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ETHIOPIA

National Health Budget Brief

2024/25

KEY MESSAGES

1

The health sector's budget rose from Ethiopian Birr (ETB) 100.2 billion in 2023/24 to ETB 143.4 billion in 2024/25, marking a 43 per cent increase. However, due to depreciation of the ETB, the budget's value in US$ has declined significantly, undermining its purchasing power, especially for capital expenditures dependent on imported medicines and medical supplies.

The government should give higher priority to the health sector by increasing investment, alongside improving the efficiency and effectiveness of spending.

2

In terms of prioritization, the share allocated to the health sector in the government budget has declined from 8.3 per cent in 2023/24 to 7.3 per cent in 2024/25. The share is also much lower than the 15 per cent target of the 2001 African Union Abuja Declaration.

Increasing the proportion of budget allocation, along with improvements in internal efficiency, should be given due attention to improve access to and the quality of healthcare services.

3

The share of capital expenditure in the total health budget increased from 32.5 per cent in 2023/24 to 41.1 per cent in 2024/25. However, at the regional level, capital budget allocation remains low at just 20 per cent, posing a major challenge to strengthening infrastructure and improving primary healthcare services.

An increase in the capital budget allocation at the regional level, and efficient and effective use of the capital budget, are crucial for communities and especially for restoring access to healthcare in communities impacted by conflict and climate-related shocks, as well as for improving the overall quality of health services.

4

The proportion of external assistance in the health sector's capital budget increased from 41.3 per cent in 2023/24 to 54.6 per cent in 2024/25. This marks a reversal of the downward trend observed in previous years. The rise in 2024/25 is largely attributed to additional allocations provided through the supplementary budget.

A heavy reliance on external assistance is unsustainable, especially as official development assistance (ODA) continues to decline amid shifting global dynamics. Ensuring sustainable financing for the health sector can only be guaranteed through increased mobilization of domestic resources.

1. INTRODUCTION

Health sector overview

The health sector in Ethiopia plays a crucial role in human capital development. It is guided by a comprehensive health policy, along with medium-term strategic plans. The country's health system is structured around a three-tier service delivery model. At the first tier, primary healthcare units (PHCUs), including health posts, health centres and primary hospitals, provide essential services. Each health centre is linked to five satellite health posts and serves a population of approximately 25,000 people, while primary hospitals cater to about 100,000 individuals, offering both inpatient and outpatient services. The second tier includes general hospitals, which function as referral centres for primary hospitals and serve an average of 1 million people. These hospitals also serve as training hubs for health professionals, including health officers, nurses and emergency surgeons. The third tier is made up of specialized hospitals, which serve populations of around 5 million and act as referral centres for general hospitals.

The Health Sector Medium-Term Development and Investment Plan (HSDIP) was developed in 2023/24 in line with the country's 10-year development plan. The HSDIP is a three-year strategic plan covering the period 2023/24 to 2025/26. This strategy is developed "to align all sectoral strategic plans to the similar period, address challenges encountered in the last three years and connect strategies with investments".[1] The strategy has an overall goal of improving the health status of the population through accelerating progress towards universal coverage, protecting people from health emergencies, transforming woredas and improving the responsiveness of the health system. The strategy has nine strategic objectives. Among the objectives are improving maternal, child and adolescent health and nutrition status; improving community ownership and primary healthcare; improving access to good-quality and equitable medical health services; enhancing public health emergency and disaster risk management and post-conflict recovery and rehabilitation; improving health system capacity and regulation; and improving health financing and private engagement.

PHCUs are the main providers of primary healthcare services, particularly for rural communities. In rural areas, PHCUs typically consist of one health centre and five health posts. In urban areas, health centres provide primary care services, and the Urban Health Extension Programme (HEP) is implemented through a family health team approach, with urban health extension workers (HEWs) operating from the health centre as their base.[2] The first and second iterations of the HEP were implemented in 2004 and 2020, respectively. Implementation of the HEP has resulted in increased prevention and control of communicable diseases, and improvements in family health and water, sanitation and health (WASH) services. A roadmap for optimizing the HEP (2020–2035) was launched in 2021 to provide structured guidance to an evolving HEP, address socio-economic changes and respond to epidemiological shifts. HEWs conduct home visits and outreach services to promote preventive health behaviours and actions.

[1] Ministry of Health. (2023). Health Sector Medium-Term Development and Investment Plan (HSDIP): 2023/24–2025/26. Addis Ababa, Ethiopia.

[2] Ibid.

This is supported by the revitalization of community engagement by introducing village health leaders and optimizing existing community structures. These have resulted in improvements in terms of reduced maternal and child morbidity and mortality, better environmental health and hygiene, and reduced morbidity and mortality from major communicable diseases.[3]

Community-based health insurance (CBHI) is a key government initiative aimed at providing universal access to healthcare, particularly for the poorest and most vulnerable groups. The country utilizes both CBHI and social health insurance systems to help households manage health-related expenses. CBHI primarily targets the informal sector, while social health insurance is designed for formal sector employees. Launched in 2012, CBHI is a mandatory health insurance scheme in which members contribute premiums into a collective fund, covering basic healthcare costs at local health centres that would otherwise be paid out-of-pocket. The government covers the premium cost of the 10 per cent indigent population. Since its inception, CBHI has improved access to health facilities, mobilized community resources, provided financial protection and empowered women.[4]

Box 1: Policy and strategy documents

- Ethiopia National Health Policy, 2024
- Health Sector Medium-Term Development and Investment Plan (HSDIP): 2023/24–2025/26
- National Health Promotion Strategic Plan: 2021/22–2025/26
- National Health Care Financing Strategy (HCFS) 2022–2031
- National Food and Nutrition Strategy: 2021–2030
- National Health Equity Strategic Plan: 2020/21–2024/25
- Health Sector Transformation Plan II (HSTP-II): 2020/21–2024/25
- Ten Year National Development Plan: A Pathway to Prosperity (2021–2030)
- A Roadmap for Optimizing the Ethiopian Health Extension Programme: 2020–2035
- Food and Nutrition Policy (2018)
- National Health Care Financing Strategy (HCFS) 2015–2035
- National Health Insurance Strategy (2008)
- National Health Accounts: used to monitor the National Health Care Financing Strategy (2021–2030)

[3] Ministry of Health. (2021). National Health Promotion Strategic Plan (2021/22–2025/26). Addis Ababa, Ethiopia. Retrieved on 24 January 2024 from https://www.moh.gov.et/site/sites/default/files/2023-03/National%20health%20promotion%20strategic%20plan.pdf.
[4] Mulat, A.K., Mao, W., Bharali, I. et al. (2022). Scaling up community-based health insurance in Ethiopia: A qualitative study of the benefits and Challenges. BMC Health Serv Res 22, 473. Retrieved on 25 January 2024 from https://doi.org/10.1186/s12913-022-07889-4.

