

Exploring alternatives for financing health care in Ethiopia: An introductory Review Article

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Abstract

Background: with increasing demand for services that is further propagated by high population growth and by people's response to newly emerging pathologies, nations in sub-Saharan African are faced with insurmountable problems in sustaining their health systems. The decline in international assistance and the effects of structural adjustment programs have made the situation even worse. Realizing the inadequacy of solely relying on the public sector, these countries are thus seeking alternative mechanisms for health care financing.

Methods: this is a synthetic literature review to describe the situation of health care financing in Ethiopia. In addition, the newly adopted health care financing strategy was looked at from the perspective of policy analysis.

Results: Health financing has been a major challenge for Ethiopia. The prospect of relying solely on public resources seems impractical and the absolute total expenditure on health is quite a small fraction of the amount needed for purchasing a minimum essential health services package. This has led to the recent adoption of a health care financing strategy and initiation of implementing its specific components. The strategy encompasses alternatives that include: improving the efficiency of allocation and utilization of public resources, expanding the role of the private sector, and encouraging the development of risk sharing mechanisms.

Conclusion: Looking at the adoption and implementation the health care financing strategy with a policy analysis approach is helpful for identifying its likely trajectory, and what needs to be done to avoid opposition, or to gain support. [*Ethiop. J. Health Dev.* 2001;15(3):153-163]

Introduction

Modern Health Services in the Developing World:

Modern medical care, that was introduced in developing countries in the first part of the twentieth century, has faced critical attacks in the sixties as being a mechanistic approach to ill health by technologically oriented medical services. Its inappropriateness was criticized on the basis of the fact that this hospital based approach, in addition to being expensive and capital intensive, couldn't cope with rapid population growth and showed a great disparity between expenditure and actual health needs in these countries. The health care provision in these countries was, thus, exposed as being

sharply limited with respect to facilities and manpower. These limited services were even less available to the rural population. This situation was made even worse by the fact that the rural population is usually inhibited by socio-cultural factors to utilize the very few technologically oriented medical services (1).

This criticism gave rise the basic health services approach that attempted to fill the gap created by the medical care model by utilizing a large number of medical auxiliaries, who can give service coming nearer to the target population. The increased number of this workers nearer to the community, somewhat tackled the problems of availability and accessibility of services. The fact that these auxiliaries can work with minimal locally oriented facilities was believed to address the question of acceptability and appropriateness

(2). However, services continued to remain largely institutionalized and the communities were not involved in decisions about health services.

These led WHO and UNICEF to re-examine their practices and options in health and led to a search for an alternative through the study of some success stories in health care. Reported successes in health outcomes in a few countries, especially China, Tanzania, Cuba, and some other Latin American countries have made a considerable contribution to the importance of community participation. Changing development theories that helped link health to other sectors, emphasized the need for an integrated, inter-sectoral approach, and stressed equity in health service access and provision. This resulted from the view that health plays crucial role in development and the input of all development sectors is necessary to bring about healthy living. This view was further developed by criticizing earlier theories of development, which gave greater emphasis to investments in physical elements, and undermined the role of the social sectors in the overall social development. Concern about population growth, which had its roots in many different places, helped later to direct support to maternal and child health services, with greater emphasis to family planning programs. Family planning programs as seen are essential part of the PHC program (3). Thus in September 1978, WHO and UNICEF convened a conference at Alma-Ata, USSR where they came up with the Declaration of Alma-Ata. The declaration reaffirmed that health is a fundamental human right, that attainment of its highest possible level is a most important world-wide social goal, and that primary health care is the key to attaining 'Health For All by the Year 2000' as part of development in the spirit of social justice (4,5). As a consequence of this, until recently public health care in most developing countries was free of charge or was provided for nominal fees.

The Crisis in Financing Health Care in developing countries:

However, as most of these countries found themselves in deplorable condition since the early 1980s due to sharply increased lack of funds, inefficiency, and mismanagement, exclusive reliance on government financing of health services has become increasingly unbearable. On the other hand, these countries have been confronted with the problem of increasing health care needs as more people have sought help from western services rather than, or in addition to, traditional services (6, 7, 8). Population growth, mainly due to greater child survival, has outpaced the expansion of health services; and new pathologies, such as AIDS, have brought about growing health cost. Several management problems were also encountered especially by developing countries launching PHC programs. Besides the bleak outlook for donor funding, implementing the Structural Adjustment Programs (SAP) have resulted in further decline in the government budget allocated to social sectors including health. In such a situation the Alma Ata ideals have become almost impossible to attain with only government resources. For all these reasons, the health sector in these countries has often found itself with a budget which has declined substantially in real terms with the overall result of deterioration in the quality and effectiveness of publicly provided health services (9, 10, 11).

