector Transformation Plan (2015-2020) – HSTP	▪ HSTP identifies multiple opportunities to engage with private health sector and proposes specific actions related to the private sector: – Clarifying dual practice – Extensive references to PPPs including outsourcing clinical and non-clinical services – Developing of PPP manual and implementation tools – Supporting and monitoring private sector engagement ▪ HSTP also acknowledges need for "organized engagement of the private sector"
MOH- Public Private Partnership in Health – a Strategic Framework for Ethiopia (June 2013) **MOH -Public- private Partnerships in Health – Implementation Guidelines (Jan 2017)**	▪ MOH developed a PPP in Health strategic framework (2013) and implementing guidelines (2017) to lay out priorities and boundaries for partnerships in health ▪ MOH identified areas of collaboration: financing; service delivery; capacity building; policy and standard design and HRH development ▪ Priority areas identified: tertiary level medial services; pharmaceuticals and medical commodities; human resources development and strengthening availability and access to high impact public health services

Overall, the health policy framework and health strategies support private sector engagement (see Table 5.2). Key policies, such as the Universal Health Coverage Plan, the Health Financing Strategy and various disease specific strategies, make several references to working with the private health sector – primarily in ***a supportive and complementary role*** to MOH's efforts to expand access, improve quality and strengthen equity. Moreover, the Ethiopia E-Health and Health Information Strategies recognize the MOH does not have reliable data on the

private health sector and propose strategies to address this gap including initiatives to encourage increased reporting by the private health sector into Ministry information systems.

Table 5.2 Health Sector Policies and Plans

Policy / Plan	Private Sector Reference
Universal Health Coverage	▪ MOH's strategy to achieve UHC has more > 100 references of the private health sector ▪ Focuses on enhancing private sector role to assist MOH to expand access and quality ▪ Discusses need to collect better data on and update the information for the private health sector
Health Financing Strategy, 2015	▪ Comprehensive review of current financing strategy ▪ Encourages private sector participation in financing strategies such as service contracting, fee exemption program and insurance schemes ▪ Proposes specific PPP opportunities including private hospital wings, outsourcing non-clinical services, etc.
Ethiopia E Health Strategy and Health Information Strategy	▪ Recognizes need for more data on private health sector ▪ Proposes actions to encourage private sector reporting data and integration into public health information systems ▪ Proposes leveraging private sector technical expertise in IT innovations
Health Strategies and Implementation Plans	▪ Multiple health strategies (e.g. NCD; Malaria, HIV, Hygiene; Maternal, Child and Newborn strategies) recognize and propose actions to partner with private sector
National Drug and Pharma Policies and Plans	▪ Minimal reference in National Drug Policy 1993 ▪ New National Strategy and Plan of Action for Pharmaceutical Manufacturing (2015-2025) proposes actions to enhance private investment in drug manufacturing ▪ EFDA initiatives underway to streamline supply chain regulations (e.g. e-licensing and drug registration portal) as well as reform the public procurement agency (EPSA) to become more efficient and transparent in procurement and warehousing.

Moreover, the systematic review of Ministry strategies and plans reveals that there ***is no overarching strategy on how and where to engage the private health sector***. Instead, there are ad hoc, diverse and at times, overlapping strategies to engage the private sector across the different MOH departments. Moreover, these strategies recommend engaging the private health sector but offer few details or implementation plans to operationalize the sector engagement.

5.2. Stakeholder Perspectives of Enabling Environment

The PSA team conducted over 20 interviews representatives from the public and private sectors to identify attitudes and perceptions on working together, policy challenges that prevent greater public-private collaboration, and market conditions hampering private health sector growth (see Box 5.3). Several important findings emerged from the stakeholder interviews:

Table 5.3 List of Stakeholder Groups Interviewed

Public Sector Stakeholders (10 groups)		Private Sector Stakeholders (8 groups)
▪ HRH Licensing Directorate (HHRID) ▪ Facility Licensing Directorate ▪ Partnership and Coordination Unit	▪ Medical Services Directorate ▪ Policy and Planning Directorate ▪ EFDA	▪ Federations ▪ Service Provider Associations ▪ Professional Associations ▪ Ethiopian Investment Commission

▪ Ethiopian Health Insurance Agency		

Finding #1: No common vision of challenges in the health sector

Each stakeholder group outlined, from their perspective, the key challenges they confront in the current health sector (see Table 5.4). Understandably, the public sector focused on challenges related to population's interests – access, quality, equity – while the private sector focused on the barriers as a healthcare business. The one area that both sectors agreed on is human resources for health (HRH) stating there is a shortage of trained and skilled health professionals in the sector. ***Focusing on HRH challenges and working together to identify solutions may be a starting point for public-private dialogue.***

Table 5.4 Health System Priorities by Stakeholder Groups

Public Sector Priorities	Private Sector Stakeholders (8 groups)
▪ **Insufficient Funds:** Government underfunds health sector; limited budget to implement. ▪ **Human Resources**: Skill-level is low; limited level of ethics; retention is low due to brain drain; limited leadership skills; benefits and challenges of dual public-private practice. ▪ **Infrastructure:** Ageing infrastructure; insufficient number of facilities to population size; little to no maintenance of facilities and equipment due to lack of expertise and funds. ▪ **Shortages:** Constant stock-outs of drugs, commodities and supplies in public facilities and across the country. ▪ **Bureaucracy:** Highly inefficient and duplication of functions across departments. ▪ **Inequity:** High financial burden on patients; limited reach of current financing schemes.	▪ **Facility Licensing and Standards:** 2012 facility standards have downgraded private facilities. MOH implements facility standards more stringently with private sector. ▪ **Pharma Regulations:** Highly cumbersome, long and bureaucratic process across all supply chain (but with promising recent efforts to streamline). ▪ **Customs:** Very bureaucratic and inefficient (again with promising initiatives to streamline). ▪ **Taxes:** High relative to other "favored" sectors in economy. ▪ **Land:** Very expensive. Dampens expansion or new greenfield plans. ▪ **Financing**: Limited access to local/foreign capital; Forex a significant barrier. ▪ **Human Resources:** HRH shortage and poorly trained. Private HRH have limited access to MOH training. ▪ **Perception:** MOH has negative perception and suspicious of private sector. Limited (but improving) engagement between MOH and private sector.

Finding #2: Incomplete data on the private health sector *but* MOH initiatives to address this gap

As noted earlier, data on the private health sector is a significant barrier to private sector engagement. The stakeholder interviews confirmed the significance of this barrier and add the following observations:

> *"We do need private sector data to better understand the health situation in our country and even if we have to, we will force them to give it to us"*
>
> Public sector official

- **No standard definition:** MOH understanding of the private sector is mainly limited to "for profit" entities. There is no standard definition used across the MOH that recognizes the full range and diverse groups active in the private health sector.
- **Inconsistent reporting:** Private sector data is not reported consistently and/or from one MOH report to another. For example, sometimes the private sector is defined as private not-for-profit or MOH reports includes data on the private sector in one year but not the others.
- **Data is fragmented**: The federal level licensing authority has some private health sector data while all the regional health bureaus capture other private sector data. The data is not routinely aggregated nor reported on due the lack clarity on which department is responsible for this function. Some interviewed said it is the licensing authority while others believe it is policy and planning department's responsibility.

> *"We do not know who they are and how to get in touch with them…too many associations and not representative"*
>
> Public sector official

- **Data quality:** Data quality is poor because there is not standard definition for private health sector, creating room for MOH staff at different

levels to interpret it differently. In addition, the publicly available data on the private sector is out-of-date sector and considered questionable.

- **Data collection systems are out-of-date:** In addition to being fragmented (collected by different authorities), all major systems related to the private health sector are paper- and/or desk top based and as a result, are not integrated. Systems include facility and medical training institute licensing, HRH certification and continuing professional development hours.
- **Under-reporting:** Even the private sector stakeholders acknowledge that they do not regularly report data to the ministry health systems. Barriers to reporting include i) fears of taxation, sanctions or closure, ii) cumbersome MOH reporting requirements, and iii) private sector data not included in MOH reports and plans nor shared consistently with the private health sector.
- **Limited capacity:** In additions to the data collection challenges described above, MOH stakeholders admitted limited capacity to present and interpret data on the private health sector as well as how to use the data for policy and planning.

The overall policy environment supports private sector engagement and public private partnerships.

MOH initiatives: In response to these challenges, the public sector stakeholders shared the different initiatives underway to overcome these barriers: i) the MOH Policy and Planning Directorate has organized a platform to engage the private sector on increasing reporting to the HMIS; i) the MOH Health IT Directorate is procuring IT services to digitize MOH paper files and to create a web-based platform integrating the different data systems; iii) the MOH Health IT Directorate will include all private health facilities by the end of this year in the Master Facility list and iv) the MOH Human Resource and National Health Professionals Competency Assessment and Licensure Directorates are creating a registry of all – including private sector - health professionals. Even though the MOH acknowledge the need to collect data on the private health sector, many public stakeholders interviewed stated they would like assistance to better understand what data is critical for key MOH policy and planning functions as well as routine MOH reports to reflect the private sector contribution in health.

There a few challenges to operationalizing this support such as incomplete data on the private health sector and weak regulatory framework.

Finding #3: Weak (but improving) regulatory framework and implementation

The overall regulatory framework is out-of-date and contains many barriers to growing and harnessing the private health sector. Key policy gaps are concentrated in the areas of facility licensing, HRH certification and licensing, dual practice, private medical training institutes accreditation, and PPP authority and capacity. There are, however, several regulatory review processes underway to address some but not all barriers. Moreover, the

The FMOH recognizes these barriers and has multiple initiatives underway to address them.

private health is not always invited to participate in the reform process even though it directly affects their healthcare businesses. Stakeholders pointed to the following barriers:

- **New facility standards have created barriers:** The land requirement creates high burden for entry to market. New facility standards have reclassified many private facilities to lower "categories". The current process to apply and renew one's facility is lengthy with long time delays creating added costs. Finally, the MOH has limited capacity (e.g. enough staff) to implement standards and to "fairly" monitor private sector quality.
- **HRH policies are out-of-date but changing (slowly):** There is no mention of the private health sector in the "Health Professionals Establishment Proclamation" and "Medical Practitioner Registration". Although 2016 National HRH Plan recognizes private health professionals, but there are no policies and regulations to govern and guide private health professional in practice. The policies on dual practice policy and public staff working in private wings in public hospitals are unclear and poorly monitored. Moreover, the process to renew one's professional license is cumbersome and time consuming, requiring a private provider to take time off from work to hand carry the documentation to MOH offices.