Health sector performance

The country's healthcare system is under significant strain due to multiple socio-economic shocks. Improvement in access to health services in both rural and urban areas has been negatively impacted by a series of shocks, such as conflicts, climate-related events and economic instabilities.. The rising number of internally displaced people (IDPs), along with the growing demand for health services driven by conflict, malnutrition and disease outbreaks, has increased the burden on the health system. As a result, the provision of basic health services – including primary healthcare services, immunization, nutrition interventions, as well both preventive and curative health services – has been severely impacted.

Ongoing conflicts have rendered many health facilities non-functional. In 2021/22, there was a decline in the number of operational health facilities caused by the northern conflict. While the situation began to improve in 2022/23, particularly due to the functional restoration of health facilities in Tigray, the number of functional facilities has still not returned to pre-conflict levels, especially for health posts. The decline in the number of functional health posts is due to approximately 1,900 health posts merging with health centres to become community health units at health centres.[5] The ongoing conflict in Amhara, Oromia and other regions has negatively impacted the functioning of health facilities due to lack of access to or shortage of required resource inputs to operate effectively. The growing number of non-functional health facilities in conflict-affected areas has significantly hindered both access to and utilization of good-quality health services. Furthermore, the rising influx of IDPs, due to both conflict and climate shocks, has placed immense pressure on health facilities, overwhelming them and preventing them from providing adequate services. This has further exacerbated challenges in accessing and receiving good-quality care.

Table 1:

Number of functional health facilities

	2020/21	2021/22	2022/23	2023/24
Health posts	17,699	17,457	17,569	15,531*
Health centres	3,777	3,587	3,826	3,954
Public hospitals	367	343	431	449

Source:

Annual Performance Reports (2020/21–2023/24)

Note:

** Total number of functional health posts has decreased in 2023/24 because about 1,900 health posts were merged with health centres to become community health units at the health centres.*

[5] Ministry of Health. (2024). Annual Performance Report of 2016 EFY. Addis Ababa, Ethiopia.

The number of health professionals is not keeping pace with the growing population and the increasing health challenges in the country. The current health worker-to-population ratio is 17.2 per 10,000, significantly below the World Health Organization's (WHO) recommended threshold of 44.5 per 10,000, which is essential for ensuring comprehensive health coverage and achieving universal healthcare. The HSDIP aims to improve this ratio, targeting 2.3 health workers per 1,000 people by 2025/26.[6] Moreover, the proportion of physicians (comprising general practitioners and specialists) per 1,000 population remains alarmingly low at 0.1, falling behind the sub-Saharan average of 0.2 and significantly lower than the average seen in lower-middle-income countries, which stands at 0.7.[7] Due to conflicts and the mounting strain on healthcare service delivery resulting from climate-related disasters, health professionals are compelled to work in dire circumstances, burdened by multiple challenges. These include the scarcity of essential medical supplies, delayed remuneration, as well as an increasing demand for healthcare due to disease outbreaks, malnutrition and the impacts of conflict. Furthermore, the displacement of much-needed healthcare workers has left certain communities lacking healthcare professionals to address their vital healthcare requirements.

Overlapping socio-economic and climate shocks are likely to result in increased malnutrition, particularly among children. Drought and other climate shocks in many parts of the country have aggravated the issue of poor nutritional outcomes. Conflict- and crisis-affected communities bear a heavy burden of malnutrition, with limited access to essential healthcare services. Rising food prices and inflation have further weakened household food security, disproportionally affecting the poor and vulnerable. These factors have negative implications for nutritional outcomes, thereby hindering progress in addressing child and maternal malnutrition. According to the National Food and Nutrition Strategy Baseline Survey, the prevalence of stunting among children under 5 years of age rose to 39 per cent in 2022, up from 37 per cent in 2019. Similarly, wasting increased from 7 per cent to 11 per cent, and underweight prevalence grew from 21 per cent to 22 per cent over the same period. The combination of worsening household food insecurity and strains on the health system threaten to reverse progress in the health sector.

[6] Ministry of Health. (2023). Health Sector Medium-Term Development and Investment Plan (HSDIP): 2023/24–2025/26. Addis Ababa, Ethiopia.
[7] World Bank. Physicians (per 1,000 people). Data retrieved from https://data.worldbank.org/indicator/SH.MED.PHYS.ZS on 20 March 2025.

Table 2:

Selected health and nutrition outcome indicators

Key indicators	EDHS		
	2011	2016	(Mini-EDHS) 2019
Neonatal mortality rate (per 1,000)	37	29	30
Infant mortality rate (per 1,000)	59	48	43
Under-5 mortality rate (per 1,000)	88	67	55
Child mortality rate (per 1,000)	31	20	12
Maternal mortality rate (per 100,000)	676	412	-
Use of modern contraceptives (%)	27	35	41
Antenatal care provided by skilled provider (%)	34	62	74
Total fertility rate (%)	4.8	4.6	-
Birth occurred in health facility (%)	10	26	48
Skilled birth attendance (%)	10	28	50
Exclusive breastfeeding (infants <6 months, %)	52	58	59
Children aged 12–23 months who received all basic vaccinations (%)	24	39	43
Under-5 children who had diarrhoea in the two weeks preceding the survey (%)	13	13	-
Prevalence of anaemia in children (%)	42	57	-
Stunting prevalence (children <5 years, %)	44	38	37
Wasting prevalence (children <5 years, %)	10	10	7
Underweight prevalence (children <5 years, %)	29	24	21

