April 2021

Policy Brief

Introducing Medical Office Practice in Ethiopia

Why is Medical Office Practice Important?

Countries learned the painful lesson that if they want to achieve Universal Health Coverage (UHC) then they need to keep track of the size, dis- tribution, and composition of their health workforce and anticipate a future need for human resources for health. Lessons from the Millennium Development Goals showed that the health workforce underpins every function of the health system and is the rate-limiting step. The three di- mensions that continue to limit the success of the develo- pment agenda are availability, distribution, and performan- ce of health workers. The Sustainable Development Goals cannot also be achieved without addressing all three of them. A paradigm shift is required in the design of sys- tems that can properly identify, train, allocate and retain health workers.

Despite the efforts made in the past two decades to in- crease the number and skill mix of health workforce, Ethi- opia is one of the countries with very low health workforce density at 0.96/1000 population compared to the conti- nental density of health workers (2.2/1000 population) and five times less than the minimum threshold of 4.45 per 1000 population . The last two decades saw a signif- icant increase in production capacity for doctors, health officers, nurses, and midwives. However, another problem surfaced complicating the vision: Health professionals in- cluding the doctors are facing the unusual challenge of unemployment, where there is a significant lag between production and deployment.

The deployment or practice modalities for health workers is very limited, and decades old. Established public sector facilities have limited absorption capacity due to budgetary constraints and currently active private sector is financially insecure to entertain additional cost of hiring new graduates. Furthermore, regulatory barriers make health workers´ entry to the market very difficult. Given the multiple challenges in the form of training, pro- duction, and retention of health workers, different service delivery models that create opportunity for health work- ers and improve availability and affordability of care is urgently needed. Furthermore, preventive, promotive and primary care services that are closer to the community will minimize time and emotional burden for patients and the community.

Therefore, the timing urges all actors in health care in Ethi- opia, in public and private sector to come together, break policy barriers and explore new business models and ex- pand work opportunities for health workers and service opportunities for the community by bringing together the best in health care delivery and business operations.

A Closer Look: The New Business Model

With different services delivery models showing promise in improving access and quality, it is high time that the Ethiopian health care delivery includes new or renewed models.

New business models (such as solo and group practices), revision of unresponsive regulatory standards, increasing financial access to small and medium sized private actors is critical in this coming decade if we are to have a chance to meet the UHC target.

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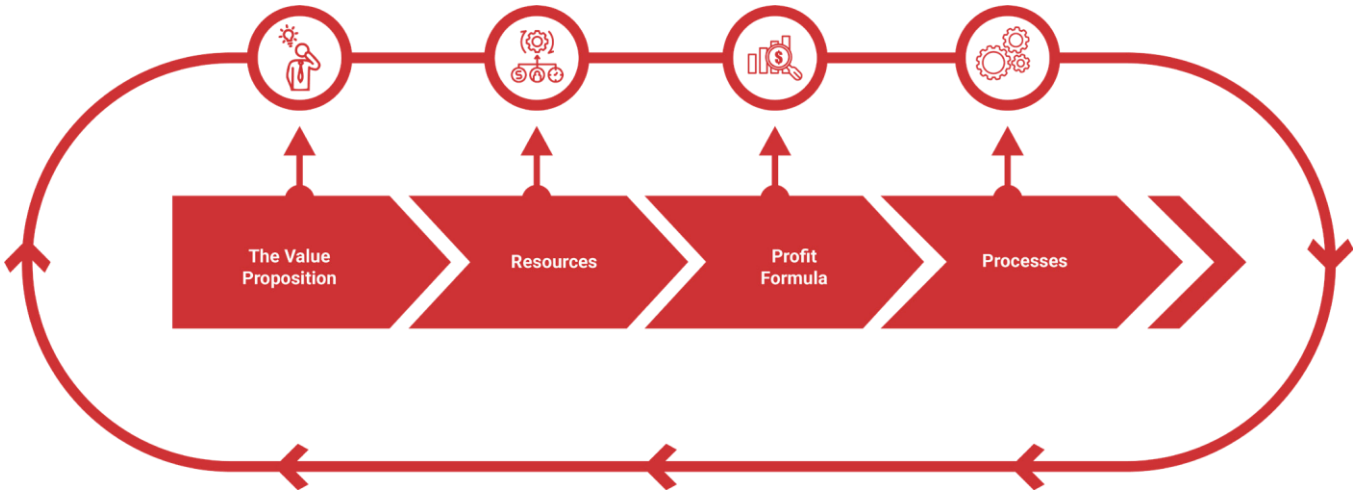

