



# Health Expenditure Analysis for Oromia Regional State

2012/13 - 2020/21

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## KEY MESSAGES

1

**The nominal total regional government health expenditure in Oromia increased from ETB 2.5 billion to ETB 11.7 billion between 2012/13 and 2020/21. However, the per capita spending of the sector remains very low at US\$8 in 2020/21. The low per capita public spending on health leads to higher out-of-pocket spending by poorer households.**

Recommendation: The regional government should continue to prioritise health spending through enhanced domestic resource mobilisation efforts, along with improved efficiency of spending.

2

**The share of regional government spending on the health sector was on average 12.2 per cent between 2012/13 and 2020/21. Although the share of expenditure on health in the region was higher than the national average (10.2 per cent) in 2020/21, it is still lower than the target (15 per cent) set by the African Union under the Abuja Declaration (2001).**

Recommendation: The regional government should continue to progressively increase its spending in the health sector to meet the 15 per cent target of the Abuja Declaration.

3

**Programme-based budgeting has not yet been adopted by the region, making it difficult to conduct disaggregated budget and expenditure analysis by programme. The line-item budgeting in place makes it very difficult to identify nutrition, and maternal and child-related health expenditures from the aggregate budget and expenditure lines.**

Recommendation: Programme-based budgeting should be in place to identify and track budget and expenditure for nutrition and maternal and child health programmes within the health sector.

4

**Health sector spending in the region is predominantly recurrent, with little resources left for capital spending. With primary healthcare services being delivered at health centres and health posts, which are financed by regional budgets, the lack of capital budget for the region could significantly hamper health service delivery.**

Recommendation: Resource mobilisation within the region should be given due attention to increase capital spending on health at regional bureau and woreda levels.

5

**The region's health budget credibility was an average of 89 per cent between 2012/13 and 2020/21, indicating under-utilisation of the health budget. The budget under-utilisation is impacted by a low capital budget credibility. The lack of project management capacity in the region, the shortage of foreign currency, and delays in the procurement of inputs required for capital investments are just some of the reasons for the low health capital budget credibility.**

Recommendation: Since most capital expenditure is executed by the regional health bureau, the bureau should give due attention to improving capital budget utilisation.

# 1. INTRODUCTION

## Health sector overview

### **Ethiopia's health sector is organised in a three-tier health service delivery model.**

Primary healthcare units are at the first tier of the health service and are composed of health posts, health centres and primary hospitals. Each health centre is connected to five satellite health posts and provides services to approximately 25,000 people, while primary hospitals offer inpatient and ambulatory services to about 100,000 people. In the second tier are general hospitals, which are referral centres for primary hospitals and serve an average of 1 million people. They also serve as training centres for health officers, nurses and emergency surgeons. In the third tier are specialised hospitals that provide services to populations of around 5 million, as well as serve as referral centres for general hospitals. Teaching and research hospitals, which are mostly located in Addis Ababa and the regional state capitals, are directed and managed by the Ministry of Health.

**The Health Extension Program (HEP) is the health sector's primary healthcare delivery platform in the country.** The HEP has played a significant role in improving access to healthcare services by providing a package of primary healthcare services for to address family health, disease prevention, hygiene, and environmental sanitation. Primary healthcare services, such as for maternal and child healthcare, tuberculosis, HIV, and family planning, among others, are more accessible to the community through the HEP. In 2020/21,

there were 42,630 health extension workers (HEWs) deployed in the country, of whom 15,918 were in Oromia region (Table 1).<sup>1</sup>

### **The numbers of primary healthcare delivery facilities and health professionals in the region are low, with health professional density much lower than the Sustainable Development Goal (SDG) threshold.**

With regard to lower-tier primary health facilities, the region has 1,411 health centres and 7,099 health posts (Table 1). The health facility to population ratio indicates that one health centre serves around 27,693 people, while one health post serves 5,504 people. In terms of health workers, there are 29,473 health professionals (medical doctors, nurses, midwives, health officers) and 15,918 HEWs in the region. One medical doctor (general practitioner and specialist) is expected to serve 15,414 people, with varying proportions for different categories/levels of other health professionals such as nurses, midwives, health officers, medical laboratory technicians and pharmacists. According to the World Health Organization (WHO), the health professional density level is a key criterion to measure health sector staffing in a country. While the SDG index threshold recommends a minimum density for health workers of 4.42 doctors, nurses, and midwives per 1,000 population, the health professional density in Oromia is 0.75 per 1,000 population – a little lower than the national rate of 1.1 but much lower than the SDG threshold, and of the Health Sector Transformation Plan (HSTP II) target of 2.3.

<sup>1</sup> Ministry of Health (2021). Annual Performance Report (2020/2021).

Table 1. Primary health facilities and Health workers

	Number	Health facility/health worker to population ratio	
		Oromia	National
Health posts	7,099	1:5,504	1:5,811
Health centres	1,411	1:27,693	1:27,231
Medical doctors*	2,535	1:15,414	1:8,448
Nurses, midwives, health officers	26,938	1:1,450	1:963
Health extension workers (HEWs)	15,918	1:2,455	1:2,413

Source: Ministry of Health (2020/21). Annual Performance Report

\* General practitioners, specialists, sub-specialists, dental surgeons

**Although Oromia region has the highest number of hospitals compared to other regions in the country, the hospital to people ratio is lower than most of the larger regions** (Table 2). While the number of hospitals inevitably varies from region to region – in response, partly, to differences in population sizes – although Oromia region has the largest population size and geographic coverage in the country and the region has a relatively larger number of hospitals, the hospital to people ratio is low. Data from the regional health bureau shows that there are 109 hospitals, of which eight are referral and teaching hospitals that belong to universities within the region. The next populous regional

state in the country, Amhara, has 84 hospitals, followed by SNNPR<sup>2</sup> with 72 hospitals, which comprise university hospitals and those managed by regional health bureaus.

Though the number of hospitals is higher in the larger regional states, only a few of the hospitals are functioning properly with the expected standard and quality. In addition to the teaching, referral and primary hospitals, Oromia regional state has three regional laboratories, three health science colleges, 10 blood banks, two HIV centres and two rehabilitation centres, which help to enhance health facility access and coverage within the region.

Table 2. Population and public hospitals in the major regions of the country

Region	Hospitals in 2021	Population in 2021	Hospital to population ratio in 2021
Addis Ababa	13	3,773,999	1:290,307
Amhara	88	22,535,997	1:256,090
Oromia	109	39,075,002	1:358,486
SNNP	62	21,021,000	1:339,048
Tigray	41	5,641,005	1:137,585

Source: Ministry of Health (2020/21). Annual Performance Report; CSA population estimate for 2021<sup>3</sup>

**The health sector within the region has approved and disseminated its own five-year strategic plan that includes the sector's direction, priorities, and targets.** The five-year Health Sector Transformation Plan (HSTP II) for the period 2020/21 to 2024/25 was finalised, approved, and disseminated in 2021. To build the capacity of leaders within the health sector, leadership management and governance training courses were designed and delivered to selected leaders from zones, town health offices, and hospitals in the region. The training covered issues such as improved resource mobilisation, human resource development and management, and health facility access to improve clinical care, emergency critical care and laboratory services. Additionally, support to enhance procurement capacities to purchase medical equipment, drugs and supplies was provided to prevent and control non-communicable and neglected tropical diseases. The strategic plan, as well as capacity-building training, also