> *"MOH staff do not always have the experience! So even if a minister is encouraging, implementation is slow and different"*
>
> Private sector representative

- **Private medical training institutes are mostly unregulated:** With limited staff, HERQA struggles to keep pace with the demand to license a growing number of private medical training institutes. Moreover, they do not have enough staff to monitor the quality of the private medical training institutes curriculum. Currently there are no plans in place to resolve the issues of HRH graduates from unlicensed private medical training institutes and to address oversight of the mushrooming number of unlicensed private medical training institutes in operation.
- **Limited capacity to monitor private sector quality:** Many public officials stated they are too few staff to monitor quality. Even if there are enough staff, the private sector stakeholder interviewed stated that the quality standards are not implemented fairly and that there is a "double standard" in which the private sector quality is judged more strictly. Moreover, private sector providers have few opportunities to improve quality. Standards are not widely disseminated. There are minimal site visits and supportive supervision to reinforce the quality standards. And private providers are not included or have access to donor- of government-supported training to upgrade clinical skills.
- **Limited capacity to implement public private partnerships in health:** Many private sector stakeholders stated that public-private partnership opportunities are important to them and that they want to work more closely with the MOH. Public officials also shared the same perspective that collaboration and partnerships are important to the MOH. However, the same stakeholders expressed the challenges in translating the recently enacted PPP policy to health sector: there is no overarching private sector strategy outlining the goals and objectives of private sector engagement; MOH does not have enough staff with relevant skills needed to implement health PPPs; and there are no implementation guidelines and/or tools (e.g. contracts) in place.

MOH initiatives: The public sector stakeholders shared the MOH's efforts to address some of the identified barriers:

- **HRH:** The MOH Human Resource Development and the National Health professionals Competency Assessment and Licensure Directorates are reviewing the licensing processes and are currently updating the regulations for continuing profession development hours and will later digitize HRH licenses.
- **Medicines and technologies:** The new Ethiopian FDA or Federal Drug Agency has launched an e-registration and licensing platform)
- **Health financing:** The Procurement Fund and Supply Agency (PSFA) is reforming and streamlining public procurement and distribution to address bottlenecks, and

- **Governance:** The MOH is updating the Health policy initially developed in 1993 and is circulating the revised version to key private stakeholders. There are positive reforms and process streamlining as it comes to pharmaceutical licensing and registration. See Box on the Ugandan example of modernizing regulatory system s governing the private sector.

Promising Approach to Modernize Regulatory Systems-Uga
Tools of Government to GROW the Private Health Sector

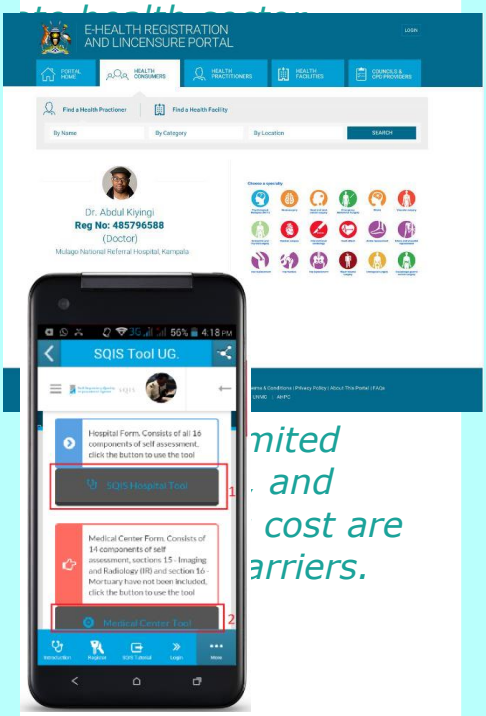
The four health professional councils, with support from USAID, are updating and modernizing professional certification and facility licensure using technology. The Councils have created a web-based platform that enables all healthcare professionals to reapply and pay for their professional certification and for private businesses to apply for facility licenses. The new system will:

- Develop a single, uniform application and process to be used by all Councils
- Collect consistent and standardized information that clearly delineates public, private-for-profit and not-for profit and dual practices among professionals and facilities
- Centralize all data collection and reporting
- Align and apply MOH facility classification across all sectors, and
- Streamline facility inspection using a web-based tool.

In addition, the councils are developing a single, universal tool common to all councils and regulatory authorities to inspect facilities. The linked continuous professional development (CPD) hours to clinical standards and developed a system to track and issue CPD hours.

In addition, the Ministry of Health and private sector developed a self-regulatory quality tool. It is a simple web-based tool that can be self-administered by private facilities. The tool gives a quality "score" that can be ranked with other facilities. The MOH and Councils approved the tool and it is now a requirement for professional certification and facility licensure. The Uganda Healthcare Federation is training its member associations to use the tool while the Ministry is training its District Health Officers to apply SQIS and other tools with private providers and facilities.

Market conditions present biggest constraint to



mited and cost are arriers.

e are limited nomic and financial incentives to attract and retain private health businesses.

Finding #4: Poor market conditions limit private health sector opportunities

In addition to delivering health services, private providers are also businesses. They face the same challenges that other businesses do when operating in the Ethiopian economy. The key market barriers health businesses confront include:

- **Difficult to access credit:** As many private stakeholders shared, the banks do not understand the health sector and are unwilling to lend to healthcare businesses. Nor do these financial institutions have the capacity – for example loan products, favorable terms of credit – to lend to health businesses. Lack of access to capital creates barrier to market entry, dampens growth and limits expansion of existing businesses.

> *"Banks do not understand healthcare investments and no 'knowledge capital'…it is all brick and mortar as assets"*
>
> Private sector representative

- **Difficult to purchase key inputs:** Lack of access to capital restricts private businesses ability to purchase inputs and equipment needed to comply with quality standards. But limited access to forex is an even greater barrier, increasing the cost of medical equipment, drugs and other medical imports. Moreover, changing customs and banking policies along with high turnover in staff at the regulatory agencies creates confusion on what is allowable for import. There are a few exceptions: MOH exempts import taxes on medical equipment for new businesses and raw materials for manufacturing as incentives to grow these segments of health businesses
- **High income taxes:** Although many private healthcare providers offer healthcare services to the rich, as the data shows they also deliver health to the poor – often at a loss (e.g. waive or reduce fees). But health sector does not enjoy tax "relief" like other favored sectors in the economy.
- **Land a barrier:** Both land and rent costs are significant barriers to entry to market as well as expansion. Currently, facility regulations require a seemingly unfair land size (e.g. 10,000 sqm minimal for a medical center) as a requirement to license a new health facility. In today's real estate market, it is almost impossible to raise the funds needed to purchase land. Even if a healthcare business manages to buy the land, s/he cannot get a loan to develop the property; in Ethiopia, one can only collateralize a developed asset. High rent costs also create a barrier to market entry or expansion: it is estimated that upwards of 50% of a health businesses cost is attributed to rent.
- **Unlevel playing field and competition with public sector:** As stated before, several private sector stakeholders consider the MOH insists on seemingly higher standards for the private sector yet many of public facilities would not meet MOH quality standards. Moreover, they state they are at a huge disadvantage since the MOH investment costs (e.g. land, utilities, etc.) are subsidized by the government.

- **Limited government incentives to "crowd-in" more private sector providers:** Unlike several countries in the region, the MOH has a limited number of financial (e.g. contracting, insurance, etc.) and economic incentives (e.g. tax relief, subsidized inputs, etc.) to attract more healthcare providers to open a healthcare business. The MOH, however, is slowly rolling out these types of incentives but the private sector would like them to scale up and expand the range of inducements.

Regional Examples of Economic Tools of Government to HARNESS the Private Sector

Grants / subsidies

- Several MOHs provide **direct grants and/or subsidies** for key inputs (e.g. staff, drugs) for Faith Based Organizations (Uganda, Kenya, Tanzania, Malawi) to deliver hospital services on behalf of the govt. Also formalized arrangement through Service Level Agreements (e.g. input based, medium term service contracts).
- Tanzania provides payment to non-government hospitals based on number of beds allotted to indigent patients. Called **"bed grants"**, hospital is subject to quality standards and negotiated rates.

Economic regulations

- Several Latin American/African countries **offer income tax relief** for provider sector to expand services to under-served areas. Private provider does not pay income taxes until business turns a profit.
- Tanzania rationalizes facilities location through **"certificate of need",** restricting MOH from building a new facility if private providers are present and vice-versa. In case of private provider facility, MOH establishes a service referral contract and reimburses the private provider.

Supply side financing

- Tanzania MOH has prequalified a small set of wholesalers/distributors to sell to MOH public health facilities. The MOH established a drug list and negotiated below market rates. During stockouts, MOH facilities can use their own budget to **purchase medicines from these prequalified distributors.**
- Decades of experience in **contracting private providers** and/or networks in OECD countries, ten years' experience in LMIC contracting non-government organizations (Afghanistan, Bangladesh, Cambodia, Uganda) and private midwives to deliver primary health care (Philippines, Indonesia).
- Several African countries (Kenya, Uganda) have **contracted-out key functions** of public supply chain. Most common examples are short-term (1 to 3 years) with local transport companies to perform logistics and/ distributors to perform warehousing.
- Ministries in Kenya, Malawi, Tanzania and Uganda have **contracts** with faith based medical training institutes to train para-medicals on behalf of MOH.

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Finding #5: Lack of trust due to limited engagement but promising initiatives

Public-private dialogue (PPD) and greater number of public-private interactions are critical to build trust between the public and private health sectors. Trust is fundamental precondition to greater integration of the private health sector in the overall health system as well as large-scale collaboration and partnerships. Both public and private stakeholders interviewed expressed a strong desire to move beyond mistrust and suspicion and to improve the relations between the public and private sectors. The stakeholders identified several of the challenges to building trust.

> *"I believe both parties have to try harder…we cannot blame one side or other for lack of dialogue"*
>
> Private sector representative

There is still distrust between the public and private health sectors, but the suspicion is breaking down.

- **Limited capacity of existing mechanism(s) as a platform for PPD:** The MOH dialogues with the private health sector in various forums that address specific topics (e.g. EFDA procurement reforms, HRH licensing and CPD reforms). But there is not a mechanism that address sector-wide issues. Moreover, private sector engagement in the topic driven PPD has been inconsistent and irregular. MOH recognizes that they need to develop a formal mechanism or platform for regular dialogue on topics that cut across departments.
- **Ad hoc engagement:** Private sector consultation is irregular and infrequent. Since the private sector is still fragmented, private sector engagement is based on personal relationships. Both sectors acknowledge that they need to do a "better job" to reach out and talk to each other more regularly.

Both sectors have limited experience in PPD but a strong commitment to build capacity to strengthen communication and improve relations.

> *"Very difficult to engage them (private sector)…we even forget to include them!"*
>
> Public sector official

- **Fragmentation of the private health sector:** The private health sector is still fragmented into multiple professional and trade associations representing the diverse range of health care providers and health activities. Recently, several private health sector leaders have re-energized a prior effort to form an umbrella organization, but it is still struggling to be sufficiently representative.

> *"We do not know how to find the private sector and vice versa. There is no point person for the FMOH…it is mostly through individual relations and contacts"*
>
> Public sector official

There are several ongoing projects to improve PPD. FMOH engages the private sector in thematic forums and the private sector groups are organizing into an umbrella association.

- **Prejudicial perceptions of each other:** The MOH considers that "private sector is only motivated by money" while the private sector thinks the "public sector is motivated by position, power and control." These opinions, if not addressed, will maintain the divide between the two sectors.