Source:

Central Statistical Agency. EDHS, 2011, 2016; Mini-EDHS 2019

In the 2023/24 fiscal year, 85 per cent of woredas across the country were implementing the CBHI scheme. The number of woredas providing healthcare through CBHI increased from 1,011 in 2022/23 to 1,052 in 2023/24. In woredas that provide CBHI, around 11.1 million households (76 per cent of eligible households in the woredas) are enrolled in the scheme. Of these, 8.5 million are paying members. The remaining 2.6 million households (23 per cent) are indigents whose premiums are paid by the government.[8] Despite the expansion in CBHI, there is persisting disparity in membership among regions. Enrolment rates are highest in Harari and Addis Ababa, and lowest in Somali region. Data for Tigray region is not yet available. The HSDIP aims to increase the proportion of eligible households enrolled in CBHI from 81 per cent to 90 per cent by 2025/26.[9] Several challenges hinder the scheme's performance, including conflicts that have disrupted implementation, lack of medical supplies/commodities and services at health facilities which affect quality of care, and budget constraints in some woredas to cover for the indigent component of the programme.[10] To enhance CBHI effectiveness, including reducing low utilization and high dropout rates, priority should be given to strengthening the Ethiopian Health Insurance Agency (EHIA), increasing social mobilization and awareness efforts, and improving healthcare service delivery for members.

Key takeaways

- The country's healthcare system is under significant strain due to multiple socio-economic shocks. Improvement in access to health services in both rural and urban areas has been negatively impacted by conflicts, climate change and macroeconomic instabilities.
- Rising food prices and inflation have weakened household food security, disproportionately affecting the poor and vulnerable. This has negative implications for nutritional outcomes, hindering the progress in addressing child and maternal malnutrition.

[8] Ministry of Health. (2024). Annual Performance Report: 2023/24. Addis Ababa, Ethiopia.
[9] Ministry of Health. (2023). Health Sector Medium-Term Development and Investment Plan (HSDIP):2023/24–2025/26. Addis Ababa, Ethiopia.
[10] Ministry of Health. (2022). Annual Performance Report: 2021/22. Addis Ababa, Ethiopia.

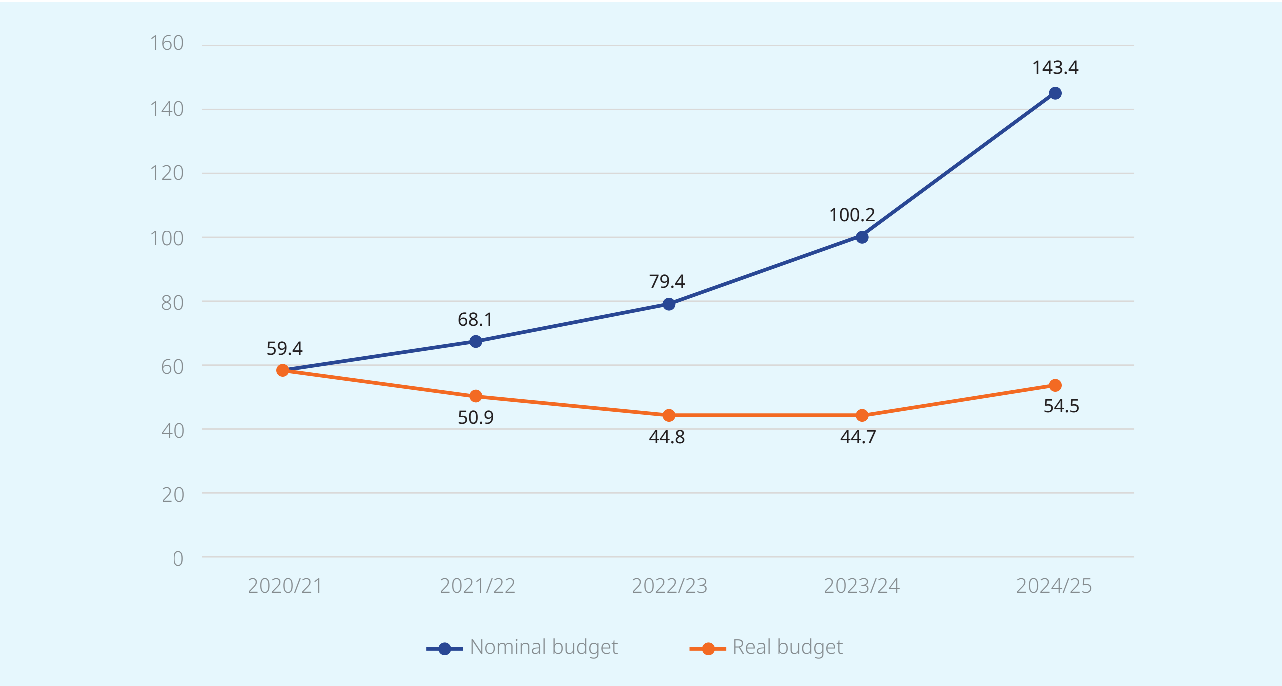
2. NATIONAL HEALTH BUDGET

Ethiopia's total health sector expenditure is financed through various sources, including the government, bilateral and multilateral donors, out-of-pocket expenditure, CBHI (voluntary prepayment) and private employers. However, the analysis in this budget brief focuses only on public budget the government (both federal and regional) allocated for the health sector for the periods under consideration.

Budget allocation to the health sector continues to rise in nominal terms, increasing by 43 per cent in 2024/25 compared to 2023/24 (Figure 1). The budget grew from ETB 100 billion in 2023/24 to ETB 143 billion in 2024/25. In real terms, the budget also saw a 22 per cent increase, though at a much lower rate than the nominal rise. Following the COVID-19 pandemic, the nominal health budget experienced substantial growth. However, when adjusted for inflation, the real value of the budget declined year-on-year until 2023/24. The trend for the real value slightly reversed in 2024/25 due to lower inflation in the first half of the 2024/25 fiscal year, driven by the National Bank's strict monetary policy following the macroeconomic reform in July 2024. Despite this increase, the depreciation of the ETB after the reform has led to a significant decline the budget's value in US$ terms. Given that the health sector relies on foreign currency for importing medicines and medical supplies, this depreciation is expected to weaken the budget's purchasing power, particularly for capital expenditures.