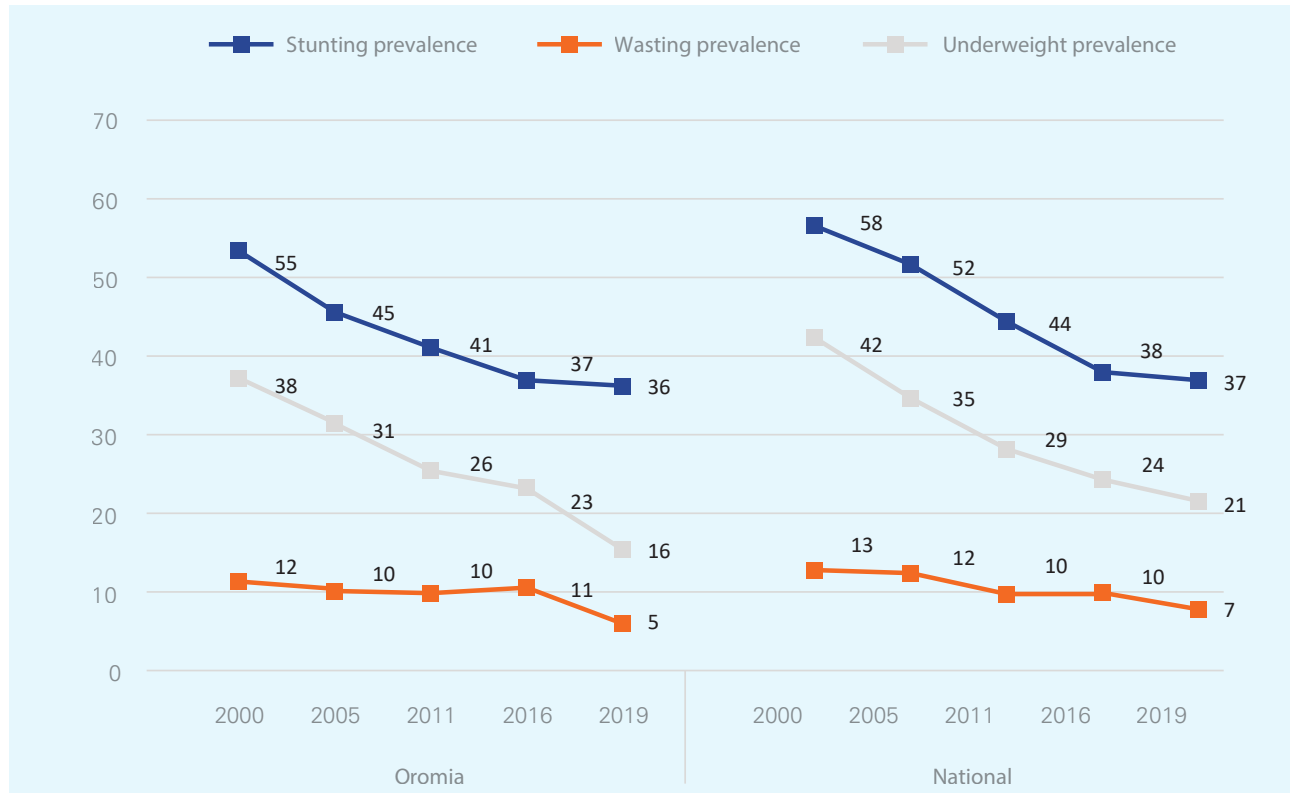
focused on improving health financing and budget utilisation to provide universal health coverage within the region.

### Key health sector performance indicators

**Although the percentage of stunted, wasted, and underweight children in the region is slightly lower than the national average, undernutrition remains a major challenge.**

The region has relatively low rates of stunted, wasted and underweight children compared to national rates. It was able to reduce stunting from 55 per cent to 36 per cent between 2000 and 2019, which is a 19-percentage point decline (Figure 1). The region was also able to decrease the prevalence of wasted and underweight children, achieving a slightly better performance compared to the national average. However, the percentage of children who are undernourished is still very high, with 36 per cent, 16 per cent and 5 per cent of under-5 children being stunted, wasted and underweight, respectively.

Figure 1. Indicators of undernutrition in under-5 children: Oromia and national averages (percentage)



Source. UNICEF Ethiopia (2019). *Situation Analysis of Children and Women: Oromia Region*

<sup>2</sup>The number is before Sidama and Southwest regional states were established, which were both previously part of SNNPR..

<sup>3</sup>Central Statistical Agency (2013). *Population Projections for Ethiopia 2007–2037*.

**Despite reducing neonatal, infant, under-5 and maternal mortality rates between 2011 and 2016, Oromia has relatively high rates compared to the nation as a whole.**

The regional state has reduced infant and under-5 mortality in the past 10 years, but performance is below the national averages (Table 3). Between 2011 and 2016, the rate of neonatal mortality (per 1,000) declined from 40 to 37, while the infant mortality rate (per 1,000) declined from 73 to 60. Similarly, the under-5 mortality rate (per 1,000) declined from 112 in 2011 to 79 in 2016. Although the decline in mortality rates is encouraging, much remains to be done to bring the rates down even further to ensure better health outcomes for children and mothers in the region.

**The regional health bureau had better performance and improvement in antenatal care, in improving the number of women**

**giving birth at health facilities and reducing children’s susceptibility to diarrhoea.**

Although the proportion of children aged 12–23 months who have received basic vaccinations has increased, the immunisation rate is still lower than the national average. Around 70 per cent of children in the region were not fully immunised in 2019. With regard to maternal health, the proportion of women delivering children in health facilities increased from 8 per cent in 2011 to 41 per cent in 2019. In line with this, the proportion of women with skilled birth attendance drastically increased from 17 per cent in 2011 to 44 per cent in 2019. Similarly, the regional health bureau had better performance in creating awareness about modern contraceptive usage, increasing the proportion of beneficiaries from 26 per cent to 41 per cent between 2011 and 2019.

Table 3. Key health indicators: Oromia and national averages

Region	Oromia			National		
	2011	2016	2019	2011	2016	2019
Neonatal mortality rate (per 1,000)	40	37	–	37	29	30
Infant mortality (per 1,000)	73	60	–	59	48	43
Under-5 mortality (per 1,000)	112	79	–	88	67	55
Child mortality (per 1,000)	42	20	–	31	20	12
Antenatal care provided by skilled provider (%)	31	51	71	34	62	74
Total fertility rate (%)	6	5.4	–	4.8	4.6	–
Birth occurred in health facility (%)	8	19	41	10	26	48
Children aged 12–23 months who received all basic vaccinations (%)	16	25	30	24	39	43
Under-5 children who had diarrhoea in the two weeks preceding the survey (%)	11	11	–	13	12	–
Prevalence of anaemia in children (%)	52	66	–	24	57	–
Use of modern contraceptive (%)	26	45	41	27	35	41
Skilled birth attendance (%)	17	20	44	10	28	50

Sources: EDHS 2011, EDHS 2016 and Mini EDHS 2019

## Interventions to improve maternal and child healthcare

**Child health-related interventions, especially for neonatal and under-5 children, are being implemented through the HSTP.**

The health bureau has undertaken high-impact interventions at kebele and community level to address child health issues. Interventions focus on advanced neonatal care, the expansion of neonatal intensive care units, community- and facility-based integrated management of neonatal and childhood illness, early childhood development, and strengthening the immunisation programme. Additionally, the regional office has improved the referral system for women who have complicated births, providing them with access to comprehensive post-natal services within a few hours of giving birth. The health bureau also implemented specific WASH interventions to deal with child-related diseases such as diarrhoea, which is the second leading cause of death in children under-5 in the region.

**The regional bureau is increasing the number of health facilities that provide adolescent- and youth-friendly health services.** Oromia health bureau is currently engaged in expanding the number of health facilities that provide youth-friendly services for adolescents and youth, specifically a comprehensive sexual and reproductive health information service, counselling services, and access to psycho-social support. In the past five years, the number of health facilities that provide these services increased from 232 in 2015/16 to 610 in 2019/20, which equates to 40 per cent of the health facilities (hospitals and health centres) in the region.

**Despite undertaking and implementing nutrition-related programmes, the increasing numbers of people in need of nutrition interventions is a critical challenge.**

Security and instability within the regional state and at national level are critical challenges that hinder the smooth delivery of health services. Extensive drought is continuously increasing the number of people who demand nutritional support from the bureau, which is sometimes beyond its means to meet. The national-level shortage of foreign currency also impedes the bureau from procuring imported medical and other supplies in support of its health, nutrition, and related interventions.

## WASH in health facilities

**The lack of access to basic WASH facilities is one of the major challenges faced by health facilities in the region.** According to information gathered from the health bureau, 62 per cent of health centres and 10 per cent of health posts provide access to drinking water services (Table 4). The share of lower-tier health facilities that have handwashing facilities is also very low (56 per cent of health centres and 13 per cent of health posts). Hospitals have better WASH facilities, with 87 per cent and 82 per cent offering drinking water and handwashing facilities, respectively. Toilet facilities are available in 95 per cent of hospitals, although only available in 60 per cent of health posts. As primary healthcare services are delivered at health posts and health centres, the lack of availability of basic water and sanitation facilities makes service delivery very challenging.