Alternative Options for financing health care:

All the above situations have led to the urgent exploration of options that would expand available resources for health and assure their efficient use while also assuring access by as much of the population as possible. Of course, looking for ways of properly and effectively financing health care has been an important preoccupation of governments everywhere (whether these are developed or poor countries). However, the problem is more acute in developing countries since they cannot collect as high a proportion of their gross domestic

product in taxes. Among the suggested (and some are being implemented) options are (12, 13, 14, 15, 16, 17):

I. Efficient use of available resources. This includes the improvement of budgeting and resource allocation by reorienting the size and functions of health ministries, in addition to gradually granting autonomy to hospitals in terms of both management and financing.

II. Revision of user fee systems with gradual and varying modalities of cost sharing and cost recovery.

III. Enhancing the role of the Private Sector (including NGOs) in the provision and financing of health care.

IV. Establishing health insurance schemes. In a sense, system of health financing based on general tax revenue and that attempts to provide health services to the population for free or for nominal prices can be considered as a "national health insurance". However, due to the unevenness of the distribution of health resources, health benefits cannot be uniformly distributed among the population. In addition, public sector inefficiency in producing and financing of services has made the system almost ineffective. Decentralized forms of insurance schemes will have the incentive for taking full and active responsibility. In addition, the beneficiary will also be in a relatively more "concentrated" and "negotiating" position for transparency and enforcing efficiency.

In light of this background, the purpose of this introductory article is to review the situation of health sector financing in Ethiopia and to analyze the elements of the newly adopted health care financing strategy.

Methods

This is a literature review of published articles, books, and unpublished manuscripts and government documents on the subject of health care financing in Ethiopia. A synthetic app-

roach was used to review these documents. In addition, the health care financing strategy is looked at from the point of view of policy analysis in an attempt to analyze some of the factors that affected, or will affect, its implementation. This is done by taking into account context, actors and processes.

Results

Highlights of Health Care Financing in Ethiopia:

1. Magnitude and sources of financing:

The Ethiopian government has been making budgetary allocations since 1949. For the fiscal year 1998/99 the share of health expenditure to the total public expenditure amounted to about 6.5%. With this, the overall public per capita health expenditure was only 13.6 birr (about 1.8 US dollars per year) (18). International assistance (bilateral and multilateral) also plays significant role in the financing of health service projects.

Private expenses are the most important sources of health expenditure in the country. For instance, the private share of total expenditure on health in 2000 was estimated to be about 62% (19). With regard to cost recovery in public facilities, Ethiopia is among those countries where some national system of fees is present but enforcement is minimal or not effective. Revenue from user charges in 1986 amounted to birr 19 million that was 16% of the government recurrent expenditure. Non-government providers seemed to have higher cost-recovery rate than public facilities. In a facility based survey that was done on 31 sampled NGO health institutions, 16.1% had 91-100% cost recovery capacity, 6.5% had 81-90% recovery capacity, and 77.4% had 70% recovery capacity, while average revenue from user fees as a percentage of recurrent hospital expenditures were about 23% in public rural and 32% in public urban hospitals in 1984/85 (20, 21).

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Table 1: Source of health care financing (Millions of birr) (Ethiopia, 1986/96)

	Fiscal Year 1986				Fiscal Year 1996			
	Recur.	Capital	Total	Share of Total	Recur.	Capital	Total	Share of Total
Private Payments								
2. Fees to MOH units	226.5	0.0	226.5	63.4	388.4	0.0	388.4	39.3
3. Fees to Other Units	19.0	0.0	19.0	5.3	79.7	0.0	79.7	8.1
Government Expenditure	79.0	3.4	82.4	23.1	281.7	142.0	423.7	42.9
External assistance	20.0	22.0	42.0	11.8	75.2	95.9	171.1	17.3
Insurance scheme	0.6	0.0	0.6	0.2	5.0	0.0	5.0	0.5
Other local sources	5.7	0.0	5.7	1.6	—	—	—	—
Total	331.8	25.4	357.2	100.0	750.3	237.0	988.2	100.0
Health as share of GOE			12.6				10.2	
Health as share of GDP			3.2				2.7	

Source: The World Bank Ethiopia: Social Sector Note, 1997.