New public and private sector initiatives: On the government side, the current MOH is strongly committed to strengthen dialogue with the private sector and to establish a formal mechanism to facilitate meaningful engagement. Key MOH departments hold monthly or somewhat regular meetings with relevant private sector stakeholders on policies and strategies. Examples include: i) the PCD and Resource Mobilization Directorate hold regular meetings with private sector representatives on specific topics, ii) the Council of the Ministers under the monthly "lunch and learn" program invites the private health sector and iii) the Policy and Planning Directorate

is currently engaging the private sector more systematically as there is plan to develop the next five year HTP plan. On the private sector side, a significant portion of the private sector associations have come together to form an interim leadership group. The interim leadership group's mandate is to establish the Ethiopia Private Health Federation as the umbrella association. The process has accelerated in recent months but there are continuing competing efforts within the private health sector that slows the process down

Regional Examples of Public-Private Dialogue and Collaboration

Tanzania-Public Private Heath Forum is an inclusive dialogue forum that raises awareness on private sector role in health. The Board meets quarterly to discuss policy changes and PPP opportunities. Convenes annual meeting of over 250 public and private participants to establish reform agenda and prioritize health PPPs.

Uganda-PPP Technical Working Group is a participatory forum led by the Ministry's PPP Unit. The private sector umbrella organization – Uganda Health Federation– serves as the secretariat and convenes quarterly meeting to discuss PPP opportunities. The Technical Working Group presents its activities to the Joint Annual Review (planning meeting) and the Health Policy Action Forum.

Tanzania – The Ministry of Health has "gazette" that each County level health officer convenes annual meetings with all health stakeholders to review the Ministry health priorities, develops a county level workplan that includes all non-state health actors, and develops a budget. Many "home grown" collaborations are identified during these annual meetings.

Uganda – The Uganda PPP Unit assigned district PPP Focal Persons to establish working relations with the local private sector, improve private sector reporting, foster coordination and identify partnership opportunities. Many districts have exceeded annual planning targets by including private sector data and integrating private sector resources.

6. Health Financing[34]

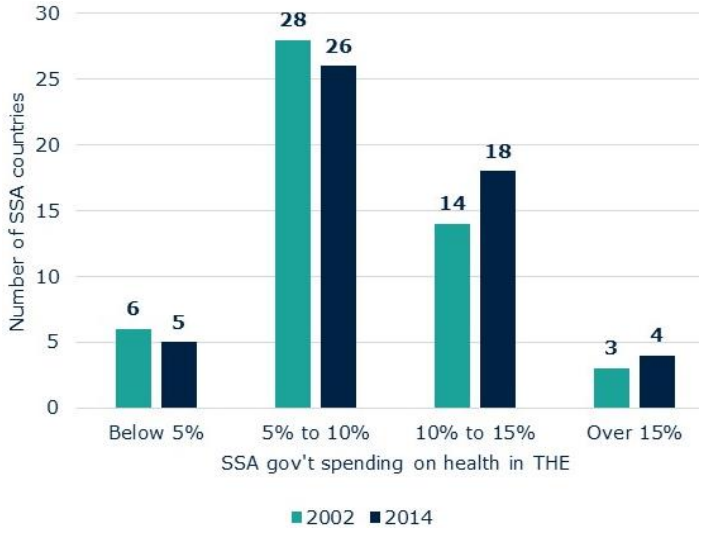
The following section examines trend data on how Ethiopia funds its health sector and benchmarks these trends against similar indicators in Sub-Sahara Africa. The amount the government allocates to the health sector sends important signals to the private health sector – showing whether this segment of the economy is a priority and worthwhile investment. Moreover, the different ways the government finances health can create incentives or barriers to the private health sector to enter and stay in the health sector.

6.1. Trends in Total Health Expenditures (THE)

Ethiopia's total health expenditure (THE) in the latest national health accounts (or as it is referred to as health accounts [HA] in Ethiopia) was estimated at nearly 50 billion Birr. At this level, THE represented 4.73% of the country's GDP, a decline from 5.2% in 2010/11 NHA. Moreover, 4.73% of GPD is lower than the Sub-Saharan Africa average of 6.18%.[35]

Figure 6.1 shows how Ethiopia's level of health spending as a share of total government spending compares to other SSA countries. Ethiopia is among the 26 African countries whose health spending as a part of GDP is between 5% to 10%. As noted earlier, Ethiopia's level of spending has grown compared to the overall trend in the region. As Figure 6.1 shows, government spending on health has decreased in half of the countries in the African region. In 2014, only four countries met the Abuja target of 15% of general government spending.

Figure 6.1 Government Spending as a Percent of Total Government Spending (2002 – 2014)



Source: World Bank, 2016 ; Figure 1

Many countries recognize that investing more funds into the health sector is critical to move towards the goal of universal health care (UHC). International and historical evaluations have shown that a rich country is likely to spend a bigger share of its national budget on health than a poor country, although the evidence on this

[34] Please note that the NHA VII was not available during the analysis and drafting of this report.

[35] African Regional Health Expenditure Dashboard. World Health Organization, 2015. http://www.who.int/health_financing/topics/resource-tracking/African-Regional-Health-Expenditure-Dashboard.pdf?ua=1

correlation is not fully conclusive.[36] Looking at government spending on health among different country income groups, one observes that low-and lower middle- countries spend around 6% of their GDP on health, while upper middle-income countries spend about 7% and OECD countries around 10%.[37]

Figure 6.2 shows that Ethiopia is far from international standards on health spending. The Ethiopian government's total health expenditure (including external) and government health expenditure (GHE) are below WHO's recommended level of 5% to reach UHC. Ethiopia government spending was only 1.6% at its highest level in 2004/05 and GHE has in fact dropped to its current level of .8%. Even with external funds added, THE will not reach the 5% level. As Ethiopia becomes a middle-income country, the government will need to allocate more public funds to the health sector to accelerate its progress towards UHC.

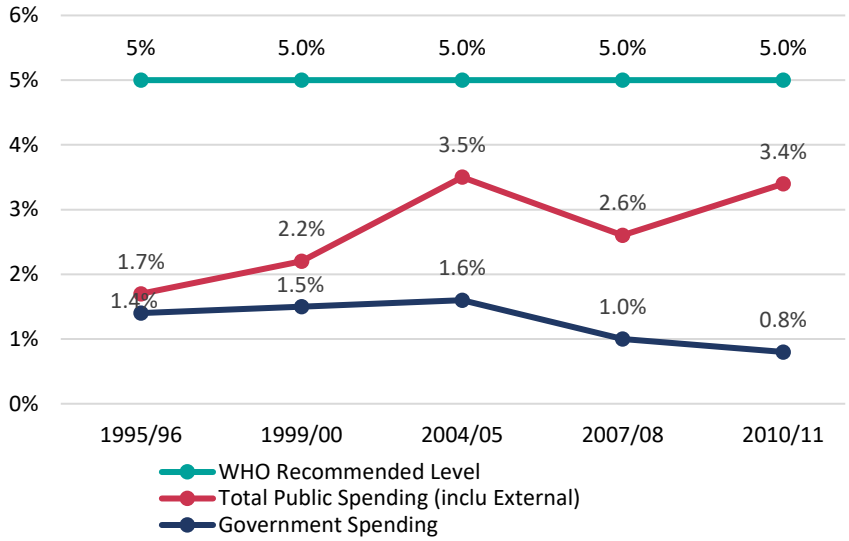
Ethiopia's total health expenditure of 4.73% is lower than the SSA average of 6.18%.

Total birr the government spent in health has grown steadily and significantly.

Per capita spending has also increased: $4.50 in 1995 to $29.70 in 20012.

Ethiopia's per capita health spending ($29.70) is below the average for a low-income African country ($37.70) and far less than WHO's estimate to achieve UHC ($60.00).

Figure 6.2 Total Health Expenditures and Government Health Expenditure (1995 – 2011)



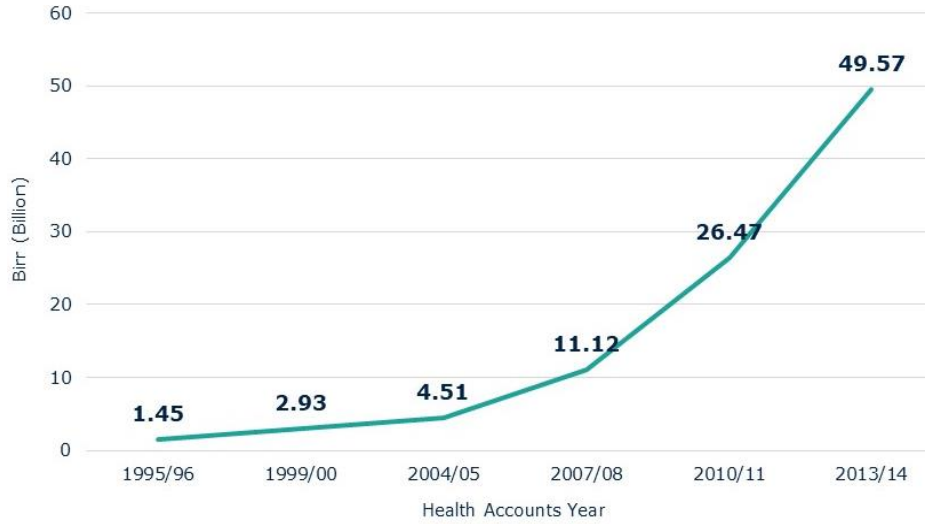
Source: FMOH, 1996; FMOH, 2003; FMOH, 2006; FMOH, 2010a and 2014b

Despite the low level of THE as a percentage of country's GDP, THE has grown steadily and significantly since 1995/96 (See Figure 6.3). THE growth started to accelerate in 2004/5 from 4.51 billion Birr to 11.12 billion in 2007/08 to 49.57 in 2013/14. THE grew, in nominal terms, by 87% from 2010/11 to 2013/14. During this same time period, THE grew 17% in real terms. In 2013/14, the health sector was valued at over US$2.5 billion - although sizeable – is considerably less than the $8.83 billion annual investment needed under the HSDP-IV base scenario. (In 2013/14, the annual average exchange rate was US$1 = Birr 19.675.

[36] State of Health Financing in the African Region, 2013.
[37] Ibid.

The

Figure 6.3 Total Health Expenditures in Billion Birr (1995 – 2014)



Source: NHA, 2013/14; Figure 1

growth in THE came from different financing sources; most notably the government of Ethiopia in the recent years (see Table 6.1). Government spending increased from 15.5% to its current level of 29.8%. The proportion of financing coming from government almost doubled, from 16% to 30% (25% from the Treasury and 5% from parastatals). Accelerated expansion of health care services, opening of 1,839 health facilities (health posts, health centers, and hospitals), and concomitant increases in staffing and worker salaries as well as operational budgets fueled the rapid increase in government spending during this time period.