Table 4. Availability of WASH facilities in health centres, health posts and hospitals

Type of facility	Health centres		Health posts		Hospitals	
	No.	%	No.	%	No.	%
Drinking water service	881	62	709	10	89	87
Handwashing facilities	796	56	922	13	84	82
Toilet facility	1,179	83	4,254	60	97	95
Placental pit	1,208	85	71	1	101	99
Incinerator	1,251	88	496	7	99	97
Solid waste disposal pit	1,108	78	3,616	51	96	94

Source: Oromia Health Bureau (2022)

### Key takeaways

- Although Oromia region has the highest number of hospitals compared to other regions in the country, the number of people served by each hospital is very high: one hospital for every 358,486 people. Increasing the number of health facilities that provide services to the population is a key area the regional bureau should focus on.
- The high neonatal mortality rate, poor nutritional status of children and low vaccination rate continue to challenge the health sector in the region. With increasing population pressure, internal conflicts, drought and displacements, the number of people who require health and nutritional services is increasing. These multiple burdens on the healthcare system could cause a reversal of the crucial gains in the health sector that have been achieved over the past 20 years.
- The share of lower-tier health facilities (health centres and health posts) that have WASH facilities is very low. The lack of availability of drinking water, handwashing and toilet facilities at primary healthcare facilities makes service delivery very challenging. The regional government should focus on improving and making more widely available WASH services at health facilities.

## 2. PUBLIC EXPENDITURE FOR THE HEALTH SECTOR IN OROMIA REGION

**Due to a lack of disaggregated budget and expenditure data, the expenditure analysis in this report focuses only on the Oromia regional government financed health spending for the region.** Total health expenditure in the region is financed by the regional government, bilateral and multilateral donors, out-of-pocket expenditure, Community-Based Health Insurance (CBHI) (voluntary prepayment) and private employers. However, the analysis in this report focuses only on regional government public expenditure on the health sector between 2012/13 and 2020/21. Programme-based budgeting has not yet been adopted by the region, making it difficult to conduct disaggregated budget and expenditure analysis by programme. With line-item budgeting in place, the expense category for the health sector has only three lines: wages and salaries, goods and services, and capital investments. This makes it very difficult to identify nutrition and maternal and child-related health expenditures from the aggregate budget and expenditure lines. Due to the difficulty in getting disaggregated expenditure data by programme, the analysis focuses on aggregate government health expenditure in the region.

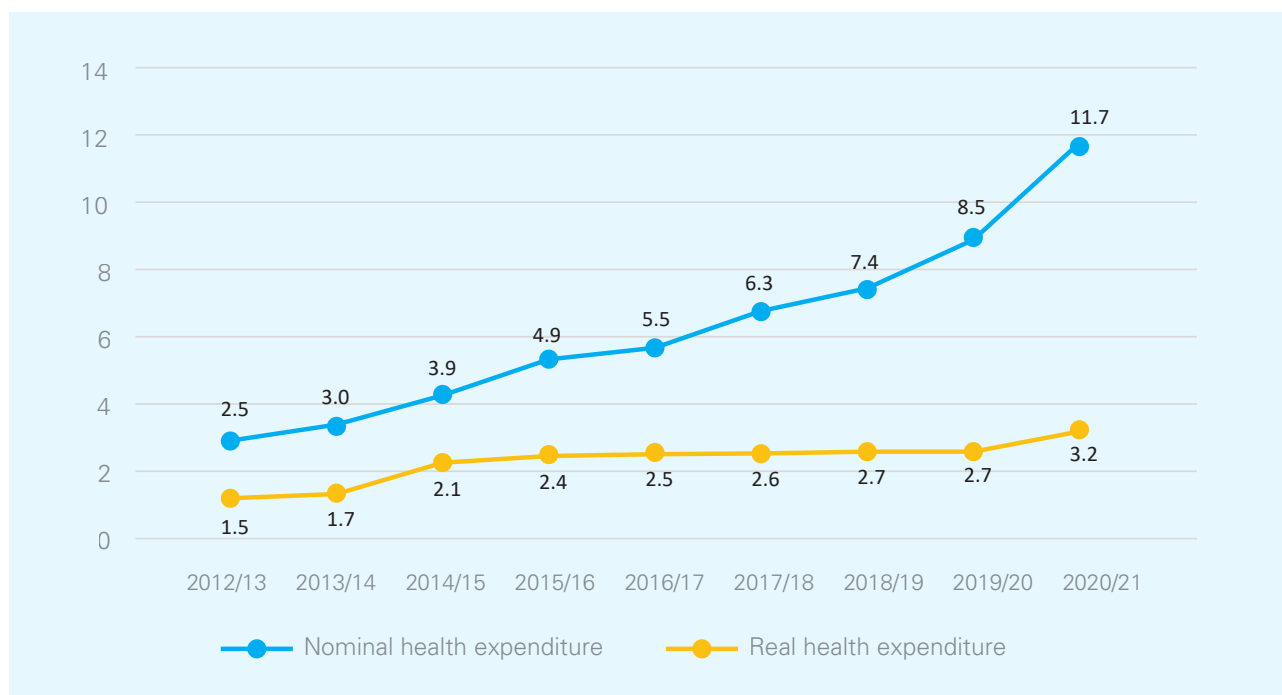
### Trends in health sector spending

**The nominal total government health expenditure in the region increased by almost four-fold between 2012/13 and 2020/21.** The highest increment in expenditure was between 2019/20 and 2010/21, with nominal expenditure increasing at 37 per cent compared to an average increase of 20 per cent for the previous years (Figure 2). The spending surge in 2020/21 was partly in response to the COVID-19 pandemic, which resulted in increased resource flow to the health sector both in the region and nationally. Real spending on health also showed an increasing trend, although at a lower rate (Figure 2). The gap between the nominal and real values has widened over the years due to inflation, which has increased in recent years. In terms of per capita health spending, the nominal per capita spending in the region in 2020/21 was ETB 307 (Figure 3), which is equivalent to US\$8.<sup>4</sup> This is much lower than the national per capita health budget allocation in 2020/21, which was ETB 576 (US\$14.8)<sup>5</sup>

<sup>4</sup> Average exchange rate for 2020/21: US\$1= ETB 39.

<sup>5</sup> UNICEF Ethiopia (2021). Public investments in health in the COVID-19 pandemic era: Health Budget brief 2020-21. Retrieved from <https://www.unicef.org/ethiopia/reports/national-and-sector-budget-brief>

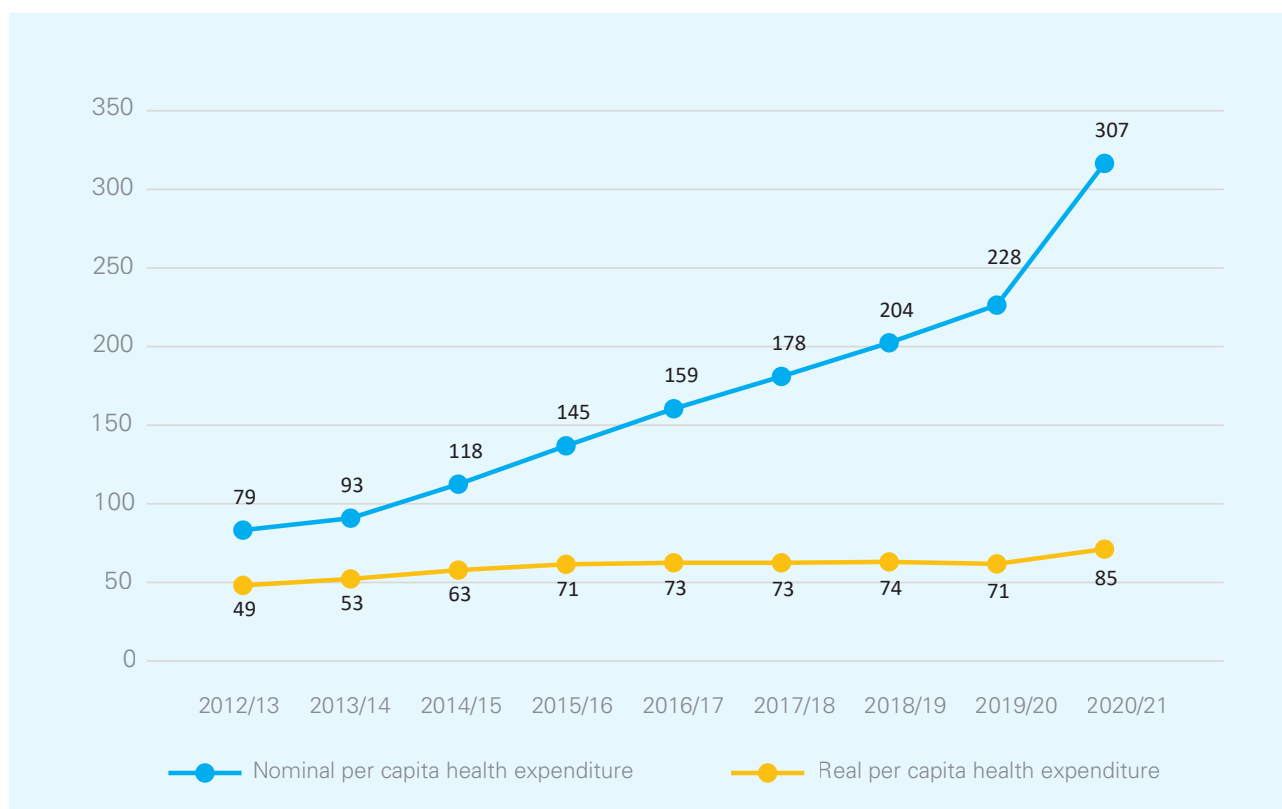
Figure 2. Nominal and real public expenditure (billion ETB)



Source: Oromia Regional Plan and Development Commission (2012/13–2020/21)

Note: Real expenditure computed using the consumer price index (CPI), taking 2010 as a base year.