Figure 1:

Nominal and real health sector budget (in billion ETB)



Source:

Data from Ministry of Finance (2020/21–2024/25)

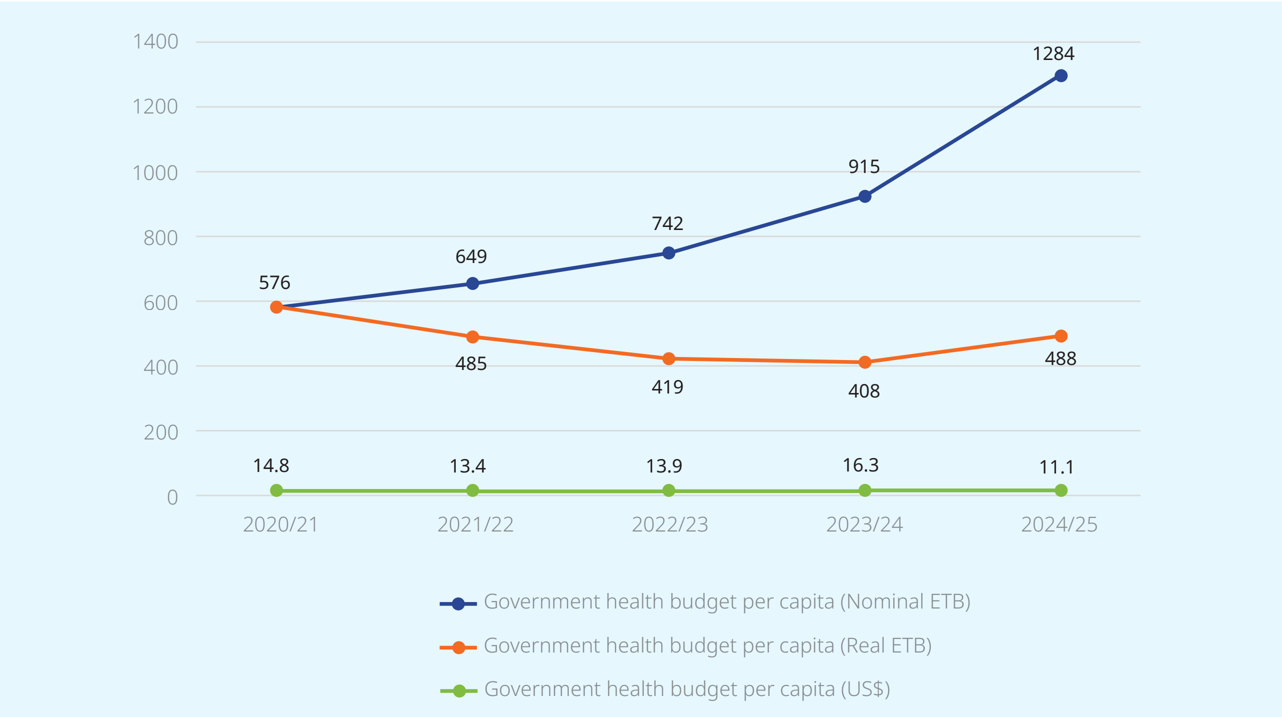
Note:

Real values are calculated using 2020/21 prices; Inflation for 2024/25 is calculated using the average inflation rate from July 2024 to January 2025.

In line with the national health budget trend, the per capita health budget increased in nominal terms from ETB 915 in 2023/24 to ETB 1,284 in 2024/25 (Figure 2). This translates to a 24 per cent nominal increase and a 6 per cent increment in real terms. Except for the year 2024/25, the real value of the budget has been declining due to high inflation. The recovery in the real value of the budget in 2024/25 was driven by a budget increase alongside a relatively lower expected inflation rate. This highlights that increasing budget allocations can enhance the real value of investment only if the overall macroeconomic environment remains stable. Despite this growth in ETB terms, the per capita budget in US$ terms declined from US$16.3 in 2023/24 to approximately US$11.1[11] in 2024/25, primarily due to the depreciation of the ETB following the macroeconomic reform in July 2024.

Figure 2:

Per capita government health budget allocation



Source:

Data from Ministry of Finance (2020/21–2024/25)

Note:

Real values are calculated using 2020/21 prices; Inflation for 2024/25 is calculated using the average inflation rate from July 2024 to January 2025.

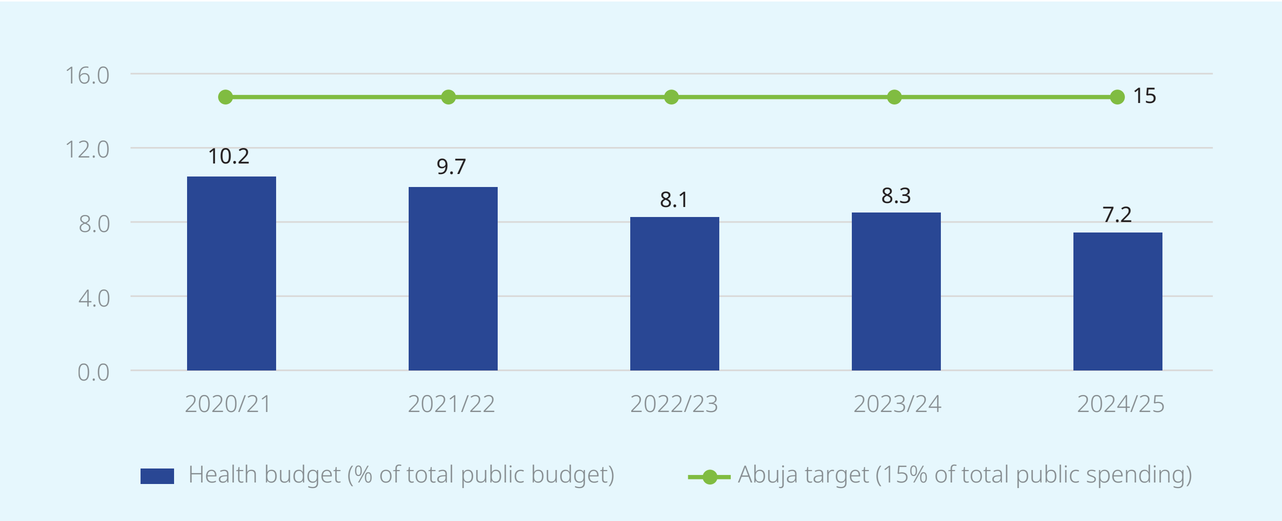
In terms of prioritization, the share of the health sector in the government budget has declined from 8.3 per cent in 2023/24 to 7.2 per cent in 2024/25 (Figure 3). The budget share is much lower than the average share of 8.5 per cent over the past decade. Currently, the sector ranks fifth in terms of government allocation priority,