Table 6.1 Total Health Expenditures by Source by Birr, 2004/05 to 2013/14

Source of Financing	NHA III 2004/05 (Birr)	NHA IV 2007/08 (Birr)	NHA V 2010/11 (Birr)	NHA VI 2013/14 (Birr)
Government*	1.4	2.5	4.1	14.8
Private**	0.1	0.1	0.2	0.7
Households	1.4	4.1	8.9	16.5
Donors	1.6	4.4	13.2	17.6
Total	4.5	11.1	26.4	49.7

*Government spending includes parastatals **Private spending includes employers, NGOs and others

Source: NHA, 2013/14; Table 2

During this same time period, donor contributions have remained constant (approximately 35%) (see Figure 6.4). However, there was a spike in donor levels from 50% in 2010/11 returning to 35.5% in 2013/14. Household out-of-pocket (OOP) expenses also remained at the same level, ranging from 31.1% in 2004/05 to 33.3% in 2013/14.

Figure 6.4 Source of THE (1995 – 2014)

Source: HA, 2013/14; Table 2

Donors (35.6%) and households (33.3%) are the largest funders of health in Ethiopia followed by the government (29.8%).

6.2. Sources of Health Finance

According to the NHA estimates, the major driver of the increased per capita spending in Ethiopia in recent years is the accelerating contribution from external resources. As can be seen from Table 6.4, with the exception of 2007/08, more than 80% of the change in per capital health spending came from increased external resources. The lower share of the external resources in 2007/08 in the per capita change can be explained mainly due to different methods to estimate household spending on health by replacing the Household Income, Consumption and Expenditure survey (HICE) with a special purpose NHA household survey. This resulted in doubling the estimate of household spending on health, and thus lowering the percent contribution of per capita health expenditures from external resources.

Growth in total health expenditures has been fueled by donor funds and OOP – an unsustainable and inequitable strategy to finance health.

The largest portion of OOP is spent on drugs (73%) and lab tests (20%).

There are four main sources of financing in the health sector including:

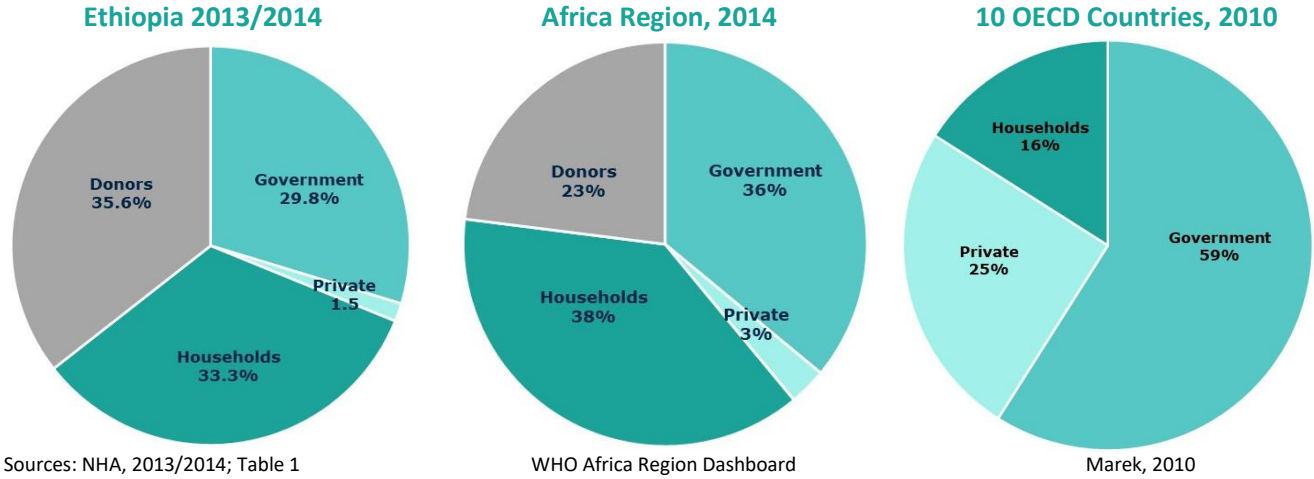
- **Government**: This category covers government spending in the health sector from all government sources (federal, regional, city, and woreda) and by providers.
- **Donors (bilateral and multilateral):** All bilateral and multilateral donors are included in the donor "category"; also referred to as "rest of the world". The 2013/14 NHA included 39 donors, many of which are reflected in the landscape of the Ethiopia health sector (see Figure 3.2).
- **Private:** This category contains several sub-categories including insurance companies, local and international non-government organizations, employers (parastatal and private companies)

When examining OOP by health areas, households spent more on "other" (64%), child health (15%) and reproductive health services (10%).

- **Household:** The last category contains all out-of-pocket spending by individuals and households in the health sector.

Figure 6.5 illustrates current sources of health finance in Ethiopia according to the 2013/14 HA. Donors, despite the rapid decline from 2010/11 NHA to the 2013/14 NHA, are still the largest funder of health in Ethiopia at 35.6%. Households, at 3.33%, are the second most important source of financing in health. Government funds are third at 29.8%. Private sector contribution is still low at approximately 1.5%. This funding pattern raising concerns of long-term sustainability and equity. Evidence shows that catastrophic health expenditure and impoverishment remain low in countries where out-of-pocket expenditure is less than 15% to 20% of THE.[38]

Figure 6.5 THE by Financing Source



Sources: NHA, 2013/2014; Table 1 | WHO Africa Region Dashboard | Marek, 2010

Figure 6.5 also illustrates the structure of health expenditures by financing source for the African Region. Ethiopia funding sources differs in two important ways: the Ethiopia government under funds health when compared to the region and relies more heavily on external funders to finance health. Donor funds in Ethiopia helped subsidize households, resulting in a lower percentage of OOP spending when compared to the region.

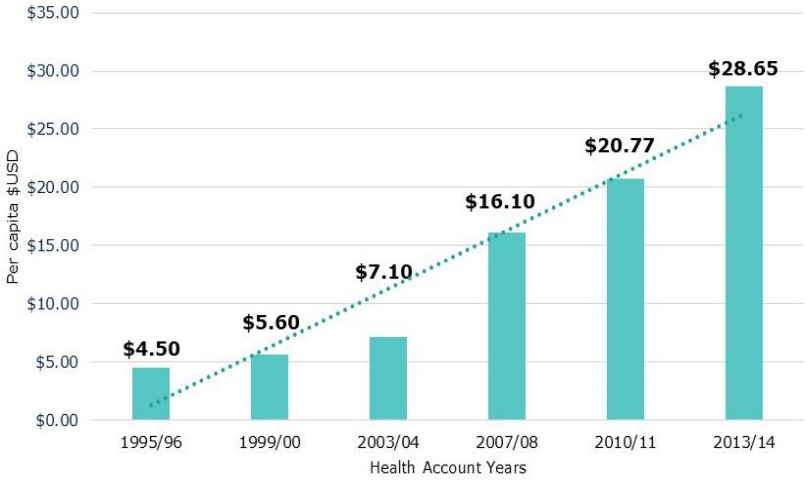
A more equitable and sustainable funding pattern is shown in Figure 6.5. In ten OECD countries, the government is the major funder of health care followed (59%) by private health insurance and employers (25%). Far fewer individuals and households spend out-of-pocket for health: 33% in Ethiopia compared to 16% in OECD countries.

6.3. Per Capita Health Expenditures

Ethiopia's per capita health expenditure has grown steadily over the past two decades, from USD $4.50 in 1995/96 to USD $28.65 in 2013/14 (see Figure 6.6). Though this growth is encouraging, the amount is still very low compared with UDS$37.7 [39] for low-income African countries and USD$114 average for the African region.[40] For example, and it is far less than the USD $60 per capita spending the WHO recommended for delivery of essential health services by 2015 (Jowett et al. 2016).

[38] State of Health Financing in Africa, 2013.
[39] WHO global health expenditure database: http://apps.who.int/nha/database, accessed on April 27, 2017
[40] African Regional Health Expenditure Dashboard. World Health Organization, 2015.

Figure 6.6 Trends in Per Capita Health Spending (1995 – 2014)



Source: HA, 2013/2014; Figure 2

Table 6.2 organizes forty-five SSA countries into three levels of THE per capita. As the table shows, Ethiopia was classified in the lowest category at USD$20 in 2010/11. Due to increased government investment (USD$28), Ethiopia has moved into the middle category but is the low end of the middle category along with Burundi (USD$24), Guinea (USD$25), Madagascar (USD$21) Mozambique (USD$28) and Niger (USD$26).

6.4. Out-of-pocket Expenditures

Table 6.2 THE in per capita in 2010 and 2015 US$

Year	Less than USD$ 20	USD$ 20–US$ 44	More than USD$ 44

Figure 6.7 Trends in OOP as Percent of THE (2004/05 – 2023/14)

Source: HA, 2013/2014; Table 2

**Mauritania moved up to this level

In the last ten years, out-of-pocket payments (OOP) in Ethiopia have remained constant as a percent of THE. In 2004/05, OOP were 31.1 percent of THE compared to 33.3 percent in 2013/14 (see Figure 6.7).
Ethiopia's level of OOP increases the likelihood of impoverishment. Evidence points out that where out-of-pocket spending is below 20% of THE, catastrophic health expenditure and impoverishment levels drop to

negligible levels (WHO African Region Expenditure Atlas, 2014). In 2014, only 10 out of 47 SSA countries had OOP spending less than 20% while 16 accounted for OOP over 40% of THE (see Table 6.3).

Table 6.3 OOP as a percent of THE 2010 and 2014

Year	Less than 20%	20%–40%	More than 40%
2010	Angola, Botswana, Lesotho, Malawi, Mozambique, Namibia, Seychelles, Tanzania, Swaziland, South Africa, **(10 countries)**	Algeria, Burkina Faso, Burundi, Cape Verde, Comoros, DRC, **Ethiopia**, Equatorial Guinea, Gambia, Ghana, Liberia, Madagascar, Rwanda, Senegal, Zambia, **(15 countries)**	Benin, Central African Republic, Chad, Cameroon, Congo, Côte d'Ivoire, Eritrea, Gabon, Guinea, Guinea-Bissau, Kenya, Niger, Nigeria, Mali, Mauritius, Mauritania, Sao Tome and Principe, Sierra Leone, Togo, Uganda **(20 countries)**
2014	Algeria, Botswana, Gambia, Lesotho, Malawi, Mozambique, Namibia, Seychelles, South Africa, Swaziland **(10 countries)**	Angola, Burkina Faso, Burundi, Cape Verde, Central African Republic, Congo, DRC, **Ethiopia,** Gabon, Ghana, Guinea-Bissau, Kenya, Liberia, Madagascar, Mauritania, Rwanda, Senegal, Tanzania, Zambia **(19 countries*)**	Benin, Cameroon, Chad, Comoros, Cote d'Ivoire, Eritrea, Equatorial Guinea, Guinea, Mali, Mauritius, Niger, Nigeria, Sao Tome and Principe, Sierra Leone, Togo, Uganda **(16 countries)**

Source: 2010 data from State of Health Financing in Africa, 2013. Annex V. 1
2014 data from WHO African Region Health Expenditures Atlas, 2014. Table 2.
*OOP improved in Algeria, Central African Republic, Congo, Kenya, Mauritania as they moved from higher to lesser OOP sending
**OOP deteriorated in Angola, Comoros, Equatorial Guinea and Tanzania as they moved from a lesser to greater OOP spending

Due to low levels of government spending – as is the case of the majority of SSA countries in Ethiopia (see Table 2.1) – a large share of the financial health burden falls on patients in the OOP. Yet OOP spending has declined: 20 countries in 2010 had OOP spending more than 40% dropped to 16 countries. Rapid influx of donor funds, particularly from United States Agency for International Development (USAID) and Global Funds to Fight AIDS, Tuberculosis and Malaria (GFTFAM), have exceeded government funding gap and helped reduce OOP in the region.