Figure 3. Trend in nominal and real per capita health expenditure (ETB)



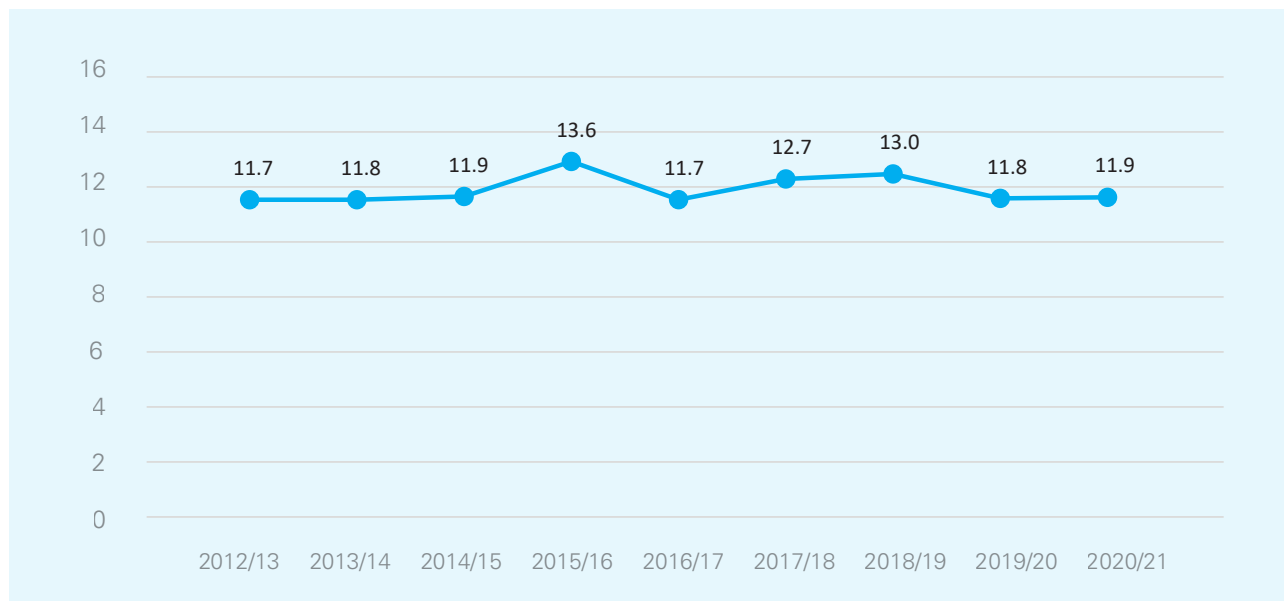
Source: Oromia Regional Plan and Development Commission (2012/13–2020/21)

Note: Real expenditure computed using the consumer price index (CPI), taking 2010 as a base year.

**The share of regional government spending on the health sector was on average 12.2 per cent between 2012/13 and 2020/21** (Figure 4). After education, the sector ranks second in terms of the regional government's expenditure priorities. Although the share of

expenditure spent on the health sector in the region is higher than the national average (10.2 per cent in 2020/21), it is still lower than the 15 per cent target set by the African Union under the Abuja Declaration (2001).

Figure 4. Health expenditure as a proportion of total expenditure



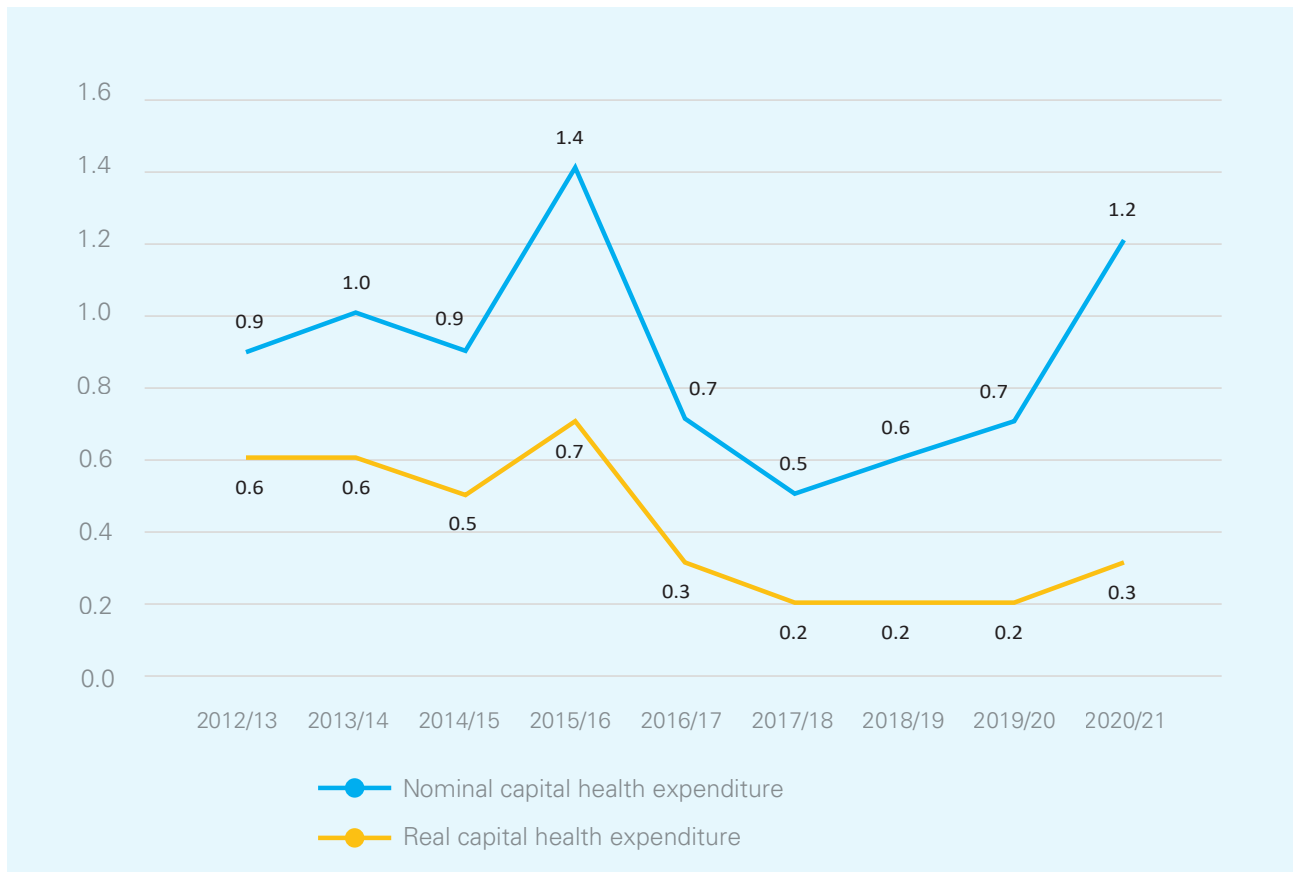
Source: Oromia Regional Plan and Development Commission (2012/13–2020/21)

### Composition of health sector spending

**Nominal capital and recurrent health expenditure in the region both show upward trends, with recurrent expenditure increasing at a faster rate than capital expenditure.** Between 2012/13 and 2020/21, the nominal percentage growth of capital