[11] Exchange rate for 2024/25 is calculated using the average exchange rate between July 2024 and January 2025.

following miscellaneous expenditures (which includes emergency response expenditures), general development, debt repayments and education. The share of budget allocation directed towards health is declining due to the recent shift in government priority and shrinking fiscal space due to the increase in spending on debt repayment and emergency responses. Moreover, the budget allocated to the sector remains below the 15 per cent target set by the African Union Abuja Declaration (2001). To address the increasing healthcare demands resulting from various shocks – such as conflict, internal displacement, disease outbreaks and climate-related crises, including drought – increased investment in the health sector is essential. Prioritizing health spending is crucial for advancing human development and ensuring a more resilient healthcare system.

Figure 3:

Government health budget as a share of total national budget (per cent)



Source:

Data from Ministry of Finance (2020/21–2024/25)

Key takeaways

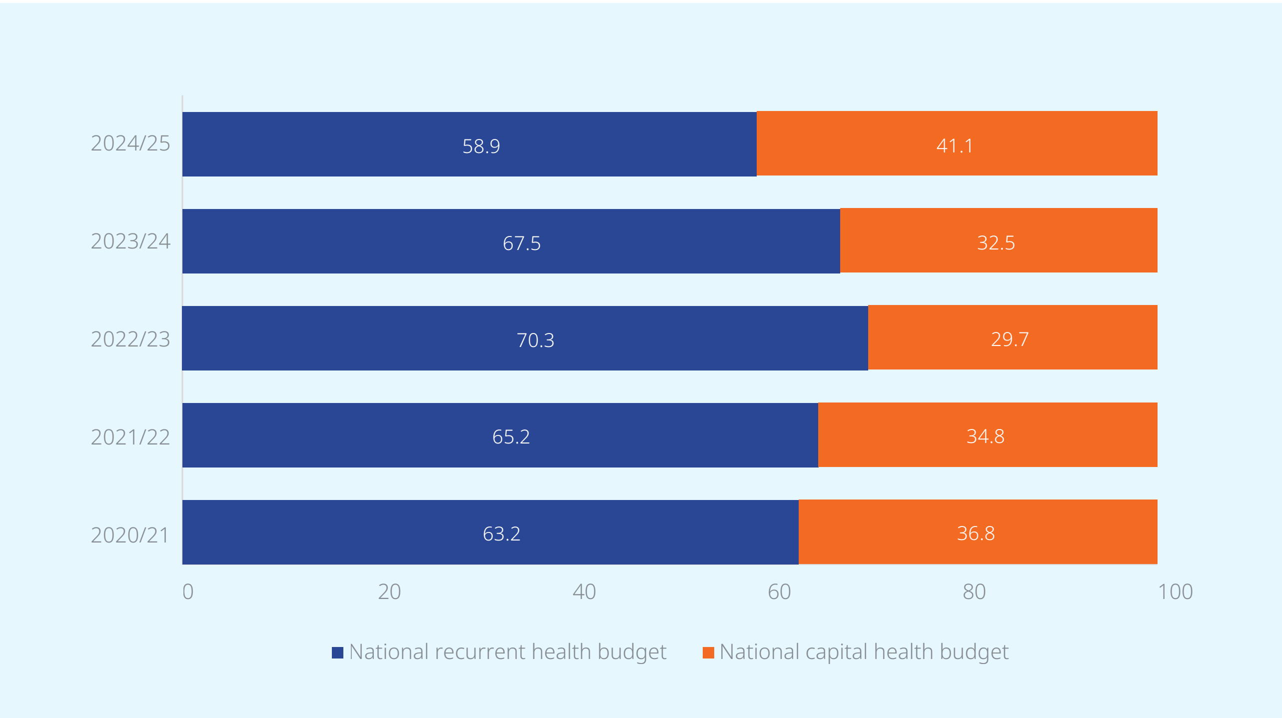
- Budget allocation to the health sector continues to rise in nominal terms, increasing by 43 per cent in 2024/25 compared to 2023/24. However, its share from the total budget is declining due to shifting priorities toward debt repayment and emergency assistance.
- The depreciation of the ETB after the macroeconomic reform has led to a significant decline in the value of the health budget in US$ terms. Given that the health sector relies on foreign currency for importing medicines and medical supplies, this depreciation is expected to weaken the budget's purchasing power, especially for capital expenditures.

Composition of the health sector budget

The proportion of capital expenditure within the total health budget has increased significantly, rising from 32.5 per cent in the 2023/24 fiscal year to 41.1 per cent in 2024/25 (Figure 4). This upward trend reflects a notable recovery from the 2022/23 fiscal year, during which the capital expenditure share reached its lowest point at just 29.7 per cent. The recent rise is particularly commendable, considering it occurred in the face of declining capital expenditure in the overall national budget, as a result of shrinking fiscal space and competing demands across sectors. However, while the progress is encouraging, the current level of capital allocation still falls short of what is urgently required. The health sector continues to grapple with the aftermath of conflict, which has left many health facilities either severely damaged or completely non-functional. In this context, a further boost in capital expenditure is imperative for the reconstruction and rehabilitation of these facilities and to restore essential health services in conflict-affected and vulnerable communities. Scaling up capital investment is also important for strengthening the overall healthcare delivery system, improving service quality, expanding coverage and building resilience to future shocks.