The 2014 NHA V Health Expenditure Survey presented data OOP. The survey shows that two thirds of (62%) households incurred OOP expenses to fully or partially pay for outpatient services. This level increases for inpatient admissions: almost all health consumers (95%) paid OOP for hospital care (NHA V, 2014). More than half (52%) of the total household OOP health spending was paid to government health service providers compared to 43% to private health service providers in 2011/12. The remainder (5%) of the total OOP health spending went to not-for-profit health facilities, traditional healers, and religious institutions (NHA V, 2014).

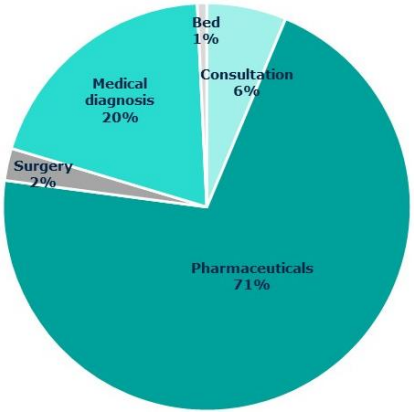
Figure 6.8 shows that most of the household OOP spending in health was for pharmaceuticals (71%nt), followed by payments for medical diagnosis (20 percent), such as for x-rays and laboratory testing. Medical consultation and registration accounted for 6% of total OOP.

Table 6.4 Household Spending by Type of Health Care, 2014

Type of Service and Supply	Outpatient Services	Inpatient Services	Total OOP
Consultation	5.98%	1.53%	5.60%
Pharmaceuticals	65.49%	33.68%	62.84%
Surgery	--	33.68%	2.26%
Medical diagnosis	18.17%	9.06%	17.41%
Bed	--	5.79%	0.67%
Other related expenses	10.36%	20.59%	11.22%
Relative share	91.66%	8.34%	

Source: 2014 NHA V, Table 43.

Figure 6.8 OOP by Type of Health Service



Source: NHA V, 2014; Table 43

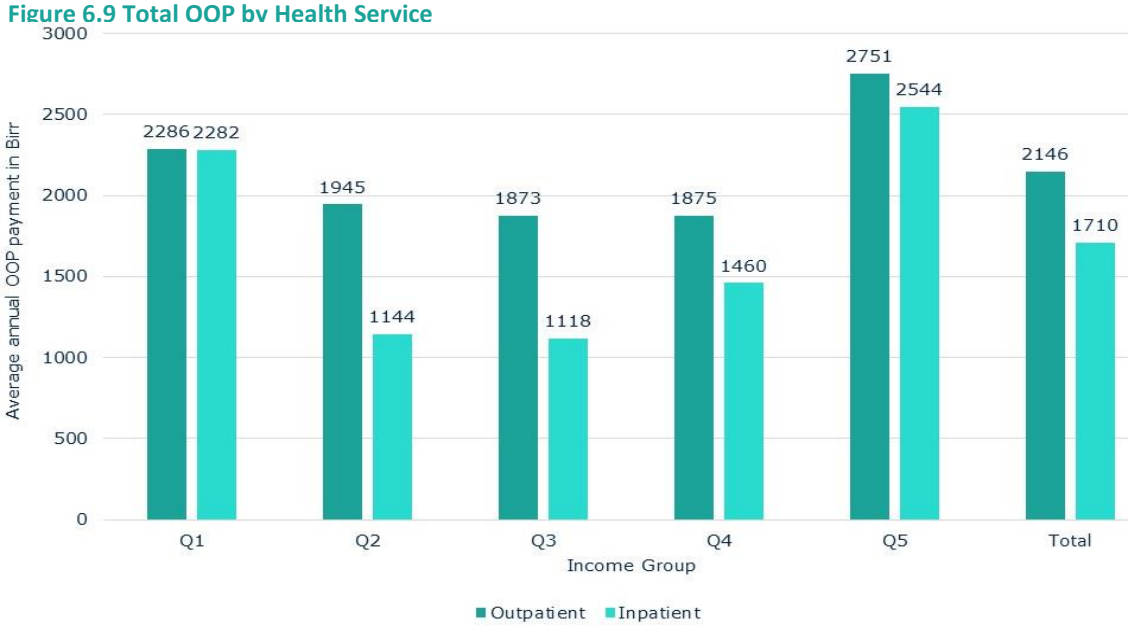
The NHA V also calculated average OOP for outpatient and inpatient services. On average, people spent more on outpatient care (2,146 Birr) than on inpatient care (1,710 Birr) (see Figure 6.9). This pattern holds across all wealth quintiles. As expected, individuals in the highest wealth quintile (Q5) spent a larger amount of money for both outpatient and inpatient care services compared to those in lower income quintiles. It is interesting to note that the poorest quintile (Q1) spent a disproportionately higher amount of their household income on health compared to richest income group (Q5) even though the poorest household OOP spending is relatively in the same level (2,286 for Q1 compared to 2,751 for Q5 for outpatient and 2,282 and 2,544, respectively for inpatient).

Drug Benefit Plan for the Poor

Developing (CIV, Jamaica, Tanzania) and transitioning countries (Kyrgyzstan) are implementing Drug Benefit Plans as part of social health insurance scheme to reduce the OOP related to drug and tests. These plans share several features:

- **Beneficiaries:** Drug plan is ***only for the poor***. Beneficiaries do not have to pay at point of sales. Non-eligible individuals can participate in plan to access affordable drug prices but must pay dispensing fee and set (in most case lower) medicine price.
- **Benefit package:** The plan covers a set package of essential medicines (e.g. FP methods including LARC; ORS, ZINC, micro-nutrients; malaria nets and AZT; TB DOTS; and drugs to treat opportunistic infections and manage NCDs). It also includes all childhood and adolescent vaccines and same diagnostics (e.g. rapid lab kits to test for HIV/AIDS, malaria, and TB).
- **Drug supply:** All drugs are sourced from qualified distributors to ensure quality products and tests. Sourcing with pre-qualified distributors helps the MOH achieve economies of scale to negotiate more affordable price and distribution cost.
- **Providers:** The drug benefit package is available through a network of private pharmacies and drug shops. The drug plan pays a contracted service provider - in most cases a pharmacist or pharm tech and in a few cases a healthcare provider - a "dispensing fee" and a set price to cover the cost of the drug/test. In a few countries, the MOH donates medicines and test kits and only pays the dispensing fee.
- **Administration:** In a few countries, the MOH outsources the drug plan's administration.

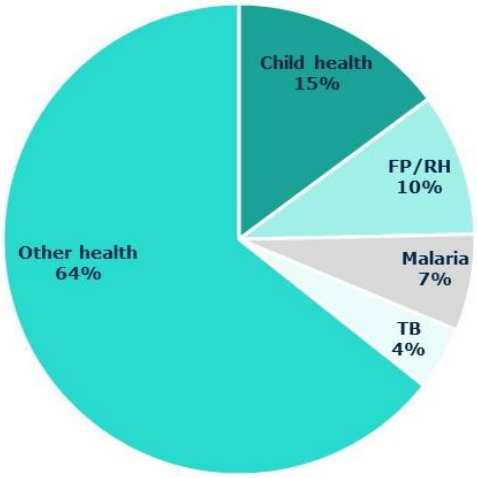
Figure 6.9 Total OOP by Health Service



Source: NHA V, 2014; Figure 15

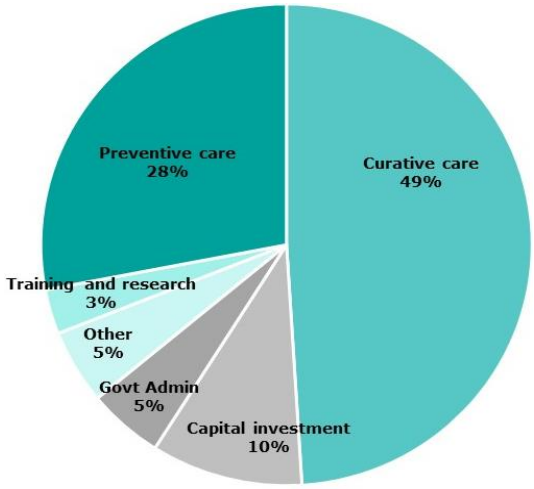
Figure 6.10 estimates household OOP spending on major health sector priorities. As the Figure shows, 36% of households' total OOP spending on health was incurred to obtain services for malaria, child health, TB, and

Figure 6.10 Total OOP by Sub Account



Source: NHA V, 2014; Table 44

Figure 6.11 General Health Spending by Type of Service, 2013/14



Source: NHA, 2013/2014; Figure 8

reproductive health. After "other" health, child health services took the largest share (15%) of households' OOP health spending, followed by reproductive health services (10%).

6.5. Allocation of General Health Spending by Type of Health Service

Figure 6.11 shows how health funds are spent by type of health service. Almost half of health spending (49%) was on curative health care services followed by preventive care services (28%). Out of the 49% of the total spending on curative care, 45 percent was for outpatient services and only 4% of the total spending was for

inpatient care. Over half (55%) of the curative care spending paid for services at primary health care providers (again, district hospitals, health centers, clinics, and health posts), 39% went to services at general and referral hospitals (both public and private hospitals), and the remaining 6% went to services at all other providers. Capital formation, together with training and research and other (ancillary, medical good and non-specific services) accounted for 13%. Governance and administration accounted for 5%.

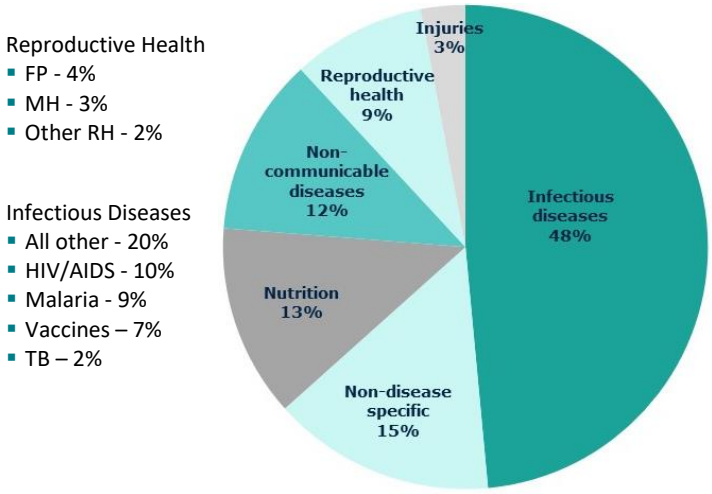
Approximately 16% to 18% of total health expenditures is spent in the private health sector, translating to 9 billion birrs.