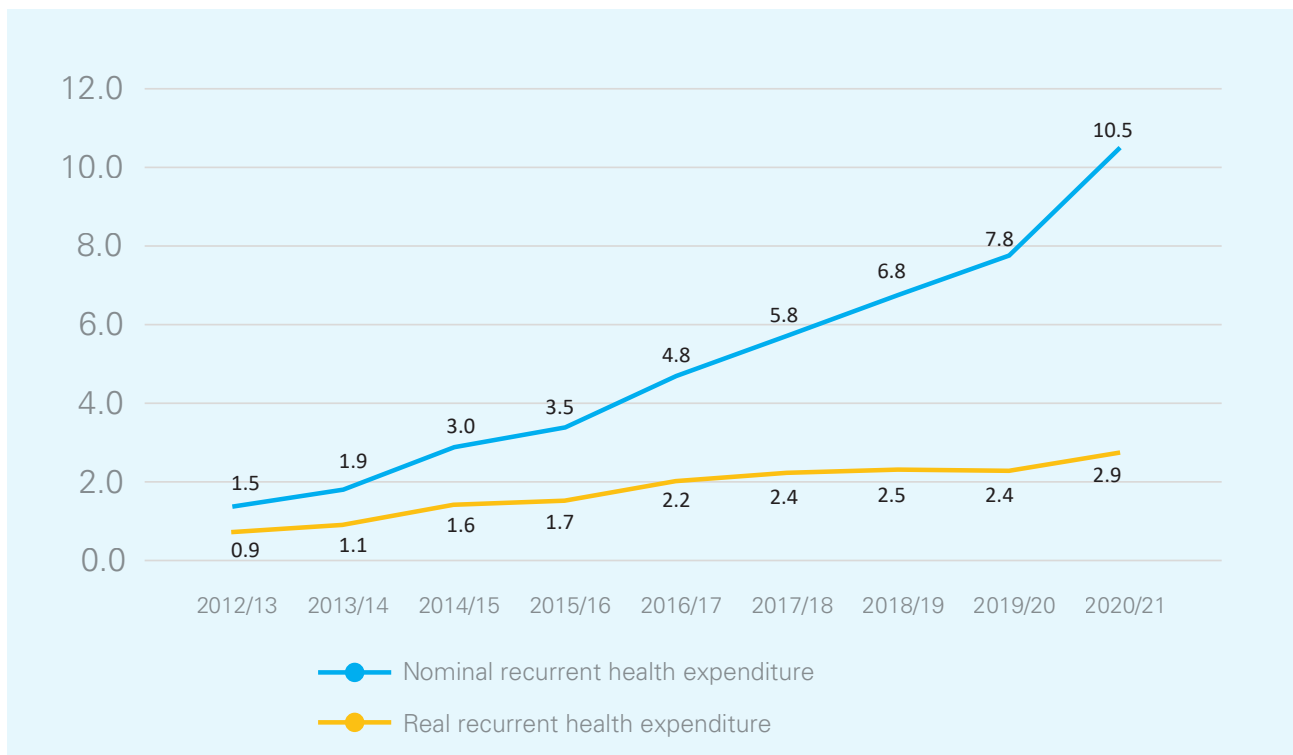
expenditure was 31 per cent, while recurrent expenditure grew almost 10-fold (Figure 6). Although capital expenditure has increased nominally in recent years, its real value declined by 50 per cent between 2012/13 and 2020/21, while real recurrent expenditure increased by two-fold over the same period (Figures 5 & 6).

Figure 5. Nominal and real capital health expenditure (billion ETB)



Source: Oromia Regional Plan and Development Commission (2012/13–2020/21)

Figure 6. Nominal and real recurrent health expenditure (billion ETB)



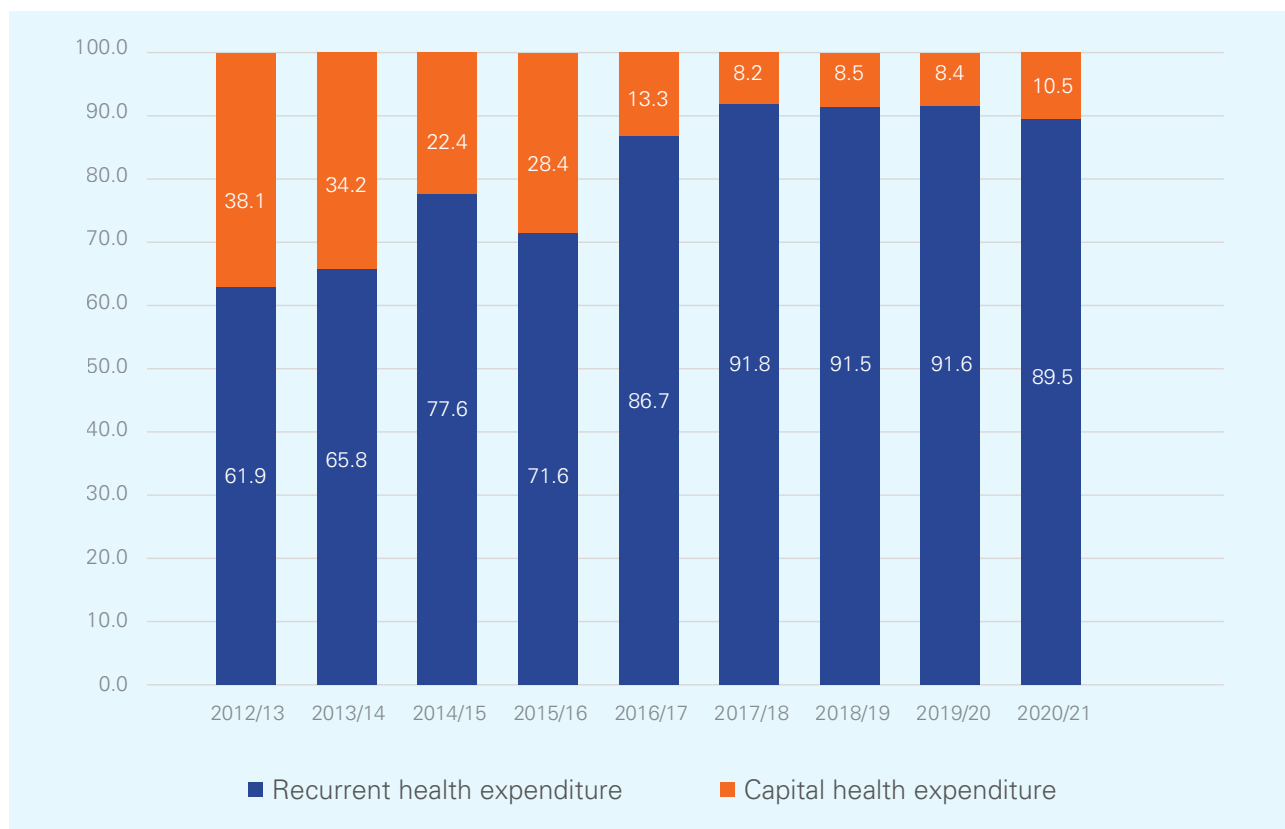
Source: Oromia Regional Plan and Development Commission (2012/13–2020/21)

**Spending in the health sector has remained predominantly recurrent, while the share of capital spending has declined.**

The share of capital spending declined from 38 per cent in 2012/13 to 10.5 per cent in 2020/21 (Figure 7). High capital investment undertaken a decade ago now requires recurrent spending to run and maintain the health infrastructure. With the higher share of spending being absorbed by recurrent expenses (mainly to cover salaries and operational costs), there is

little resource left for the region to undertake capital investments. Currently, the regional health bureau is focusing on completing existing healthcare projects, but not launching new ones due to the lack of capital budget. As primary healthcare services delivered at health centres and health posts are financed by regional budgets, the lack of capital budget at the regional level could significantly hamper health service delivery.

Figure 7. Share of capital and recurrent health spending (per cent)



Source: Oromia Regional Plan and Development Commission (2012/13–2020/21)

## Key takeaways

- Although the nominal value of health spending in Oromia region is increasing, per capita spending remains very low at US\$ 8 in 2020/21. The low per capita spending could lead to higher out-of-pocket spending by poor households. The regional government should continue to prioritise health spending through enhanced domestic resource mobilisation efforts, along with improving the efficiency of spending.
- Health sector spending in the region is predominantly recurrent, with little resources left for capital spending. With primary healthcare services being delivered at health centres and health posts, which are financed by the region's budget, lack of capital budget at the regional level could hamper health service delivery significantly. As the number of primary health facilities in the region is very low given the size of its population, capital investment in primary healthcare facility delivery units should be improved.