Components of the New Business Model

- **The Value Proposition:** Service/product that helps patients/clients access effectively, conveniently, and affordably.
- **Resources:** Assets and fixed cost structure, and margins and velocity required to cover them: financing start up.
- **Profit Formula:** People, technology, equipment, facilities, brands, and cash that are required to deliver this value proposition to the targeted customers.
- **Processes:** Ways of working together to address quality and access gaps consistently; training, development, budgeting and planning etc.

Model options

- Private/Solo practice - physician practices alone and typically with minimal support staff.
- Group practice - two or more physicians who all provide medical care within the same facility.
- Chronic care.
- Hospice or end of life care.
- Nursing home (Long term care) run by a physician.
- Tele-health.
- Home health care.
- Locum Tenens - temporary employment to hold the place of.
- Maternity clinics owned by group of midwives and nurses.
- Large HMOs which employ providers.

Key Challenges

The limited diversity of private health care delivery models caused a slow expansion of the most needed care for the community. While such models have been around for quite some time in many locations globally, including in countries with comparable socio-economic situations like Ethiopia, their adoption or expansion is stifled by stringent standards, and regulations. Regulations with good intentions; but devoid of local context or evidence contributed to the lower production, deployment and retention of health workers in Ethiopia. It has come abundantly clear to the federal and regional health leaders that the status quo only widens the chasm between the public and private health actors, poor quality of care and increased unemployment of health workers. Leaders in the healthcare field voiced their concern about the overly choking standards that kill the upcoming private healthcare in the country and the employment opportunities for many health workers in urban and rural areas.

Making matters worse, the ever-narrowing access to finance for health care start up or expansion of health care businesses for new models or existing private health actors is worsening.

Furthermore, the failure of government actors to engage the private health sector in the consultation has contributed to the development of standards that haven't incorporated the needs of all key stakeholders.

The Way Forward: Recommendations

Policy changes therefore are critical at this point in time to unleash the potential of the young and energetic health workers joining the workforce and spearheading new models of care despite the multifaceted challenges of running business in Ethiopia. While protection of the community through proper oversight and regulation is an important role of the government, this task should not come at the expense of improving access, quality and affordability of health services. Many voices in the government and established private sectors remain cautious about diversifying the private health care delivery model, especially that of solo and group practices. These cautions are mostly the result of a long-standing fear of the private sector as a trustworthy stakeholder and the premature introduction of competition to the already struggling private health sector. Therefore, the following specific policy related initiatives are recommended to address the problem and contribute for enhancing access to health for all in the country.

- FMOH to complete the policy framework for medical office practice, through a Public Private Technical Working group,
  Development of regulatory standards for solo andgroup practices by inviting all actors mainly the private sector,
- Designing a clear mechanism to ensure enhanced patient safety and quality of care regardless of the care model,
- Quality assurance mechanisms should be put in place including capacity development for the providers (training and mentorship on patient centered care, entrepreneurial and business management etc.)
- Urgent need to start publishing comprehensive data on the number/type of health professionals seeking jobs should be available,
- Develop a communication strategy to introduce and educate the public about the new models of practice (solo and group) and engage the public, media, and leadership in the health system at all levels,
- Government should facilitate relationships and access to finance for small and mid-sized health care businesses which is critical to ensure expansion in both urban and rural areas.

Note:

This document is an extraction and summary of key findings from a formal study conducted by Precise Consult International. Both primary and secondary data were used. While the former were collected via key informant interviews and focus group discussions, the latter were collected from different organizations as well as from internet resources. In addition, the study employed descriptive data analysis techniques and benchmarking of best-practice lessons for Ethiopia.

All data that were used in this brief are referred in detail in the full research document which can be found by visiting www.preciseethiopia.com or by email request to info@preciseethiopia.com.

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