6.6. Total Health Expenditure by Health Area

A significant share (49%) of Ethiopia's THE was allocated to infectious and parasitic diseases - in line with the country's disease burden (see Figure 6.14). Of this, nearly 20% was spent on infectious and parasitic disease, 10 percent on HIV/AIDS and other sexually transmitted diseases (STDs), 9%

A significant percent (62%) of Ethiopians pay fully or partially for outpatient services and (95%) for inpatient services. Drugs and lab tests were the highest cost of health care.

Figure 6.14 General Health Spending by Disease, 2013/14



Source: NHA 2013/14; Figure 13

Government underspends (9% of total budget) on reproductive, maternal and child health services even though they have a higher burden of disease.

on malaria, 7% on vaccines and 2% on tuberculosis. Nutritional accounted for 13% and 9% on reproductive health services including 4% on family planning, 3% on maternal and perinatal conditions and 2% on other reproductive health conditions**.**

Low government spending on these key health services often results in non-use or OOP spending.

6.7. Health Financing Strategies

The Ethiopian government has multiple strategies in place to enhance financial access to health services and to ensure financial protection (see Table 6.5). Progress on the various health financing strategies is documented in the 2013 Health Sector Annual Performance Report (MOH, 2013).

- While user fees were institutionalized for more than 50 years, the first generation of reforms clearly articulated that user fees will be set based on cost sharing

principle and will be retained at the facility levels. As of the 2014 (Ethiopian fiscal year (EFY) 2006), 2,558 health facilities (101 hospitals and 2,457 health centers) are retaining and utilizing revenues generated by user fees to improve the quantity and quality of health services.

- In addition, several public facilities are implementing Targeted Fee Waiver scheme for the poor for the services they rendered. As of August 2012, 2.5 million beneficiaries were screened for the fee waiver program and the government allocated a budget of Ethiopian birr (ETB) 25,527,418 to cover expenses incurred by health facilities for these beneficiaries.
- Private wings have been also established in hospitals. Forty-five public hospitals in the country have established a private wing.
- In the 13 community-based health insurance (CBHI) pilot woredas, 143,852 households registered for the insurance scheme in 2012 (EFY 20052) with enrolment coverage of almost 48%. The total number of beneficiaries from these households has reached 608,675. Among the CBHI beneficiaries, per capita health utilization in 2012 was 0.7 visits as compared to the national average of 0.3 visits (HSFR, 2015). CBHI has also contributed to an increase in revenue generation whereby in EFY 2005 alone the 13 CBHI schemes reimbursed ETB 8 million to health facilities.
- Preparations are also underway to launch social health insurance (SHI) by the end of this fiscal year.
- The MOH has also worked hard to mobilize external resources from development partners through demonstrating results and value for money for the assistance it received and by introducing different strategies to mobilize, harmonize and align aid. These reforms have resulted in increasing resources to the sector. According to the NHA, THE per capita increased by 400% from US$4.50 in 1995/96 to US$29.70 in 2011/12, at current prices.

Table 6.5 Health Financing Strategies

Strategy	Description	Implementation Issues
Exempted Services	Free for all regardless of income. Defined services are also provided free of charge in private health facilities.	▪ Long-term sustainability of health financing if and when donor resources are reduced or withdrawn. ▪ Private facilities still charge some fee to cover worker's time. No mechanisms to compensate private providers.
Essential Services	Government subsidizes almost 70% of non-medicine costs in public facilities. Medicines sold at cost + 25% markup	▪ Quality of services remains an issue. ▪ Public facilities experience regular stock-outs forcing patients to purchase drugs in private sector. ▪ No mechanisms to remove OOP costs related to medicines and lab tests.

Targeted Fee Waiver for Indigents	Local government reimburses health providers for lost user fees when treating exempt fee patients.	Problem with targeting and delay or non-reimbursement of costs to public health facilities.
Pilot Community-based Health Insurance (CBHI)	Government subsidizes 25% of premiums for members and 100% of premiums for the poor. Government pays CBHI scheme managers and staff.	▪ Low coverage of the poor ▪ Various operational issues related to membership compliance, premium collection, registration, record keeping, etc. ▪ Unable to scale scheme because of fiscal implications ▪ Health facilities not ready to provide quality service as demand increase under scheme ▪ Low community awareness of benefits of insurance ▪ Scheme does not include private facilities because of inability to estimate costs and limited capacity to contract and reimburse private providers
Private Health Insurance	Legal framework in place under the auspices of the Ethiopian Health Insurance Agency.	▪ Management capacity of Agency and SHI systems are limited. ▪ Health facilities not ready to provide quality service as demand increase under scheme

Source: Alebachwe et al. 2015. Adapted Table 2.2.

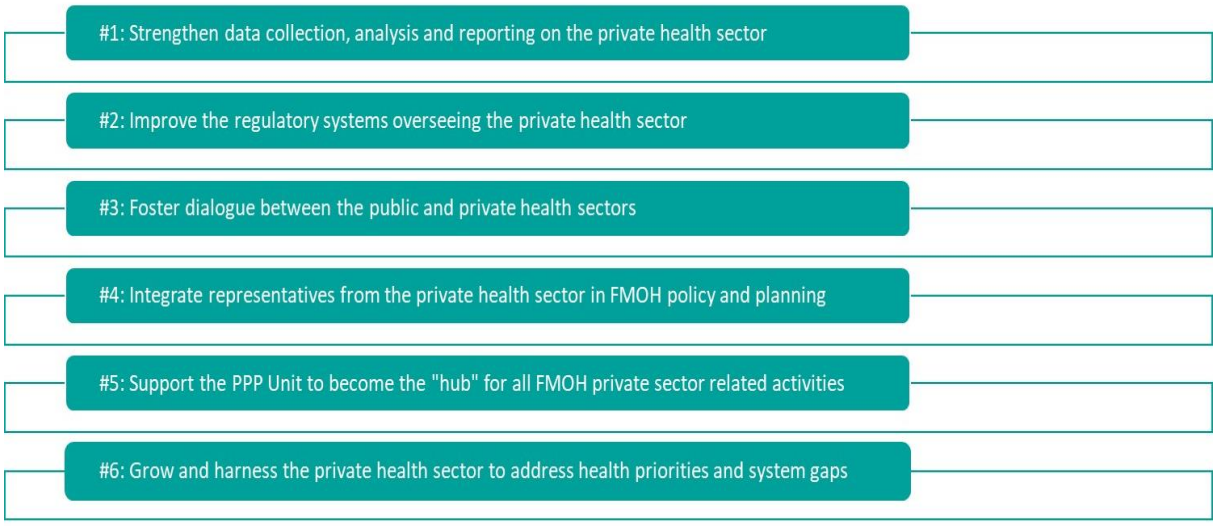
7. Recommendations to Engage the Private Health Sector

7.1. Strategies to build MOH and private sector capacity

The PSA team drafted potential recommendations based on the preliminary PSA findings with several caveats. More time is needed to: i) further develop the proposed strategies and create comparable details for each one; ii) link the health financing strategy to private sector initiatives; iii) better integrate many of the "stand-alone" strategies; and iv) fully vet and prioritize the strategies with MOH and private sector stakeholders. As a result, the current draft recommendations are a work in progress and should not be interpreted as "setting the course".

The recommendations center on the six strategic directions (see Figure 7.1). The draft recommendations can serve as a springboard for discussions between the MOH and the private health sector on how to prioritize the strategic areas and build out each of the strategies.

Figure 7.1 Six Strategies to Build FMOH Capacity and to Harness the Private Health Sector



Strategy #1: Strengthen data collection, analysis and reporting on private health sector

The PSA revealed several issues related to the quality and reliability of data on the private health sector. The PSA team proposes four initiatives to strengthen data and reporting on the private health sector: 1) Assess MOH reports to integrate private sector data in decision-making; 2) Identify and conduct additional research as needed; 3) Incentivize private sector to report; and 4) Include the private sector in data analysis and dissemination of MOH reports. Each initiative is discussed in turn.

Assess MOH reports to integrate private sector data in decision-making: Tasks include: i) Developing a core set of private sector indicators for the MOH to routinely report upon and integrate within their annual reports and other strategic documents; ii) Reaching consensus on data gaps in current MOH reports and identifying strategies to address them (e.g. ensure all MOH systems disaggregate public vs. private in the same manner, agree on the definition and scope of private sector (e.g. DHIS, HIMS, HRIS, etc. and disaggregate private sector between NGOs, FBOs, and for-profit if possible) and including additional research (see below); iii) Analyzing key MOH initiatives (e.g. Master Facility list, HRH licensing, etc.) to ensure they collect data on the private health sector and use a standardized definition of the private sector; iv) Mapping all current and future MOH reports, assessing data format and presentation in each report, developing style guidelines on basic tables with private sector data to include in routine reports; v) Monitoring first round of MOH reports to ensure they all systematically include private sector data and comply with style guidelines; vi) Building MOH team capacity across departments and directorates to collect, analyze and strategically use private sector data to inform

decision-making; vii) Review current responsibilities of relevant directorates such as the Planning directorate in regards to institutionalizing private health sector data collection and analysis and assigning responsibility to a department to oversee and synthesize all MOH data collection and reporting on private health sector; and viii) Considering drafting a "state of the private health sector" and/or "balanced score card" on private health sector that can be part of the regular MOH reports.

Identify data gaps and conduct additional research as needed: The first step is to assess private sector data gaps and identify additional research and data collection as needed. Possible data collection areas include: Review extent private health facilities integration in the Master Facility List; ii) Validating MOH licensing data on HRH, laboratory and pharma entities; iii) Scoping additional markets to explore potential private sector projects; iv) Conducting pre-feasibility and feasibility assessments to identify possible private sector partnership projects; vii) Carrying out consumer research in select health markets to better understand consumer preferences on providers (e.g. public vs. private) and service/product characteristics.

Incentivize private sector to report: As the PSA shows, the private health sector does not routinely report to the MOH for a variety of reasons. There are several steps the MOH can take to address these barriers: i) Review MOH data requirements on private health sector (e.g. licensing, quality, DHIS, etc.) to develop comprehensive list of government data needs and assess level of private sector reporting; ii) Conduct series of consultative meetings with the private health sector to understand reasons for underreporting and co-develop a strategy to address these concerns; iii) Use the consultative meetings to agree on basic set of core indicators that the private health sector is willing to routinely report on and strategies to facilitate reporting; and iv) Identify MOH and private sector champions to help increase private sector reporting.

Include private sector representatives in data analysis and dissemination: To ensure a balanced and holistic perspective on private sector data, the MOH can include representatives from different segments of the private health sector to participate in the data collection and analysis. Moreover, the MOH can also partner with the private sector to widely disseminate the data to foster dialogue on their implication for policy, planning and partnerships.