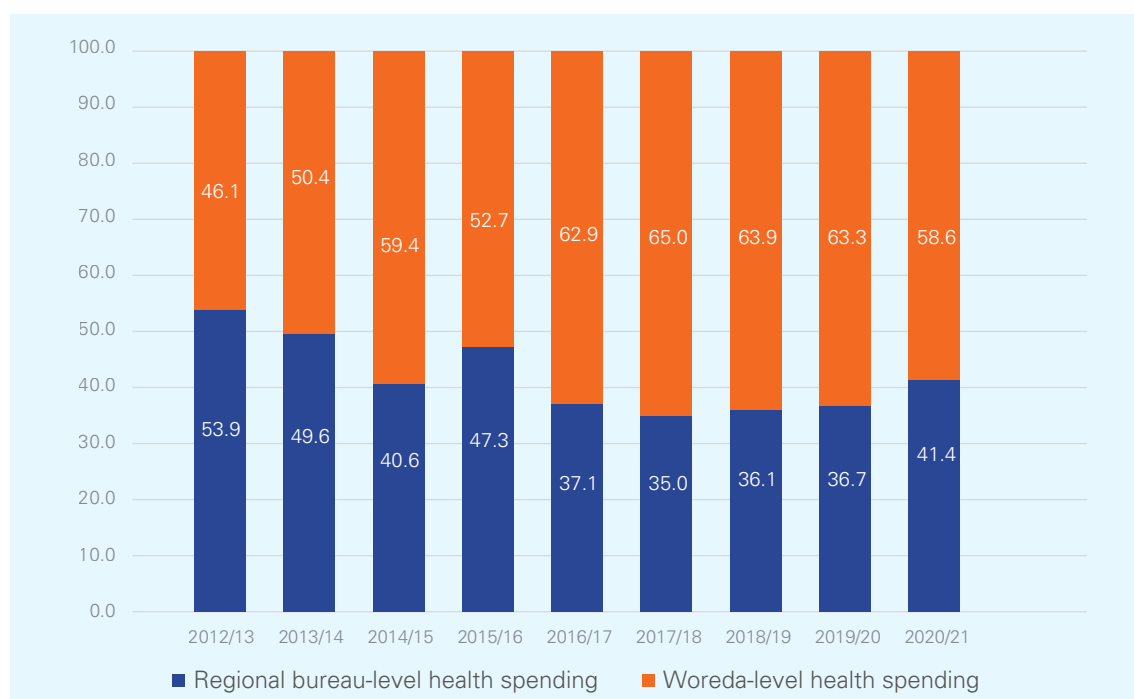
## Health sector public expenditure and fiscal decentralisation

**With fiscal devolution, a relatively higher proportion of health expenditure in the region is spent at woreda (district) level.**

Regional-level health sector budget spending is broadly divided into two levels: regional and woreda. Budget is approved at the regional level and allocated to regional bureaus woredas within the region. Each woreda then allocates the budget to the different sectors within its

administration. For the health sector, the share of expenditure spent at the woreda level has increased in recent years: from 46.1 per cent in 2012/13 to 58.6 per cent in 2020/21 (Figure 8). This increase in health expenditure at the woreda-level may have a positive impact on overall health performance, since it indicates increased spending on primary healthcare service delivery at health posts and health centres, including health extension services.

Figure 8. Proportion of regional bureau-level and woreda-level spending for the health sector (per cent)



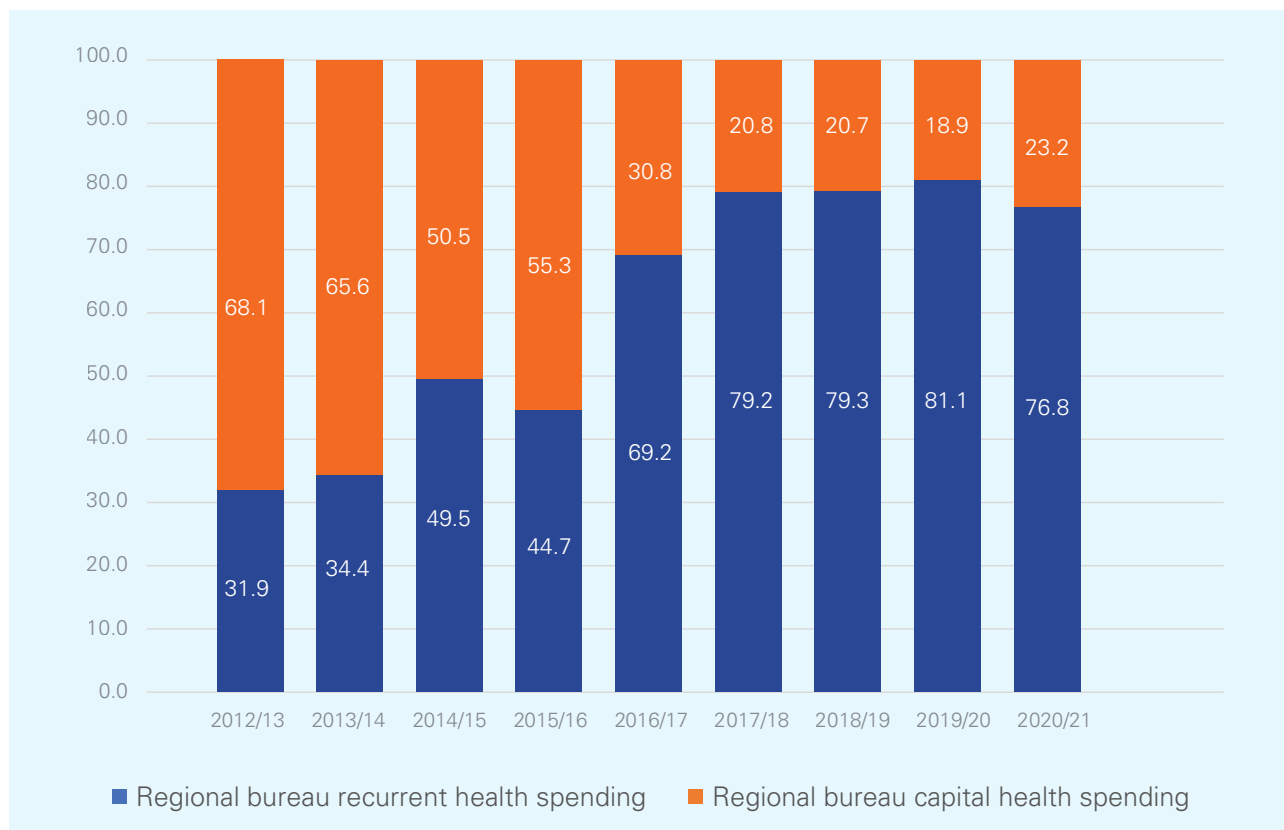
Source: Oromia Regional Plan and Development Commission (2012/13–2020/21)

**With regard to the composition of spending by level of administration, the regional health bureau has a relatively higher share of capital expenditure, while woredas spend most of their budgets on recurrent spending**

As presented in Figure 9, 23.2 per cent of the regional bureau-level health spending was on capital investments in 2020/21. The relatively higher share allocated to capital expenditure by the regional health bureau relates to projects that require a long time to roll-out and therefore require higher budgets. In contrast, almost all the spending at the woreda level goes on recurrent expenditure since most of the region’s health workforce is deployed at the woreda level and paid by woreda administrations (Figure

