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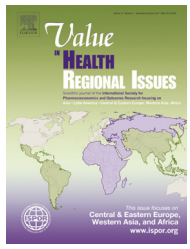

BRIEF REPORT

The State of Health Technology Assessment in the Ethiopian Health Sector: Learning from Recent Policy Initiatives

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ABSTRACT

Health technology assessment (HTA) has previously been implemented only in a fragmented manner in the Ethiopian health sector decision-making cycle, and the sector has been hampered by limited institutional capacity and skilled human resources to inform evidence-based decision making. The country is in the midst of widescale implementation of a community-based health insurance scheme and is preparing for the launch of a social health insurance scheme. The country continues to face a limited financial resource envelope, undergoing an epidemiological transition, and is facing a much greater burden of noncommunicable diseases, for which the essential health benefit package, defined 12 years ago, may no longer be suitable. This has called for an in-depth review of the application of HTA in the context of the current health needs and institutional settings. To meet the increasing need for HTA, the Health Economics and Financing Analysis (HEFA) team was established within the Finance Resource Mobilization Department under the Ministry of Health. The HEFA team is tasked with spearheading the application of evidence-based health care decision making in Ethiopia by organizing available evidence, costing interventions, and defining effectiveness measures of the different health programs and then supporting policymakers at the national and regional levels. Improving and harmonizing the institutional approach to HTA, including staffing the HEFA team with the appropriate mix of expertise, and networking with relevant sector organizations will improve Ethiopia's ability to tackle the current health sector challenges as well as protect fledgling insurance schemes' progress toward universal health coverage.

Keywords: essential health service package, Ethiopia, health economics and financing analysis team, health insurance, health technology assessment.

Overview of the Ethiopian Health Sector

Ethiopia has been able to achieve impressive health gains for its population within the limited resource envelope. In 1997, the Federal Ministry of Health (FMOH), in partnership with regional health bureaus and primary stakeholders, launched the Health Sector Development Program. Since then, significant reductions have been reported in the prevalence of major diseases including HIV/AIDS, malaria, and tuberculosis (TB) [1]. For instance, in 2014, the adult HIV prevalence was 1.2% (0.8% in males and 1.6% in females), which showed the reversing of the epidemic by more than 50% among adults over the last decade [2]. Both mortality due to TB and TB prevalence have declined by more than 50% between 1990 and 2015, and the incidence rate is falling significantly [3]. Malaria admission rates were estimated to have decreased by more than 40% between 2010 and 2015, with a decrease of more than 60% in the mortality rate during the same period [4]. Moreover, improvements in maternal and child health have also been reported across the country, including reductions in under-five and maternal mortality rates, as well as increased life expectancy. These improvements meant that Ethiopia was able to achieve Millennium Development Goal 4, attaining the under-five mortality rate of 28 per 1000 live births [5].

These achievements were made possible within the context of limited health care spending and, in particular, low government health care spending (as a percentage of total health expenditure). The Ethiopian health sector is dependent on government spending (30% of health spending), out-of-pocket spending (33% of health spending), and external development assistance (36% of health spending). The Ethiopian government has developed alternative financing options/channels to effectively invest in the health sector. These financial resources are channeled through

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three modalities. Channel 1 (program-based earmarked finance resources) and channel 2 (unearmarked pooled finance resources) are managed and decided directly by the various government levels, whereas in channel 3, the funds are managed by nongovernmental implementing partners under their own financial management system.

The per capita health expenditure trends were US $16.10 in 2007/2008, US $21.00 in 2010/2011, and US $28.40 in 2013/2014 [6,7]. In nominal terms, the total health sector spending has been increasing over the years. The health sector received 8% to 9% of the total government spending during the years 2006/2007 to 2011/2012 [6,7]. The percentage share of the country's government health spending has increased from 3.5% in 1996/1997 to 5.2% in 2010/2011 and to 6.65% in 2013/2014 [6,7]. Nevertheless, despite this increase in per capita spending on health, both percentage allocation and absolute levels of spending have been substantially lower than the World Health Organization average threshold (US $60) [8] and the target set in the Abuja Declaration [9,10].

Some of the health sector's programs, such as HIV/AIDS and TB prevention and control programs, have recently experienced a substantial reduction in external funding and limited domestic funds [11–13]. This was higher in 2010/2011, when 50% of the health sector was financed through external assistance (from local and international nongovernmental organizations), whereas households and the government contributed 34% and 16%, respectively [6]. In 2013/2014, the overall external sources share decreased to 36% of total health spending [7]. This reduction in external funding sources demands critical attention by the health policymakers and implementing stakeholders.

