IMPROVING HEALTH SYSTEM EFFICIENCY

ETHIOPIA

Human resources for health reforms

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Health Systems
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CONTENTS

1 BACKGROUND AND CONTEXT

1.1 The case study

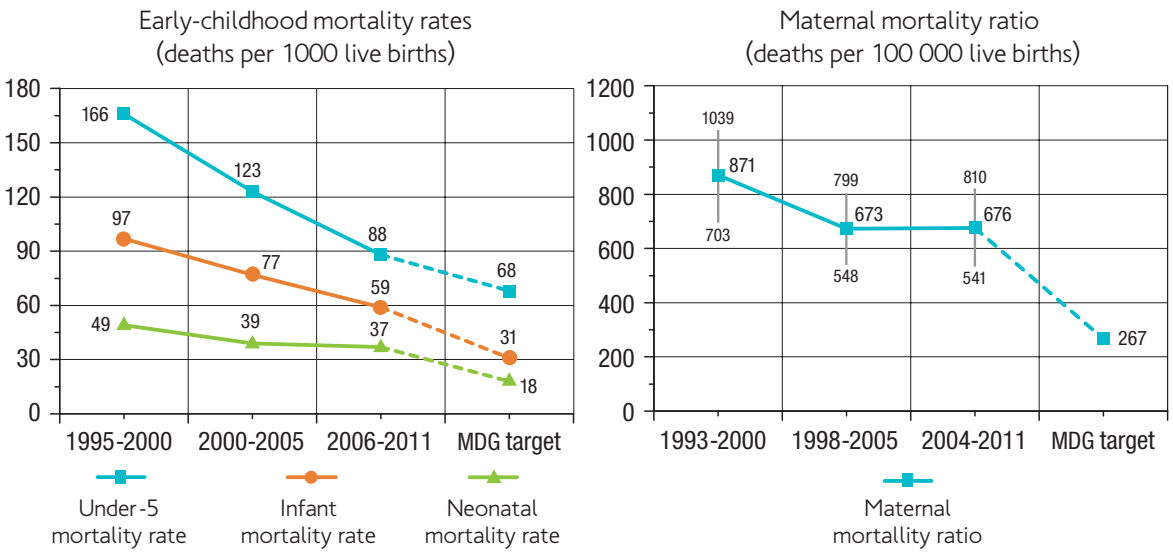
This study documents the achievements and challenges of three major reforms in the area of human resources for health in Ethiopia, which involve:

- creating a new cadre, designated health extension workers (HEW),[1] to accelerate progress towards universal coverage of community-level health services;
- task shifting and scaling up the production of mid-level health professionals to meet the human resource requirements for the accelerated expansion of primary healthcare units; and
- increasing the production and competencies of general-practice physicians through an expansion of medical schools and a reform of medical school curricula to address a critical shortage of medical doctors in the country.

1.1.1 Health profile

The health sector in Ethiopia has shown remarkable progress involving a number of health, nutrition, and population indicators over the last decade (Figure 1). The country achieved the targets of the millennium development goal on child health well ahead of time (1). The 2011 Ethiopian demographic and health survey (DHS) reported that infant mortality declined by 42% and under-five mortality by 47% over the 15-year period preceding the survey. Progress towards the targets on maternal health, however, has stagnated. Between the 2005 and 2011 surveys, no progress can be documented (2).

Figure 1. Maternal and child-health indicators in successive demographic and health surveys



Source: adapted from Demographic and Health Survey 2011.

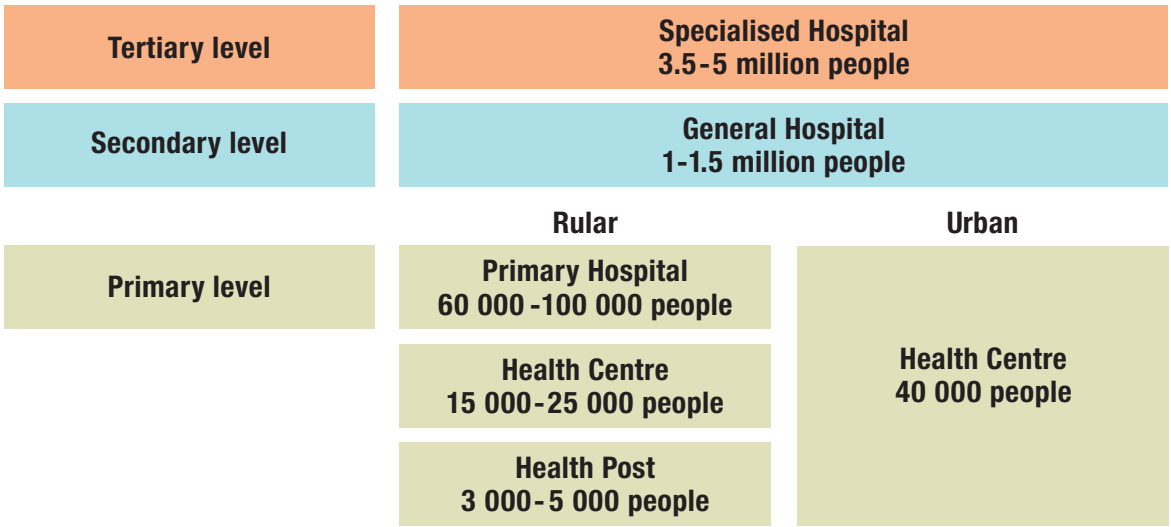
1 Please refer to the Annex for the definition of terms.