Table 2: Trends in capital/recurrent expenditure mix (Ethiopia, 1990-1998)

year	Total	Recurrent	Capital	As % of Total	
				Recurrent	Capital
1989/90	215.3	151.6	63.7	70.4	29.6
1990/91	208.0	159.0	48.9	76.5	23.5
1991/92	223.8	160.8	63.0	71.8	28.2
1992/93	274.8	190.5	84.3	69.3	30.7
1993/94	498.8	300.9	179.9	60.3	39.7
1994/95	580.0	346.0	234.0	59.6	40.4
1995/96	599.0	361.4	237.9	60.3	39.7
1996/97	598.0	363.1	11.9	55.5	44.5
1997/98	742.0	379.8	354.2	53.9	46.1
1998/99	818.0	478.9	303.1	57.3	42.7

Source: Ministry of Health. Health and health Related Indicators, 1999

2. Patterns of allocation of health care resources:

The pattern of health care resource allocation between capital and recurrent budget items is shown in table 2.

The proportion of the public budget that used to be allocated to hospital services was very

high in view of the fact these hospitals are located in the major urban centers while about 85% of the population is rural. Even in the health centers and health stations more than 60% the allocated budget goes to paying the salary of health workers, who are forced to work in situations of very scarce drugs and poor facilities (22).

Table 3: Proportion of Different Items to Total Budget

	Hospitals Health Centers			Health stations	
	All	With out Addis		All	with out Addis
Personnel/Budget	45.5%	64.1%	70.6%	60.2%	69.7%
Drug/Budget	28.5%	17.1%	14.4%	24.0%	12.9%
Other Rec./Budget	26.0%	18.8%	15.0%	15.8%	17.4%

Source: PHRD. Cost-effectiveness and management of the public health care system, 1998

3. Efficiency of services production:

To date there are very few studies that measured the unit costs of producing health services. The unit total costs of dealing with the selected health interventions at the selected hospitals were generally higher than the costs of dealing with similar situations at the

selected health centers and health stations. When this cost was disaggregated, overhead cost contributed for more than 50% of the estimated labor cost contributing the next higher proportion at all levels of institutions. When the unit overhead costs between health centers and health stations were compared, the

cost at health stations was higher. This is assumed to be a reflection of the lack of economies of scale and the underutilization of resources at the health stations. In addition, even though it is not fair to do so, comparison of the unit costs with user fees shows that most of the services are priced well below their marginal cost of production and thus facilities did not cover the costs of providing these services. For instance, the user charges for delivery services in hospitals ranged between 15-25 birr (US\$2.4-4) while the range for the estimated actual cost was 62 to 571 birr (US\$10 - 90) (23).

4. The contribution of the newly emerging private sub-sector:

Private health services have already started to flourish in the urban centers and professionals are seen to give more attention to such part time practices, since the incentives for hard work in the public sector are very weak. As of 1999 there were 7 NGO hospitals, 4 private hospitals, 9 NGO health centers, 966 private clinics, 11 Red Cross pharmacies, 263 private pharmacies, 4 Red Cross drug shops, 232 private drug shops, 2 red cross rural drug vendors, and 1856 private rural drug vendors registered and licensed to operate in various regions under the Ministry of Health (24). According to an assessment in 1998, the number of private clinics per 100,000 population varied by region, from a low of 0.64 in a region in the southern part of the country, to a high of 12.9 in Addis Ababa, the capital (25). However, approximately 50% of health professionals working in private clinics did not have government release papers and thus were operating illegally. Most importantly, the capacity of MOH as well as regional health bureaus to conduct strong and regular supervision and monitoring of licensed private providers was found to be very weak. Even though the proliferation of these services seemed to have expanded the choices available to those who can afford their fees, there were various complaints by the public about the operation of the private sub-sector. These include the poor quality of services provided,

exorbitant fees, and unnecessary investigations and prescriptions. Complaints were also expressed by the private sector that included bureaucratic constraints, limited supply of pharmaceuticals and equipment, shortage of professionals. In addition, financial constraints for capital costs and the limited effective demand for services due to low per capita income of the people were constraints mentioned by private practitioners (24).