In the health sector, resource allocation will be made following the top-down and bottom-up planning approach to link the national- and local-level priorities. This resource allocation exercise is focusing more on the annual budget exercise and is mainly managed by the budget review team (Finance Resource Mobilization, Finance and Procurement Directorate, and Policy and Planning) without applying cost-effective and efficiency concepts [14].

To consolidate and build on recent improvements in health outcomes and advocate for more sustainable health care financing, as well as to prioritize cost-effective interventions and strategies, this article assesses the overall status of health technology assessment (HTA) in the country within the context of the health insurance and recent policy initiatives and finally concludes by highlighting its relevance and future prospects. All relevant documents (published and unpublished), research articles, manuals, and program reports were reviewed by the research team.

Overview of Ethiopian Health Insurance and Essential Health Service Package

Ethiopia has recently embarked on the implementation of health insurance to improve health service utilization and financial risk protection as well as to improve access to health services. To steer these reforms, the Ethiopian Health Insurance Agency was established under the Council of Ministers Regulation No. 191/2010 in 2010. Two insurance schemes, namely, community-based health insurance (CBHI) targeting the informal and rural sectors and social health insurance targeting the formal sector, were designed as the primary vehicles to attain the envisioned objectives.

Between 2012 and 2015, the CBHI scheme was piloted in 13 woredas (districts) located in Oromia, Amhara, the Southern Nations, Nationalities, and Peoples' Region, and Tigray regions with the aim of providing financial risk protection for those employed in the rural and informal sectors [15]. Building on the experience from the pilot, the CBHI scheme has been implemented in 377 woredas. To expedite this implementation, regions adopted the new CBHI directive issued by the FMOH. The government is currently aiming to implement in 80% of the woredas and enroll at least 80% of households by 2020 [1]. The necessary legal framework for the social health insurance scheme has been developed.

At the policy level, there are plans to conduct medical auditing before insurance claim reimbursement and to make sure the services are provided as per treatment protocols. To make this possible, a medical audit manual has been prepared and proper action will be taken as per the findings from the medical auditing [16]. In addition, there is a plan to conduct continuous supervision and assessment of contracted health facilities to make sure the provision of health services is in line with the defined health service benefit package.

The first essential health service package (EHSP) was defined in 2005. The list of services comprises core health and health-related services that are promotive, preventive, and curative and rehabilitation services that are agreed to be very basic, necessary, and acceptable standards of health services to all segments of the population [17]. According to the EHSP, the document is intended to serve as a means of prioritizing service packages, defined on the basis of the criteria of cost effectiveness, affordability, equity, necessity, capacity, and accessibility. Considering these predefined criteria and assuming the newly innovated "health extension program," the EHSP outlined five core areas of minimum standard service packages: family health services, communicable disease prevention and control services, hygiene and environmental health services, health education and communication services, and basic curative care and treatment of major chronic conditions.

Despite these initiatives, the 2005 EHSP minimum services did not use HTA in designing and redefining the priority EHSPs. Instead, principally the package was developed with a priority focus for pro-poor economy policy and equity concerns. Although the criterion of cost effectiveness is indicated, there was no exhaustive and in-depth HTA analysis across these different health service interventions and technologies, and the cost-effectiveness criterion was never clearly defined. The EHSP lists were developed through successive meetings and stakeholder engagement, without a systematic and evidence-based approach [17].

HTA in the Ethiopian Health Sector

HTA is an established method for priority setting in the health sector [18]. It helps to systematically evaluate health technologies and health interventions and comprises multidisciplinary expertise from economic, social, organizational, and ethical spheres, with the aim of informing health policy decision making [19]. HTA is also used interchangeably with economic evaluation, which aims to compare costs and consequences of different choices, and it is a commonly used technical term in developed countries [20].

Despite its increasing relevance in developed countries, HTA has not been effectively implemented across low- and middle-income settings [21]. In Ethiopia, the application of HTA has not been assessed effectively. In the health sector, of the total 57 decision makers/health care managers responsible for high-level decision making, only 56% of those interviewed showed a good understanding of economic evaluation when explained in terms of cost and outcomes of alternative courses of action and value for money [22]. Three important barriers were pinpointed for the limited HTA practices: limited awareness, lack of expertise, and reliance on traditional decision making [22].

Limited research outputs were reported on HIV/AIDS programs and on the overall health systems [23–25]. Ethiopia has suffered