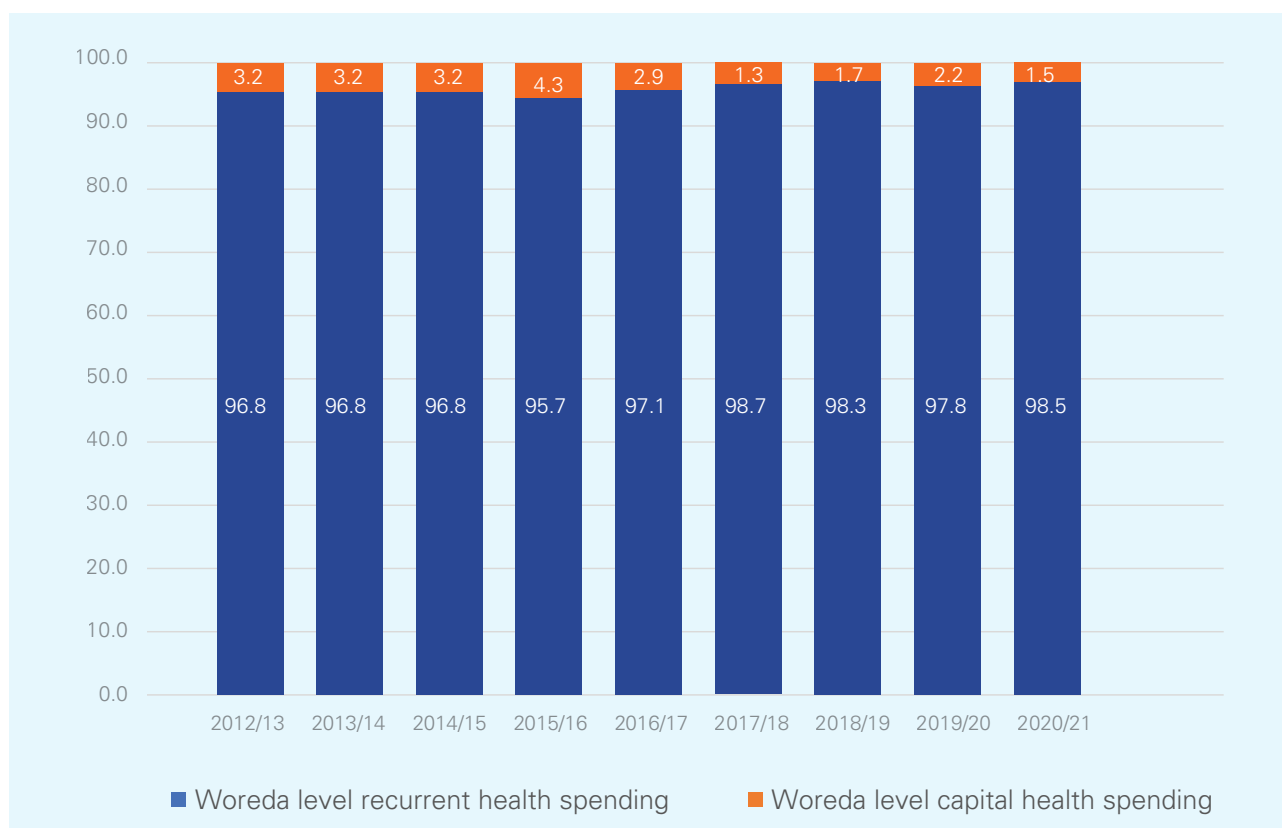
10). With the share of recurrent expenditure at woredas being on average 97.4 per cent for 2012/13 to 2020/21, budget left for health-related capital investments is close to non-existent at the woreda level. Often, the budget is not even enough to cover the operational costs involved in the day-to-day administration of health facilities, as a significant proportion of the health budget is spent on covering salary expenses. Increasing the number of health workers, and salary increments, over the years has resulted in increased recurrent expenditure at the woreda level, leaving no budget for capital investment to improve health facilities that are managed by woreda administrations.

Figure 9. Regional-level health expenditure as proportions of capital and recurrent health expenditure



Source: Oromia Regional Plan and Development Commission (2012/13–2020/21)

Figure 10. Woreda-level health expenditure as proportions of capital and recurrent health expenditure (per cent)

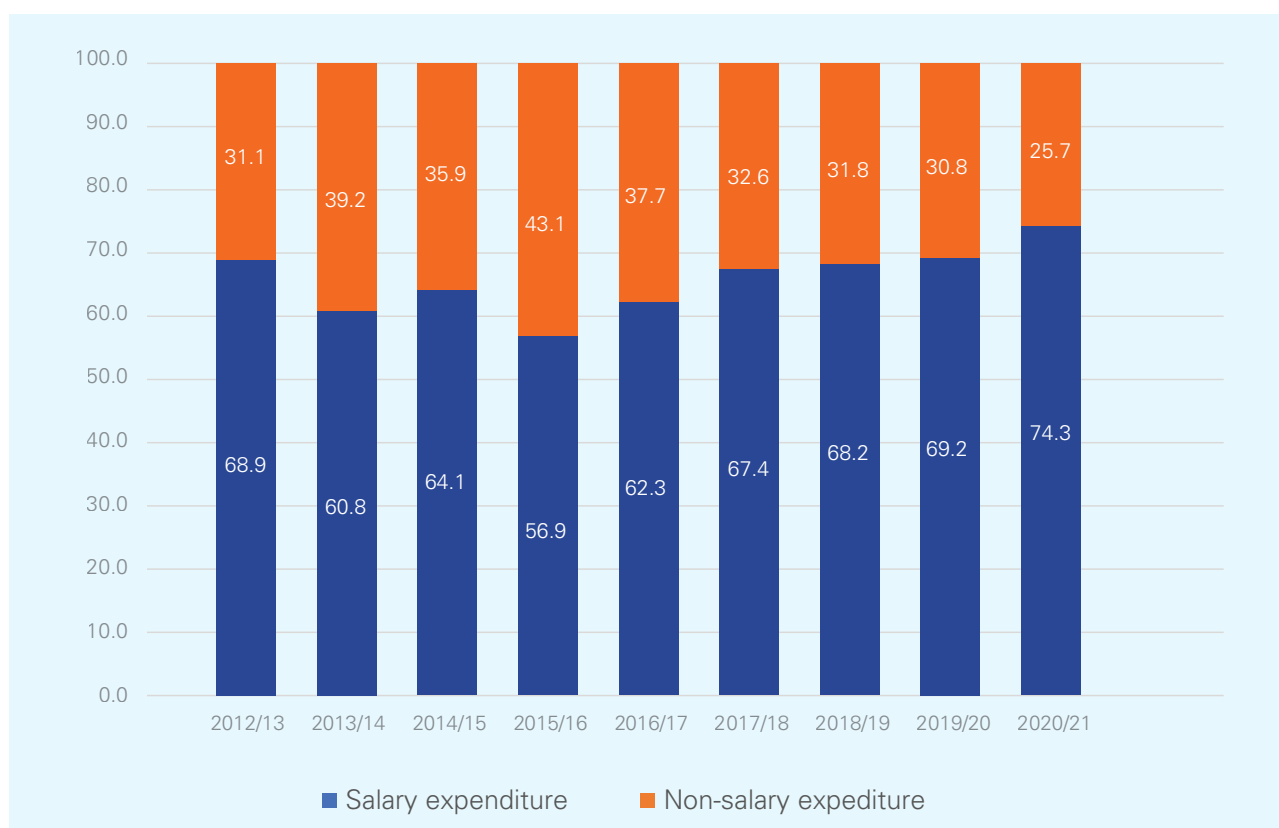


Source: Oromia Regional Plan and Development Commission (2012/13–2020/21)

**A higher proportion of recurrent expenditure in the region is taken up by salary costs, resulting in lower spending on day-to-day operations that are critical to the delivery of health services.** The share of recurrent expenditure that is spent on salaries is much higher than the share spent on operational expenses (Figure 11). Between 2012/13 and 2018/19, an average of 65.7 per cent of total recurrent expenditure on health was spent on salaries. The share of operational expenditure

was, on average, 38 per cent. With the delivery of basic health services being free or attracting a very small fee, there is little resource at the disposal of primary health facilities, which forces them to rely on the public budget to cover their operational costs. The quality of service that public health facilities provide is greatly compromised by the lack of sufficient resources to cover the required operational costs of serving the community.

Figure 11. Composition of recurrent expenditure at woreda level (per cent)



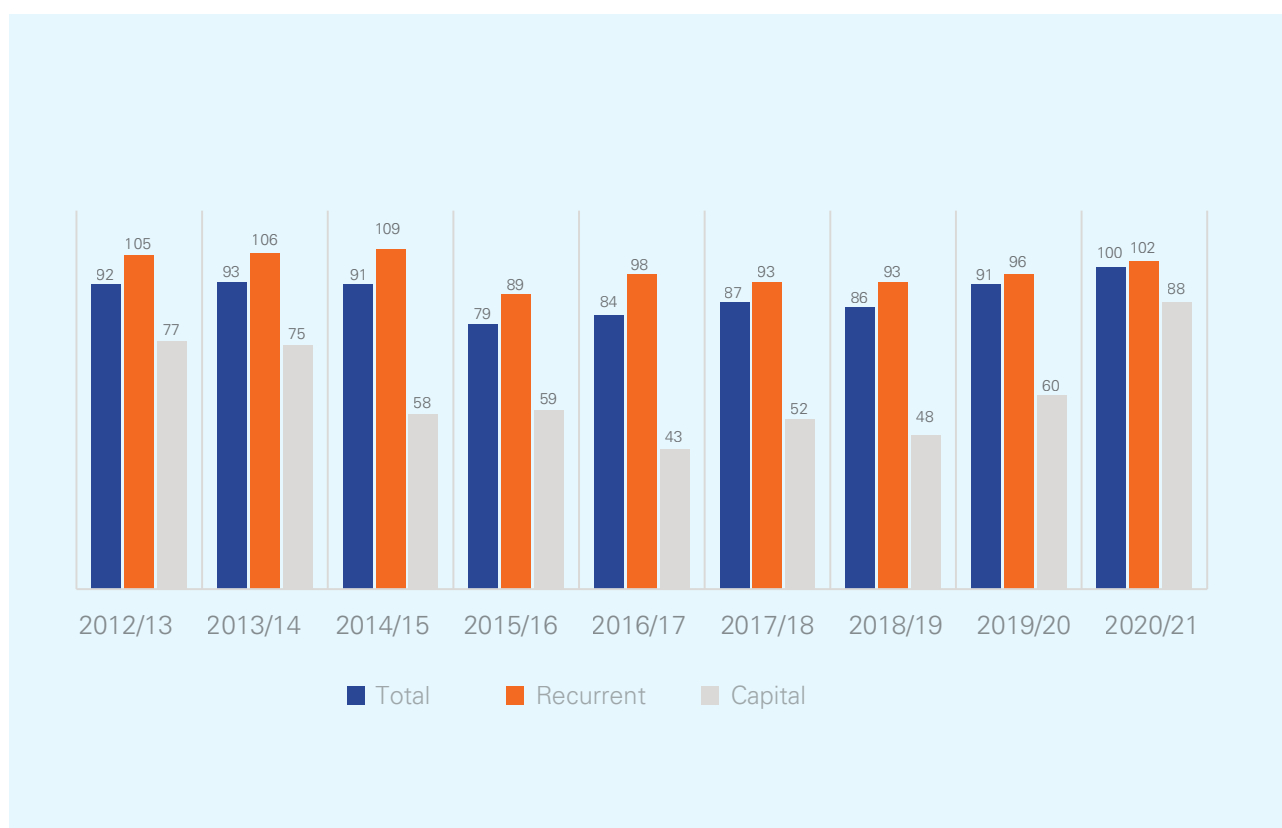
Source: Oromia Regional Plan and Development Commission (2012/13–2020/21)