1.1.2 Health system

The health system of the Federal Democratic Republic of Ethiopia is guided by a 20-year health sector development strategy, which is implemented through a series of five-year health sector development programmes (HSDP). The consecutive HSDPs are aligned with international commitments, such as the millennium development goals and national plans such as the Plan for Accelerated and Sustained Development to End Poverty (2005/06–2009/10), and the Growth and Transformation Plan (2010/11–2014/15). Currently, the country is implementing the fourth health sector development plan (HSDP IV).

HSDP IV has introduced a three-tier health-delivery service system (Figure 2). The primary level consists of primary healthcare units (health posts and health centres) and primary hospitals; secondary level services are provided by general hospitals; and tertiary services by specialized hospitals (3).

Figure 2. Ethiopia's three-tier healthcare system



Source: adapted from Federal Ministry of Health, Health Indicators 2012.

There has been a major expansion of primary healthcare units in the last decade through rehabilitation and upgrading of existing facilities and construction of new facilities (Table 1). The number of health centres has increased almost fivefold and the number of health posts has more than doubled (4).

Table 1. Expansion of primary healthcare units

Type of health facility	Baseline in 2005	Target for 2015	Available in 2013	Average staffing norms for each of the facilities
Health post	6 191	15 000	16 048	2 Health Extension Workers
Health centres	668	3 516	3 245	1 Health Officer 2 Midwives

Source: adapted from Ministry of Health annual reports.

1.1.3 Human resources for health

Development of frontline and middle-level health professionals has been one of the eight priorities of Ethiopia's health policy since 1993 (5) and a key component of successive health sector development programmes (Table 2). The main objectives of the HSDP IV are increasing staffing at all levels of the health service pyramid and the establishment of effective human resource management systems. A strategic plan for human resources for health was developed in 2008. The plan details human resource planning, management, education, training and skill development, legal frameworks, and financing mechanisms (6).

At the end of HSDP II, prior to the major human resource reforms, Ethiopia ranked in the lowest quintile among African nations in terms of density of healthcare personnel, with 0.3 physicians and 2 nurses per 10 000 population (7). There was also a problem of uneven distribution of the limited health workforce among and within districts and an inappropriate use of available skills. The reforms implemented since then resulted in a major increase in human resources for health. With the inclusion of health extension workers, Ethiopia had 11 health workers per 10 000 population by 2011 (8).

Table 2. Development of human resources for health in Ethiopia

	End HSDP I (2002)		End HSDP II (2005)		End HSDP III (2010)		Mid HSDP IV (2011/12)	
	#	Density	#	Density	#	Density	#	Density
Medical doctors	1 888	1:35 604	1 996	1:35 604	2,152	1:36 158	2 923	1:28 847
Health officers	484	1:138 884	683	1:104 050	1 606	1:48 451	4 923	1:17 128
Nurses	11 976	1:5 613	14 270	1:4 980	20 109	1:3 870	36 672	1:2 299
Health Extension Workers			2 739	1:25 940	33 819	1:2 301		

Data Source: Ministry of Health

2 HUMAN RESOURCES FOR HEALTH REFORMS

2.1 Context and drivers of the reforms

The evaluation of the first five-year health sector development programme triggered the introduction of major human resource reforms. At the end of the programme in 2003, the overall performance of the health sector had improved, but there were major gaps in the delivery of essential services in rural areas. Only one quarter of pregnant women received antenatal care, and only one third of children were fully immunized (9). Distances to health facilities were a major barrier to the use of services (10,11).

The human resource reforms were implemented in a policy environment of changing health needs and evolving priorities.

- With the aim of addressing poor performance in the delivery of essential services and of meeting the targets of the millennium development goals, the Government of Ethiopia made the expansion of access to primary healthcare its topmost priority. This was operationalized through the last three health sector development programmes (HSDPII-IV), the accelerated expansion of primary healthcare facilities, the health extension package programme, and the essential services package.
- Expanding access to primary health care required an equitable distribution of new facilities and of the workforce among regions. In Ethiopia, a federally structured country, providing primary healthcare services is a regional and district (woreda) function. The expansion of facilities, capital investment and recurrent costs (including the costs of human resources), had to be financed to a significant degree by the regional and woreda levels of government.
- Financial support to the health sector by development partners increased significantly, both through budget/sector support and through project financing. The human resource reforms benefited from this injection of additional funds.

Overall, the accelerated expansion of primary healthcare units served as the major driving force for human resource reforms. At the start of the reforms, the health workforce was inadequate to satisfy the demand