Figure 4:

Recurrent versus capital public health budgets (percentage share of total public health budget)



Source:

Data from Ministry of Finance (2020/21–2024/25)

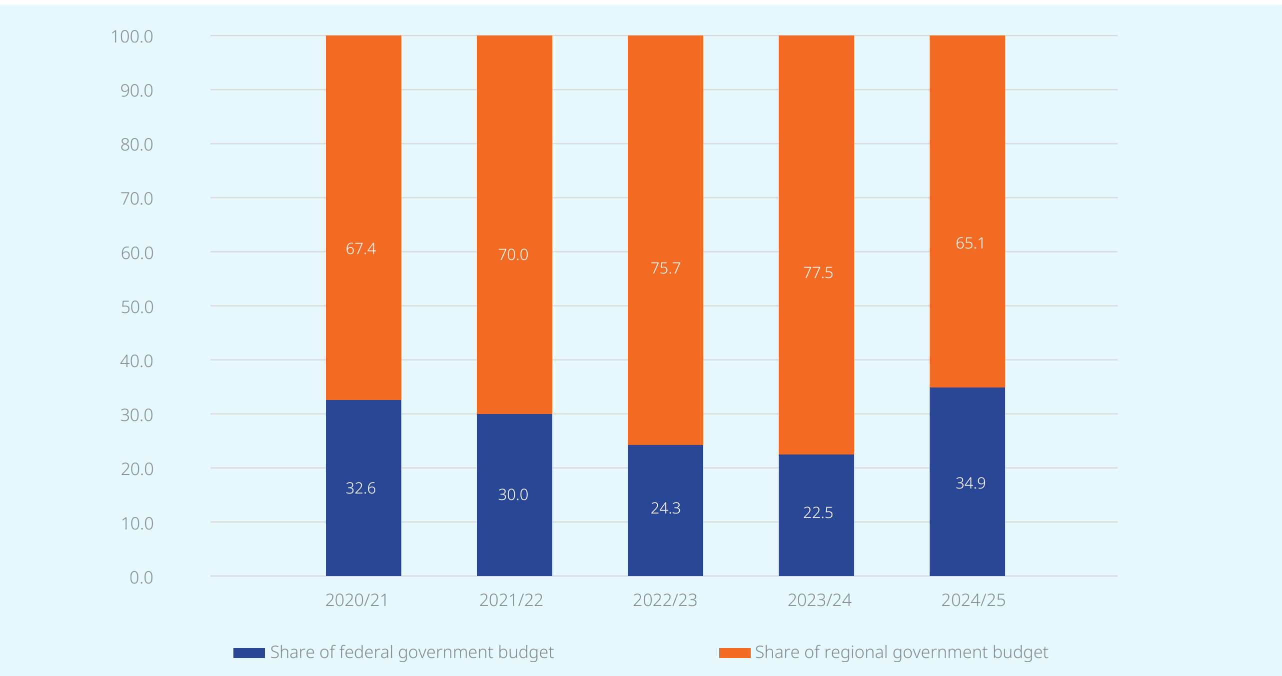
Decentralization and health sector budget

The share of the health budget allocated by regional governments has decreased from 77.5 per cent in 2023/24 to 65.1 per cent in 2024/25 (Figure 5). This decline is primarily due to a significant increase in capital budget allocations at the federal level following the supplementary budget. Despite the reduced share, the regional health budget has increased in absolute terms by 10 per cent. Given that primary healthcare services are mostly delivered through lower-tier facilities, which fall under the responsibility of the regions, increasing regional health budgets remains crucial. In terms of budget composition, only 20 per cent of the regional health budget for 2024/25 is allocated for capital investments, whereas 80 per cent of the federal health budget is allocated to capital projects (Figure 6). The federal government mainly focuses on constructing national health infrastructure and procuring medical and transport equipment. Its recurrent spending is relatively limited, covering mainly staff salaries and operational costs for tertiary-level health institutions.

Regional governments allocate most of their health budgets to recurrent costs, leaving limited funds for capital investments such as infrastructure and medical equipment. This spending imbalance restricts the ability to expand and improve the quality of regional health systems. At the woreda level, the situation is even more constrained, with almost all resources going to salaries. Budgets often fall short of covering basic operational needs, weakening the delivery of primary healthcare services. To address these challenges, stronger resource mobilization at the regional level is essential. Enhancing revenue generation and improving budget efficiency would enable greater investment in capital projects, strengthening the resilience and quality of the health system at the regional and local levels.

Figure 5:

Share of federal and regional government budgets

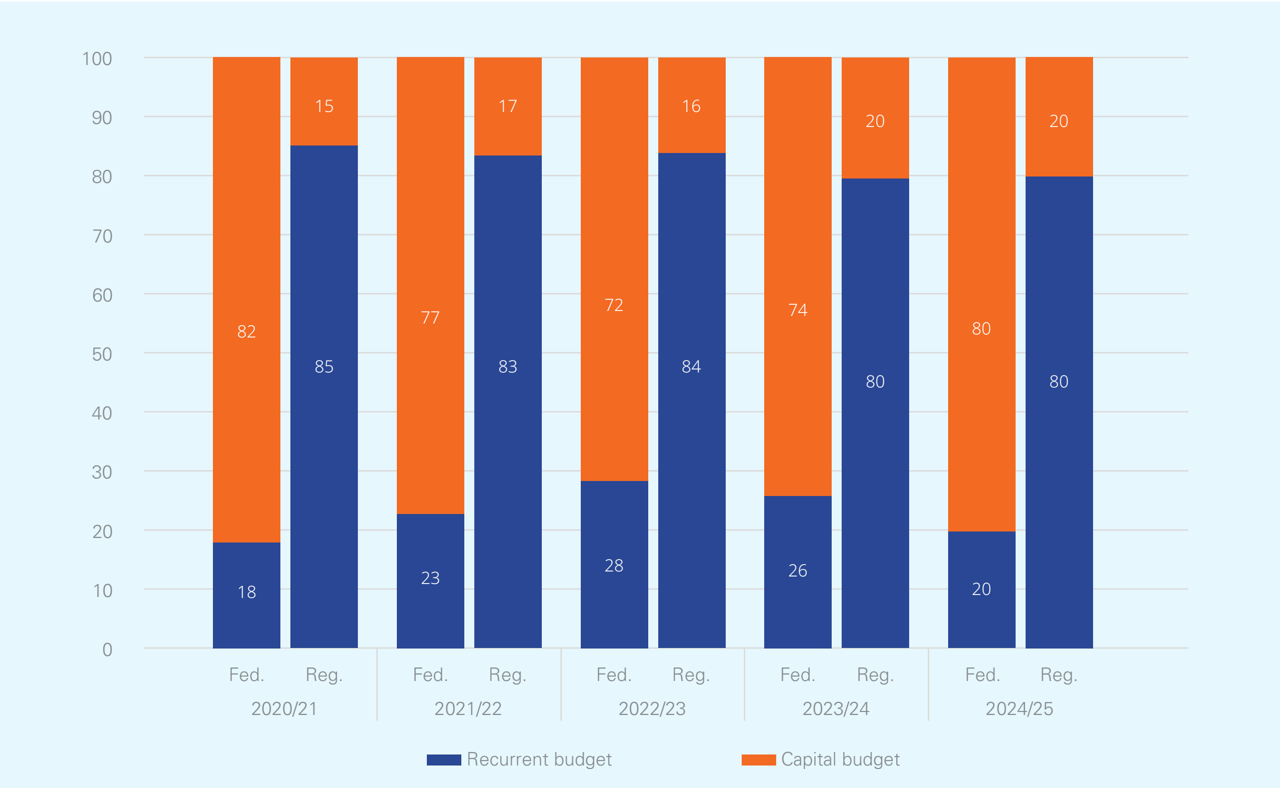


Source:

Data from Ministry of Finance (2020/21–2024/25)

Figure 6:

Share of recurrent and capital allocations for federal and regional budgets



Source:

Data from Ministry of Finance (2020/21–2024/25)

National health budget credibility

In 2023/24, the national health budget had a credibility rate of 89 per cent, reflecting an 11 per cent underspend (Figure 7). A closer look at the budget components reveals a greater discrepancy in the capital budget, which had a credibility of 83 per cent and an underspend of 17 per cent. This shortfall was largely driven by ongoing conflict, inflation and a shortage of foreign exchange. In contrast, the recurrent budget showed relatively better performance, with an 91 per cent credibility rate and a 9 per cent underspend. Improving the utilization of the capital budget is essential to ensure timely and effective spending.

Figure 7:

National capital and recurrent health budget credibility (health expenditure as a percentage of the health budget)

Source:

Data from Ministry of Finance (2019/20–2023/24)

Key takeaways

- The share of capital expenditure in the total health budget rose significantly from 32.5 per cent in 2023/24 to 41.1 per cent in 2024/25, despite national budget constraints. However, this increase remains insufficient, as greater capital investment is urgently needed to rebuild conflict-damaged health facilities, restore essential services, and strengthen the healthcare system's resilience and coverage.
- The regional share of the health budget dropped from 77.5 per cent in 2023/24 to 65.1 per cent in 2024/25 due to increased federal capital allocations. With only 20 per cent of regional health budgets allocated to capital investments, regions face major constraints in strengthening infrastructure and improving primary healthcare services. This highlights the need for better resource mobilization and more efficient budget utilization at the regional level.

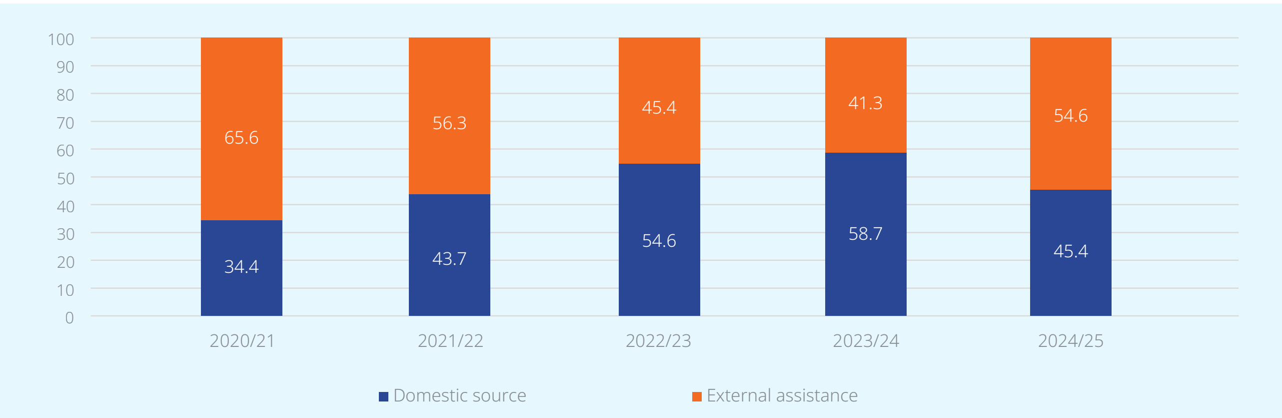
3. HEALTH SECTOR FINANCING

Ethiopia's healthcare system is primarily financed through three main sources: government funding, private sector and household contributions, as well as external support from bilateral and multilateral donors. Although the government budget includes donor-funded capital investments, a significant share of external health financing is channelled off-budget. According to the 2019/20 Ethiopia National Health Accounts Report, government spending accounted for 32.2 per cent of total health expenditure. Donor contributions made up 33.9 per cent, while household out-of-pocket payments comprised 30.5 per cent. Contributions from private employers and other sources represented only about 2.5 per cent. This relatively low level of government funding has led to increased dependence on out-of-pocket payments, exceeding the 20 per cent threshold recommended by the WHO to mitigate the risk of financial catastrophe and impoverishment arising from accessing healthcare services. High out-of-pocket costs are driven by factors such as shortages of medicines and medical equipment in public facilities, limited insurance coverage and inadequate reimbursement for exempted health services.[12]