5. Development of Health Insurance:

The coverage with formal health insurance in the country is very minimal. Some state owned enterprises reimburse 50% of the medical cost incurred by their employees. Ethiopian Insurance Corporation (EIC) is currently the only commercial establishment providing health insurance as an optional extension to its life insurance policy. The benefit package for the health component usually does not exceed US 1,000 per year. For instance, in 1995 the number of policies sold were 900 covering 10,869 people (representing only 0.03% of the total population). The total premium for these policies was 767,606 birr (about 108,113 US) and the amount claimed that year was 570,482 birr (about 80,350 US) (20). In 1998, a total of 1,022 policies were sold covering 9,153 individuals or 0.02% of the population. This represents a decline from 1995 when 0.03% of the population was covered. The total premium from these policies was 1.05 million Birr (\$145,300) and the amount claimed was 991,158 Birr (\$136,711). (These figures represent information collected to date between July 1, 1997 and June 30, 1998). Under this scenario, the health insurance fund appears to barely break-even (27).

The New Health Care Financing strategy:

In view of the problems mentioned above in effectively financing the provision of health service, the Ethiopian government has adopted a health care financing (HCF) strategy that, among other policy reforms, calls for increased cost recovery in government sponsored health services and increased reliance on the private sector including NGOs (21).

The goals of this strategy that is currently being implemented include:

1. To identify and obtain resources which can be dedicated to preventive, promotive, curative, and rehabilitative health services for the people;
2. To increase efficiency in the use of available resources;
3. To increase absolute resources to the health sector; and
4. To promote sustainability of the health care financing and improve the quality and coverage of health services.

The elements of this strategy are:

1. Improving government health sector efficiency;
2. Generating additional and new sources of revenue;
3. Encouraging the involvement of the private sector including NGOs;
4. Promotion of community participation;
5. Encouraging bilateral and multilateral agencies' participation; and
6. Developing alternative financing options for urban areas.

A health care financing secretariat based in the Health Services and Training Department of MOH serves as Secretariat for the national health care financing implementation task force. Likewise, the Regional Health Care Financing Committee in each region chaired by regional state council social sector head, where regional council women' affairs head, RHB head (secretary) RFB head, RPEDB head, representatives from NGOs, and consumer groups are members, is responsible in each region (21). This structure is supposed to go down to zones, Weredas and health facilities even though not established until the end of 2000.

For the full implementation of this strategy, the government is trying to create partnership with the community, the private sector, the NGOs and other segments of civil society in the framework of the health sector development program which it has adopted since

1995 (28). Specific components of the strategy (mainly the establishment of special pharmacies through revolving drug funds obtained from different sources) are being initiated in all the regions of the country with varying degree of arrangements and performance (29).

Discussion

The health sector in Ethiopia is financed from a number of sources: government revenues, aid from donors, external loans, and user fees. Health insurance payments and other local contributions are not significant sources of financing. However, data problems (especially for private payments) prohibit the precise estimation of the contribution made by each of the above sources. It is also not possible, at this moment, to quantify the share contributed by NGOs and the private sector in the total expenditure for health. The magnitude of fee waivers granted at public facilities is not also properly recorded (30).

Nevertheless, there are some attempts that have provided estimates for these health account figures. The total government expenditure for health during the fiscal year 1999/2000 (both recurrent and capital) amounted to Birr 866 million, corresponding to an average per capita expenditure of Birr 13.83 (about US\$1.7) per annum. This has increased from 215.3 million Birr in 1989/90, a marked increase even though the current figure is still the lowest compared to the sub-Saharan average of US\$ 14.00 (19, 31).

Following the adoption of the National Health Care Financing Strategy in 1998, various initiatives have been started on pilot basis that include establishing of revolving drug fund schemes in selected areas. The Health Care Financing Secretariat, located in the Ministry of Health, is working with a goal of identifying and obtaining additional resources for the health sector in the country (32).

For the public sector health delivery system, budget allocation by the government will continue to be the main source of finance.

Significant increase in government allocation to the health sector is a remote possibility. Therefore, there is a need to look for alternative methods that will help increase the efficiency of the already available resources. Improvements should be made to balance expenditures between high cost curative services and preventive services so that available resources are utilized in a more efficient and optimum manner. In addition, measures that will be taken for improving the efficient use of available resources include revisions of the exemption system, updating the level of financial accounting, budgeting and resource management at all levels. The government also needs to pay immediate attention for improving the administrative performance of public health institutions and for creating incentives to enhance the performance of health workers.