Strategy #2: Improve the regulatory systems governing the private health sector

The PSA identified regulatory gaps and the administrative systems needed to effectively regulate and govern the private health sector. Key among them are systems to license and inspect facilities and PMTI (for quality), as well as certify and update HRH professional licenses. In addition, the MOH needs to put in place a simple system to ensure minimum quality for all private health facilities. Many of these systems are out-of-date, fragmented, incomplete or non-functioning. The MOH, therefore, has an opportunity to modernize its systems and "leapfrog" into the 21st system by creating a web-based platform with interoperability between these different functions of licensing; quality and HRH. Such initiatives have proven effective in other countries such as Kenya and Uganda and the PSA team discussed this strategy key relevant MOH directorates to integrate this type of platform with their new IT initiatives. To create this state-of-the-art platform, tasks include:

Modernize key licensure functions (e.g. HRH licenses and CPD hours, facility licensing and inspections, private medical training institutes licensure, and linkages to a quality tools [see below]): The first step is to hire an IT systems firm to perform the following tasks: i) Review and streamline the processes for all health professionals – public and private alike - to obtain a professional license and CPD hours, and for private health facilities to obtain a facility license and undergo facility inspections; ii) Ensure all licensing functions specify sector (e.g. public, private-for-profit, private-not-for-profit) according the consensus definition of "private sector" (See Strategy #1); iii) Create a web-based platform enabling all licensure functions -both from the user and government sides-to be performed electronically ; iv) Ensure all licensure functions are linked to each other (inter-operability); v) Expand the Master Facility list to include the full range of private health facilities (e.g. health facilities, labs, pharmacies, etc.) and link the Master Facility List to the platform; and vi) Ensure the platform can track (e.g. dashboard) and produce reports the MOH needs to evaluate turn-around and pipeline. The IT firms, with MOH support, should convene a series of consultative meetings with both public and private

sector representatives to ensure the Platform is user friendly and test the beta version before going "live" with the final licensing platform.

Establish minimum quality requirements and a process by which to certify minimum standards in private health facilities (including pharmacies, drug shops, laboratories and diagnostic centers). There are several examples in the region of simple quality assessments (e.g. Uganda, Kenya, and Tanzania) using a self-regulatory checklist. Tasks entail: i) Facilitating a series of consultative meetings between the public and private sectors to agree on the standards for a minimum level of quality and indicators to measure it; ii) Hiring an IT firm to create a web-based platform to "house" the quality tool; iii) Ensuring quality tool is linked to licensing platform; iv) Building capacity among private professional associations to train private provider members in new quality assessment tool; and v) Building MOH capacity to draft and disseminate quarterly reports on "state of quality in private health sector" and to use the data in policy dialogue and regulatory reforms.

Build MOH's capacity to use the licensing platform as a management tool. The related MOH departments will have to learn how to: i) update and maintain the data bases embedded in the platform; ii) monitor the efficiency of the licensing and inspection processes; iii) analyze size and scope of private health sector activities; iii) monitor private sector quality (in terms of updating professional licensure, facility registration and facility inspection); iv) triangulate the platform data with MOH quality tool(s) to develop a comprehensive picture of private sector activities and level of quality; v) develop strategies to improve licensing and ensure quality; and vi) Use platform and quality data to inform policy and Health PPPs. Internal capacity and relevant skills will need to be developed and deployed across the MOH directorates to ensure sustainability and use of this platform.

Introduce and roll out licensing platform to all health facilities and health professionals: To transition from the old paper-based system to web-based platform will require significant efforts to inform all public and private health professionals and private sector entities of the change in licensing procedures and to orient them to the new platform. The second major task entails hiring a local public relations firm to: i) Carry out a PR campaign to raise awareness and promote registration; ii) Work with professional associations to register all health professionals and facilities; and iii) Conduct meetings to help professionals register and become familiar with the web-based platform.

Strategy #3: Foster dialogue between the public and private health sectors

Establishing trust between the public and private sectors is a precondition for successful partnerships. Frequent and consistent communication and increased interactions between the sectors is key to building this trust but it requires a structure, process and commitment from both sectors to build this trust. Although communications between the public and private sectors is irregular and infrequent, the PSA reveals that both sectors are committed to improving public-private relations. Several efforts are underway to foster greater communication including the MOH convening more meeting with the private sector to discuss health system priorities and the establishment of a meaningful private health sector umbrella organization (Ethiopia Healthcare Federation) that can regularly dialogue with MOH. Steps to foster current public private dialogue (PPD) in health in Ethiopia include:

Institutionalize a Public Private Dialogue (PPD) platform to provide the structure for the dialogue. Various dialogue initiatives have been created over time in Ethiopia, but these efforts have been ad-hoc due to the lack of a clear structure and organization. To strengthen the PPD platform, the MOH can: i) Explore existing and/or establish a new platform for PPD, ii) Identify both public and private stakeholders to participate in a PPD initiative; iii) Convene public/private stakeholders to establish terms of reference and rules of engagement; iv) Identify one to two activities to focus PPD efforts (see below); v) Establish a secretariat to support the platform and support funding – through MOH budget and/or development partners' assistance – for at least two years to ensure the PPD process is well-established; and vi) Conduct regular meetings to establish the "practice" of consistent dialogue and interactions.

Support the private sector to organize itself. Effective PPD is based on both partners assuming their respective roles and responsibilities and that they can represent their respective constituent's perspective. As the PSA revealed, the private sector has established an umbrella association – Ethiopia Healthcare Federation –with over 12 member organizations. Development partners like the World Bank and GFF as well as others can continue to play an instrumental role in providing the technical expertise and resources to ensure the EHF becomes fully operational in the next two years. The EHF will require the following support by hiring consultant(s) to: i) share "best practices" in association governance and operations; ii) establish EHF's secretariat and assist newly hired Executive Director to create necessary policies and procedures; iii) train and coach EHF board members in governance skills; iv) to develop and carry out 1st year workplan including organizing and mobilizing relevant private sector actors to participate in different technical working groups (see above); and v) Strengthen member private sector associations capacity to represent their constituents in policy dialogue through training in policy analysis and advocacy. In addition, the development partners can provide "seed" funds for the EHF secretariat and its activities to help the association get established and become fully operational.

Build public and private members' capacity to effectively dialogue. Effective communication and genuine collaboration require new skills not commonly found in both the public and private sector. The training and coaching will assist the PPD members to put into practice the new skills needed. With donor assistance, the MOH can: i) hire local experts in organizational development to carry out a series of short and targeted trainings for the PPD member organizations in key skill areas such as facilitation, communication, conflict resolution, etc.; and ii) hire a consultant to serve as an outside broker to coach PPD platform leadership to establish participatory agendas, facilitate effective meetings, and assist leadership to address conflict as it arises.

Carry out one to two joint activities together to establish the "practice" of collaboration. Potential collaborations include working together to co-develop i) the next five-year HSTP; ii) indicators and strategies to increase private sector reporting; iii) a five-year private sector engagement strategy, iv) economic and market barriers; and iv) minimum quality standards. The MOH, through the PPD platform, can form a technical working group, like the current one for lab and diagnostic partnerships, for each task comprised from both the public and private sectors with related expertise and have the technical working groups report to the PPD platform on a quarterly basis on their progress.

Strengthen PPD platform members' capacity to carry out policy analysis to inform PPD process / activities. A key function of the PPD will be to analyze together existing and future policies, plans and regulations that affect all the actors in the Ethiopian health sector and to co-develop strategies and action plans that reflect the consensus between the sectors. Depending on policy issue and/or task at hand, development partners can identify and fund consultants/experts to assist PPD leadership to gather relevant data (e.g. use PSA data to inform HSTP process), conduct the analysis and recommend different policy solutions. Another complementary approach is to train PPD leadership in policy analysis and framing (e.g. use PSA data to guide situation analysis and problem definition for HSTP); advocacy and policy communications (e.g. use PSA data and recommendations to develop policy presentation on private sector strategies in HSTP); and how to develop and deliver policy presentations and/or briefs.

Strategy #4: Integrate private health sector representatives in policy and planning processes

Experience shows that integrating different stakeholder perspectives into the policy and planning processes fosters buy-in and increases the likelihood of successful strategy implementation. The MOH can take several steps to gradually integrate key private sector stakeholders into its routine policy and planning process. Steps include:

MOH maps full range of planning exercises at national, regional and woreda levels to identify strategic opportunities to integrate private health sector in policy and planning processes. Potential opportunities include: i) Creating a technical working group comprised of MOH officials and private sector leaders to co-develop the next HSTP (see above); ii) Involving private sector representatives in the Annual Review Process; iii) Integrating private sector representatives in annual workplan and budget process at the regional and even

woreda level; and iv) Involving private sector representatives in key MOH policy initiatives such as National Health Financing Strategy, proposed social health insurance project design, others.

Strengthen the MOH PCD's (Partnership and Coordination Directorate) capacity to lead public-private coordination and collaboration by: i) Training the Unit in participatory planning; ii) Establishing planning guidelines (like the ones in Tanzania) to create public private working groups at the regional level and define their role in co-developing annual plans and budget as well as increasing private sector reporting; iii) Identifying "PPP coordination" focal person in key regions with a significant percentage of private sector members to implement the coordination guidelines; iv) Developing training materials and conducting training with PPP coordination focal persons to lead participatory planning and budgeting; v) Integrating participatory planning are reflected in key MOH documents (see Strategy #1); and vi) Coordinating and involving private sector in dissemination of policy reforms and strategic plans.

Strategy #5: Support the PCD to become the "hub" for all MOH private sector activities

The MOH currently has the Partnership and Coordination Directorate (PCD) that leads most PPP and private sector activities work for the ministry. The PSA team proposes that greater investment in the PCD including hiring more staff and building their capacity to carry out their roles and responsibilities. Key actions to grow the Unit's capacity include:

Investing in building PCD's organization and operating systems by i) Developing the PCD's terms of references; ii) Drafting H/PPP implementation guidelines; iii) Establishing operating systems supporting the guidelines; and iv) training Unit staff in the operating systems.

Building other MOH staff knowledge on private sector and capacity in private sector engagement through assisting PCD to generate information needed to monitor private sector and supporting the Unit to regularly share information on private sector and PPP/Hs throughout MOH and with the private health sector.

Mentoring the Unit's staff to design/implement first generation of H/PPPs. Strategy Six proposes several partnership ideas proposed by public and private stakeholders identified during the PSA.

Strategy #6: Grow and harness the private sector role in health sector

The PSA identified several barriers to private sector growth (see box) which the MOH needs to address if they want to grow and harness the private sector. Action include:

- **Customs:** Very bureaucratic and inefficient (again with promising initiatives to streamline).
- **Taxes:** High relative to other "favored" sectors in economy.
- **Land:** Very expensive. Dampens expansion or new greenfield plans.
- **Financing**: Limited access to local/foreign capital; Forex a significant barrier.

Establish a working group comprised of public and private sector leaders to identify and prioritize economic and other regulatory constraints to private sector growth. The working group will: i) Co-develop an agenda that maps actions needed to reform specific regulations and milestones to monitor progress; ii) Hire consultant(s), as needed, to conduct analysis to inform the design and process to advocate and secure approval for regulatory reform identified; and iii) meet regularly to review progress towards milestones and trouble shoot policy design and implementation issues as they arise.