### Health budget credibility

**The region’s health budget credibility was on average 89 per cent between 2012/13 and 2020/21** (Figure 12). Measured as the share of actual expenditure from the approved regional budget, budget credibility measures the extent to which the region’s health budget is reliable. The sector’s budget credibility increased from 92 per cent in 2012/13 to 100 per cent in 2020/21. Comparing the credibility of the budget components, the average credibility for the recurrent budget is 99 per cent, yet only 62 per cent for the capital budget. The main reason why the recurrent budget has better

credibility than the capital budget is because the recurrent budget is dominated by salary expenses, which are more predictable and relatively easier to execute than the capital budget. The capital budget is commonly spent on managing mega-projects, which may be influenced by external factors beyond the control of the sector bureau. In this regard, the lack of project management capacity in the region, the shortage of foreign exchange, and delays in the procurement of inputs required for capital investments are just some of the reasons for the lower capital budget credibility of the health sector.

Figure 12. Regional health budget credibility rate (per cent)



Source: Oromia Regional Plan and Development Commission (2012/13–2020/21)

**The regional health bureau faces many challenges to improve budget allocation and utilisation in the health sector.** One challenge raised through the key informant interviews was the variation between requested and actual budget allocation to the health sector. There seem to be frequent shifts in the regional government’s priorities when allocating budget across the different sectors. For instance, in the 2021/22 budget year, the government’s major priority was the agriculture sector, resulting in a shift in resources to agriculture. The health bureau reported that the regional health bureau did not receive the whole allocated budget due to resource limitations and a shift of resources to

address various humanitarian and emergency needs. Another challenge is the lack of human resource within healthcare financing, and poor leadership and management skills, resulting in a poor data management and an inadequate reporting system. This contributes to poor decision-making in the sector. The continual increase in the number of people who demand health services and nutrition interventions, along with frequent budget delays on the part of the Ministry of Finance, have their own impact on health sector performance in the region. This may be one reason why Oromia state has the highest hospital to population ratio of all regions in the country.

## Key takeaways

- A relatively higher proportion of the region's spending is utilised at the woreda level (58.6 per cent in 2020/21). As primary healthcare services at health centres and health posts are mostly managed by woredas, the ongoing increase in spending at the woreda level is a move in the right direction.
- Recurrent expenditure in the region, particularly woreda-level spending, is taken up by salary expenses, resulting in lower spending on day-to-day operations that are critical to the delivery of health services. The service quality that public health facilities provide is greatly compromised by the lack of sufficient resources to cover the required operational costs of delivering services to the community. Increased resources should be made available at the woreda level to cover operational costs in health facilities.
- The capital budget credibility is significantly lower than the recurrent budget credibility. The lack of project management capacity in the region, foreign exchange shortages, and delays in the procurement of inputs required for capital investments are just some of the reasons for the lower capital budget credibility. As most capital expenditure is executed by the regional health bureau, the bureau should give due attention to improving capital budget utilisation.

## Key policy issues

- **The region's health sector expenditure classification system lacks disaggregation. There is no disaggregated data on health expenditure to track child-related health expenditures or nutrition-specific interventions.** This is a broad national challenge, as programme-based budgeting is only implemented at the federal level, with the sub-national regions, including Oromia, using line-item budgeting. This calls for reform of the chart of accounts and budget templates to make sure health programmes are identifiable in the budget and expenditure data. This will allow for better tracking and monitoring to measure and advocate for increased investment in specific programmes, including those that are child-sensitive.
- **Although there are funds flowing into the health sector in the region from multiple donors, there is no systematic mechanism to measure off-budget health sector expenditures.** There is a need to shift off-budget financing of the health sector to on-budget records to better plan, execute and monitor how much is being spent on healthcare services.
- **Internal conflicts, drought, health crises such as COVID-19 and an increasing population put additional pressure on the health system in the region.** This highlights the need for more commitment to increasing investment in the health sector in the short, medium and long terms, through further increments in public budget allocation and improved budget utilisation in the region.
- **Limited human resource capacity and delays in the release of budget from the federal government are also issues that challenge the health sector in Oromia region.** The federal government should deliver the required technical support and budget on time so that health and nutrition strategic plans can be successfully implemented in the region.

## Annex: Oromia regional state health expenditure, 2012/13–2020/21

Gregorian calendar	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21
Ethiopian fiscal year	2005	2006	2007	2008	2009	2010	2011	2012	2013
<b>Regional expenditure (in million Birr)</b>									
<b>Total regional expenditure</b>	21,043	25,180	32,637	36,058	47,039	49,543	57,355	71,797	98,243
<b>Total regional recurrent expenditure</b>	12,083	15,108	21,547	24,084	34,664	40,352	45,588	51,812	69,041
<b>Total regional capital expenditure</b>	8,960	10,071	11,089	11,974	12,374	9,190	11,767	19,985	29,202
<b>Total bureau-level expenditure</b>	11,333	13,252	14,960	15,802	18,476	19,579	23,267	31,200	44,463
<b>Bureau-level recurrent expenditure</b>	3,195	4,262	5,488	6,517	8,615	11,956	14,090	14,090	17,550
<b>Bureau-level capital expenditure</b>	8,139	8,990	9,472	9,285	9,861	7,622	9,176	17,110	26,912
<b>Total woreda-level expenditure</b>	9,709	11,928	17,677	20,256	28,562	31,265	34,089	40,597	53,780
<b>Woreda-level recurrent expenditure</b>	8,888	10,846	16,059	17,567	26,049	29,697	31,498	37,722	51,490
<b>Woreda-level capital expenditure</b>	821	1,081	1,618	2,689	2,513	1,568	2,591	2,875	2,290
<b>Regional health expenditure (in million Birr)</b>									
<b>Total regional health expenditure</b>	2,464	2,961	3,874	4,890	5,510	6,296	7,432	8,492	11,701
<b>Regional recurrent health expenditure</b>	1,525	1,949	3,006	3,499	4,779	5,782	6,798	7,781	10,471
<b>Regional capital health expenditure</b>	940	1,012	867	1,391	730	514	634	711	1,230
<b>Total bureau-level health expenditure</b>	1,327	1,470	1,573	2,314	2,044	2,206	2,680	3,119	4,848
<b>Bureau-level recurrent health expenditure</b>	424	506	779	1,034	1,414	1,746	2,126	2,528	3,722
<b>Bureau-level capital health expenditure</b>	904	964	794	1,279	631	459	554	591	1,126
<b>Total woreda-level health expenditure</b>	1,137	1,491	2,300	2,577	3,465	4,090	4,753	5,374	6,853
<b>Woreda-level recurrent health expenditure</b>	1,101	1,443	2,227	2,465	3,366	4,036	4,672	5,254	6,749
<b>Woreda-level capital health expenditure</b>	36	48	73	112	100	55	80	120	104

Source: Oromia Regional Plan and Development Commission

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