Enhancing the role of the private sector and NGOs in the provision and financing of health services is also another important undertaking that will be given attention in this regard. With improved and explicit operational strategies, the private sub-sector can greatly complement the efforts of the public system in the provision of services and the distribution of drugs in rural areas and provision of primary health care in relatively remote parts of the country (particularly NGOs). The HSDP promises to create the medium for proper partnership with bilateral and multilateral donors, in which case there will be the needed transparency for using resources from these quarters. In the long run, the concept of this partnership is to pool all health resources (including those of NGOs and private providers) into a "single basket" (33, 18).

Increasing the level of and/or the institution of new user fees where they are not available are one of the options available especially for curative services with private good nature. There are already evidences that individual private payments are the major source of health care financing in the country (19). Given proper institutions for channeling these

payments, exempting the poor, and incentives for facilities to implement introduced changes, this will generate significant amount of resources for the sector.

Charging user fees can negatively affect the use of health services by the poor. Therefore, implementing user fees need to be researched thoroughly and implemented gradually. If properly instituted the negative impact of prices on the demand for services can be greatly offset, sometimes completely, by improving the quality of services offered. Some strategies for efficient use of user fees include:

1. To charge fees to those who use the hospitals if they had not been referred up to the hospitals through lower level of the system.
3. Gradual implementation by initially targeting to recoup not more than 30% of operating costs from service fees.
2. To provide higher level facilities with positive incentives to collect user fees.

It has been increasingly obvious that the development of health insurance is one of the prerequisites for raising fee levels at public hospitals and for the growth of the private sector in health. Given such mechanisms for channeling individual health expenditures, there is a prospect for responding to possible increases in user charges at public facilities with proper strategies for assuring quality of services and exempting those who cannot afford to pay. Contrary to previous assumptions (34), there is already a lot of empirical evidence about the feasibility of insurance schemes in developing countries. Even though private health insurance or insurance provided by state owned enterprises is currently limited in terms of scope and coverage, building up on already existing institutions that were established for other purposes seems to be promising in this regard (27). One option to consider in this respect is to develop voluntary insurance schemes in urban areas for private sector employees in establishments with at least sizable numbers of employees. Governments can help bring about risk pooling on a

larger scale by requiring employers to provide insurance and mandating arrangements that bring small employers and the self-employed into risk pools.

External assistance has played a major role in the development of health services in the country. Such assistance will continue to be required for a long time to come, but the assistance will have to be geared and harmonized with the priorities set by the government. In the past, most of the external assistance used to be concentrated on capital projects and special programs. However, with the implementation of the HSDP this trend might change and allocation of donor resources is expected to be made on the basis of an agreed upon transparent plan. It appears that donor assistance may have to be channeled more to capacity building rather than to fragmentary set of donor-preferred projects.

From policy analysis point of view we can look at the important contextual, process and content factors that influenced the actors in adopting the present health care financing strategy (35). It is obvious that the current regime, being new and with tendencies to experiment initiatives creates the fertile political climate for introducing health sector reform. In addition, the fact that structural adjustment is taking place and there are market reforms can be mentioned as important economic contextual factors for the type of health financing strategy that was adopted in the country. The Sector Development Program that being implemented in health (HSDP) is also an important contextual factor that directly influenced the design of the Health Care Financing Strategy. In actual fact, the Health Care Financing Strategy is one of the components of HSDP. The broader organizational change that the health sector is undergoing (in terms of decentralization and change from the six-tiered to the four-tiered system) is also expected to facilitate decision making at the local levels that would again be instrumental in effecting the strategy.

The Ministry of Health is an important actor in the process of developing and implementing the Health Care Financing Strategy by virtue of its position. In addition, its influence has been seen to be strengthened by the establishment of the Health Care Financing Secretariat that is expected to clearly define the types and extent of the roles that are to be played by the different stakeholders in effectively implementing the strategy. Donors as partners to the HSDP are also very influential in the process since they are involved in planning, supporting and reviewing the whole program. However, there is a need for securing consistent commitment of the involved partners. It is obvious that the process of implementing the strategy has been slow. This might partially be due to temporary political situations (the conflict with neighboring Eritrea) that might have distracted the government's preoccupation and the partners' commitments. Since some of the political situations have currently been resolved, it should be possible that the program get implemented with full swing. The other process related issue of concern is the proper communication of the strategy and experiences of other countries that have adopted similar initiatives. Local studies on the various alternatives for financing health care should also be encouraged and their results get disseminated in time to the relevant parties.

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