Co-identify, in collaboration with private sector umbrella organization, one to two realistic partnerships to test partnership concept while building PCD's systems and skills. Potential areas, and some are already being studied closely, include:

- Modernizing the regulatory systems and processes by creating a web-based platform that links facility licensing, facility inspection, HRH licensing, CPD hours, private medical training licensing and the master facility list. The MOH will partner with private ICT company to design and institutionalize the E-licensing platform (See Strategy # 1 above).

- Improving the availability of medicines and health commodities in the health sector through different partnership strategies: i) outsourcing to private vendors different functions of the public supply chain (e.g. transport and warehousing); ii) networking private pharmacies and rural drug shops to deliver a basic basket of essential medicines (e.g. FP, HIV test, malaria test, TB drugs, etc.) and health products combined with a voucher for low income families; iii) purchase agreement with a local manufacturer to produce health products (e.g. ORS, fortified food, nutritional supplements) and/or health supplies (e.g. gloves, bed nets, etc.).
- Increasing access to maternal/reproductive health services through a voucher program with both public and private health care providers. Link Health Extension Workers to accredited public and private facilities to mobilize mothers and women to participate in the voucher scheme.
- Improving quality in private facilities by ensuring functioning medical equipment through different strategies: i) liberalizing import taxes/regulations on select medical equipment related to maternal and child health and other priority health areas, and ii) pooling public and private hospital resources to contract a regional vendor to maintain medical equipment and create local capacity to repair medical equipment.
- Improving lab and diagnostics in the health sector through different partnership strategies: i) mapping labs, diagnostic and imaging centers to identify opportunities to rationalize infrastructure between public and private sectors (e.g. certificate of need); ii) establish referral and counter-referral contracts between public and private labs/imaging centers; iii) contract private labs to collect, pool and analyze lab specimens in rural areas where there are non-functioning and/or no labs and iv) co-locate a private lab in public hospitals.
- Establishing domestic capacity to delivery tertiary services that reduce requiring sending Ethiopians abroad by first assessing private sector capacity and feasibility of PPP projects in key areas such as oncology and cardiology.

Align all partnership projects with the strategic objectives in the next five-year HSTP.

7.2. Sequencing of Private Sector Recommendations

The PSA team proposed an ambitious agenda for the MOH and private health sector and suggests sequencing and timing their implementation over the next five years. The recommendations are organized by "quick wins" in the next six months, "low hanging fruit" requiring more time two to three years and "long-term gains" building on the foundation created by the reforms and new capacity developed in the prior years. Once again, the prioritization and sequencing need to be vetted with the MOH and private sector stakeholders.

Quick Wins – Activities in the next 3 to 6 months	**#1: Strengthen data collection, analysis and reporting on private health sector** ▪ Assess MOH reports to integrate private sector data in decision-making
	#2: Improve the regulatory systems governing to private health sector ▪ Expand Master Facility list to include private health facilities and activities
	#3: Foster dialogue between the public and private health sectors ▪ Establish a Public Private Dialogue (PPD) platform ▪ Carry out one to two joint activities like developing a private sector strategy and next HSTP
	#4: Integrate private sector into MOH policy and planning processes
	#5: Support the PCD to become the "hub" for MOH private sector activities ▪ Hire more staff for Unit ▪ Build Unit's organization and operating systems
	#6: Grow and harness the private sector role in health sector ▪ Form technical working group to identify policy/market constraints
Low Hanging Fruit – Activities in the next 2 to 3 years	**#1: Strengthen data collection, analysis and reporting on private health sector** ▪ Incentivize private sector to report ▪ Identify and conduct additional research as needed
	#2: Improve the regulatory systems governing to private health sector ▪ Modernize key licensure functions through a licensing platform ▪ Introduce and roll out licensing platform to all health facilities and professionals

	▪ Build MOH's capacity to use the licensing platform ▪ Establish minimum quality requirements and a process by which to certify minimum quality in private health facilities
	#3: Foster dialogue between the public and private health sectors ▪ Continue carrying out one to two joint activities ▪ Build public and private members' capacity to effectively dialogue ▪ Assist private sector organize itself
	#4: Integrate private sector into MOH policy and planning processes ▪ Map all planning exercises to integrate private health sector ▪ Strengthen Unit's capacity to lead public-private coordination and collaboration ▪ Establish PPP focal persons in regions with significant private sector activities
	#5: Support the PCD to become the "hub" for MOH private sector activities ▪ Strengthen Unit's capacity in partnership skills including transaction H/PPP ▪ Build other MOH staff knowledge on private sector and capacity in private sector engagement ▪ Mentor Unit's staff to design/implement first generation of H/PPPs
	#6: Grow and harness the private sector role in health sector ▪ Identify two to three "quick wins" and co-develop action for reforms ▪ Co-develop partnership strategy including action plan to implement two to three feasible partnerships

Long-term Gains – Activities in the next 3 to 5 year	**#1: Strengthen data collection, analysis and reporting on private health sector** ▪ Include private sector representatives in data analysis and dissemination ▪ Build MOH capacity to use data in policy dialogue and regulatory reforms
	#2: Improve the regulatory systems governing to private health sector ▪ Build MOH capacity to draft and disseminate quarterly reports on "state of quality in private health sector" ▪ Build MOH capacity and to use data generated from platform in policy dialogue and regulatory reforms
	#3: Foster dialogue between the public and private health sectors ▪ Strengthen PPD platform members' capacity to carry out policy analysis
	#4: Integrate private sector into MOH policy and planning processes ▪ Build PPP focal persons' capacity for coordination and collaboration ▪ Unit ensures policy and planning coordination that are then reflected in MOH documents ▪ Unit involves private sector in dissemination of policy reforms and strategic plans
	#5: Support the PCD to become the "hub" for MOH private sector activities ▪ Continue building Unit's partnership skills ▪ Continue mentoring Unit's staff to design/implement first generation of H/PPPs
	#6: Grow and harness the private sector role in health sector ▪ Reform long-term, systemic policy constraints ▪ Create financial incentives to "crowd" in private sector entities ▪ Continue building pipeline of partnerships

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Annex 1. Interview Objectives by Stakeholder Group

PUBLIC SECTOR	
STAKEHOLDERS	**INTERVIEW OBJECTIVES**
Department of Policy and Planning	▪ What do you think is the private sector's contribution to national health goals? ▪ Do you have a plan or strategy to work with private sector? ▪ What is the relationship (cooperative vs antagonistic) with the private health sector? ▪ What mechanisms do you have to dialogue / engage / partner with the private sector? ▪ What are current or foreseeable challenges do you face in working with the private health sector?
Department of Health Financing and/or Health Insurance Agency	▪ What are the current challenges in financing the health system and health services? ▪ Is there a national health Finance strategy? What are its key strategies to finance health? ▪ What is the current financial contribution to the health sector? ▪ What is the government's target level of financial contribution? ▪ What is the policy on national health insurance? How is it financed? Who delivers? ▪ What is the policy on private health insurance? ▪ Does the government have effective contracting policies and procedures? If so, what type? ▪ What is the policy on user fees?
Department/Unit of PPPs	▪ Which department is responsible for PPPs in health? ▪ Do you have PPPs in health? For what activities? ▪ What type of PPPs (e.g. PPP models)? ▪ What are current or foreseeable challenges do you face in working with the private health sector?
Department of Medical Services	▪ What do you think is the private sector's contribution to national health goals? ▪ Do you have a plan or strategy to work with private health sector? ▪ Do you have partnerships with the private health sector? In what type of areas? Activities? ▪ What mechanisms do you have to dialogue / engage / partner with the private sector? ▪ What is your relationship with the private health sector? ▪ What is the current status of licensing of private health facilities? ▪ What challenges do you face in working with the private health sector? ▪ What are your main challenges in monitoring quality in private facilities?
Department of Hospitals	▪ What do you think is the private sector's contribution to national health goals? ▪ Do you have a plan or strategy to work with private health sector in hospital care? ▪ Do you have partnerships with the private health sector? In what type of areas? Activities? ▪ What mechanisms do you have to dialogue / engage / partner with the private health sector? ▪ What is your relationship with the private health sector? ▪ How does the MOH assure quality in private sector hospitals? ▪ What is the MOH institutional arrangements to assure quality in private hospitals? ▪ How does the MOH work with private sector hospitals to assure quality? ▪ What challenges to you face in working with private sector hospitals
Department of Facility Licensing	▪ What are your main challenges in monitoring quality in private facilities? ▪ Does the private sector consider the process to license a private facility easy? Difficult? Costly? ▪ Do you only register private health facilities? ▪ Why did you stop licensing private health facilities? ▪ What is your plan to begin licensing new private facilities again? ▪ What is your plan to integrate non-licensed facilities that have not been licensed in the last 10 years?
Department of Human Resources Licensing	▪ What is the department's scope regarding licensing health professionals? Does it cover private/public? ▪ How is the data for HRH licensing captured? Reported? ▪ Does your department have a standard definition for the private health sector? ▪ What are the legal/established cadres for health workers? Same for public and private?

	▪ What are the required qualifications for each cadre? ▪ What are, if any, limitations in scope of practice for a private health provider?
Department of Drug and Lab Administration	▪ What do you think is the private sector's contribution to national health goals in the pharma sector? ▪ What mechanisms do you have to dialogue / engage / partner with the private sector? ▪ Do you have a plan or strategy to work with private health sector in the pharma sector? ▪ Do you have partnerships with the private health sector? In what type of areas? Activities? ▪ What is your relationship with the private health sector? ▪ What challenges do you face in working with the private health sector?
Department of Health Management Information	▪ How do you define private sector? ▪ What data do collect on the private health sector? ▪ What system do you have in place for private health sector to report to DIIS? ▪ What challenges do you face with private sector reporting to DIIS? ▪ What information do you share with the private health sector? In what format? How frequently?

PRIVATE SECTOR	
STAKEHOLDERS	**INTERVIEW OBJECTIVES**
Private Sector Facility Associations ▪ Private Hospital Managers ▪ Clinics ▪ Pharmacies ▪ Diagnostic Services (e.g. Laboratory Services) ▪ Pharmaceutical manufacturers ▪ Wholesalers/Importers	▪ What do you think is the private sector's contribution to national health goals? ▪ Is there a govt plan or strategy to work with private sector? ▪ What is the relationship (cooperative vs antagonistic) with the public sector? ▪ What mechanisms do you have to dialogue / engage / partner with the public sector? ▪ What are the most pressing challenges / barriers you face as a private healthcare business? ▪ Do you have partnerships with the public sector? In what areas?
Professional Providers and Professional Health Associations ▪ Nurses ▪ Doctors ▪ Midwives ▪ Pharmacists	

DEVELOPMENT PARTNERS	
STAKEHOLDERS	**INTERVIEW OBJECTIVES**
▪ AFDB ▪ WHO ▪ UNFPA ▪ USAID	▪ What do you think is the private sector's contribution to national health goals? ▪ What is the relationship (cooperative vs antagonistic) between the public and private sector? ▪ Do you have projects supporting private health sector? In what areas? Activities? ▪ What do you think are the most pressing challenges / barriers confronting the private health sector?