The share of external assistance to the health sector capital budget rose from 41.3 per cent in 2023/24 to 54.6 per cent in 2024/25 (Figure 8). This is a reversal of the previous years' trend, where the share of external assistance declined from 65.6 per cent in 2020/21 to 41.3 per cent in 2023/24. The increase in the share of external assistance from 2023/24 to 2024/25 is primarily driven by additional allocations from budget support that have financed the 2024/25 supplementary budget following the macroeconomic reform. Compared to other sectors, the health sector remains heavily dependent on external grants for its capital budget financing – from multilateral organizations, bilateral governments and other philanthropic organizations. However, this level of reliance on external assistance is not sustainable, as official development assistance (ODA) continues to shrink in response to shifting global dynamics. Hence, sustainable financing to the health sector can only be guaranteed through increased domestic resource mobilization and a gradual shift towards less dependence on foreign aid.

Figure 8:

Share of financing for national capital health budget (per cent)



Source:

Data from Ministry of Finance (2020/21–2024/25)

[12] Ministry of Health. (2023). Health Sector Medium-Term Development and Investment Plan (HSDIP): 2023/24–2025/26. Addis Ababa, Ethiopia.

Ethiopia has adopted the National Health Care Financing Strategy (2022–2031), which lays out a detailed roadmap for advancing the country's health sector. This strategy focuses on several key objectives, such as boosting domestic health funding, providing fee exemptions for essential services and reducing out-of-pocket expenses through the roll-out of health insurance schemes.[13] It also aims to enhance the financial resources dedicated to healthcare by mobilizing funds from a variety of sources, including the government, development partners and households. To increase private sector contributions and enhance the utilization of user fees by health facilities, a mechanism has been put in place to retain revenue generated from these fees. The strategy also includes the implementation of private wings in public hospitals and outsourcing of services to optimize efficiency. By decentralizing revenue collection and enabling its retention at the facility level, the approach aims to strengthen community ownership and promote long-term sustainability of the healthcare system. However, the achievement of this objective will be contingent upon capability, budget and quality of management of health facilities. The timely and effective implementation of this strategy is vital to achieving sustainable progress in the short and medium term.

One of the strategic objectives of the HSDIP is improving health financing and private engagement with the aim of securing sufficient and sustainable funds to achieve universal health coverage through strengthening primary healthcare.[14] The plan indicates that health sector financing faces multiple challenges, including low government spending, inefficient use of resources and a significant reduction in pool funds. The absence of social health insurance and fragmented pooling of CBHI, with low coverage of indigents, is also a challenge in the health financing system. The health financing and private engagement objectives in the plan focus on adequate and efficient allocation of financial resources to the health sector, while ensuring improved accountability and transparency in fund utilization. Private sector engagement in a range of health and health-related activities is also given due focus as a vehicle for improving access to and quality of health services. With regards to health revenue mobilizing capacity improvement, it has set targets for increasing the per capita total health expenditure from US$36 to US$42; decreasing the out-of-pocket expenditure as a share of total health expenditure from 30.5 per cent to 25 per cent; increasing the government expenditure on health as a share of total general government expenditure to 13.7 per cent; and increasing the resource mobilized from development partners.

Key takeaways

- The proportion of external assistance for Ethiopia's health sector capital budget rose from 41.3 per cent in 2023/24 to 54.6 per cent in 2024/25. However, this growing reliance is unsustainable, highlighting the need for increased domestic resource mobilization and reduced dependence on foreign aid.
- Ethiopia's Health Care Financing Strategy aims to boost domestic funding, expand insurance, and enhance efficiency through decentralization and private sector engagement. Timely and effective implementation of this strategy is vital to achieving sustainable progress in the short and medium term.

[13] Ministry of Health. (2022). Health Care Financing Strategy 2022–2031. Addis Ababa, Ethiopia.
[14] Ministry of Health. (2023). Health Sector Medium-Term Development and Investment Plan (HSDIP): 2023/24–2025/26. Addis Ababa, Ethiopia.

In relation to nutrition, Ethiopia has a costed Food and Nutrition Strategy that was developed in 2021. The strategy is based on the food and nutrition policy "with the view to comprehensively address poverty eradication and achieve the country's vision of reaching global nutrition commitments by 2025, as well as create a conducive track for achieving nation al and SDG targets by 2030".[15] The estimated cost of implementing the strategy is US$2.5 billion over ten years. However, tracking the cost of the implementation of the strategy is problematic. The difficulty of this tracking exercise can primarily be attributed to the fact that multiple sectors and line ministries are overseeing the implementation of the strategy. At the federal level, despite the ongoing implementation of programme-based budgeting, the programmes presented in the budget are aggregated in such a way that it is challenging to identify nutrition-related budgets and expenditures from the budget documents. The complexity of tracking budgets and expenditures is further compounded at the regional level, where programme-based budgeting is yet to be implemented. The utilization of line-item budgeting at the regional level poses significant obstacles in identifying nutritional budgets and expenditures. Consequently, the lack of information pertaining to national nutrition-related budgets and expenditures hampers effective monitoring of the strategy.

[15] Ministry of Health. (2021). The Federal Democratic Republic of Ethiopia National Food and Nutrition Strategy, 2021. Addis Ababa, Ethiopia.

Annex : Ethiopia national health sector on-budget records 2020/21–2024/25

Gregorian Calendar Fiscal Year	2020/21	2021/22	2022/23	2023/24	2024/25
Ethiopian Fiscal Year	**2013**	**2014**	**2015**	**2016**	**2017**
Population (in million)	103	105	107	109	111.7
GDP at current market price (in billion ETB)	4,341	6,157	8,722	11,752	-
General inflation rate (CPI growth rate)	20.4	32.3	32.5	26.6	17.3*
Exchange rate (period weighted average)	35.47	48.6	53.3	56.0	-
Expenditure (in million ETB)					
Total national budget	**582,258**	**705,030**	**983,116**	**1,200,476**	**1,978,015**
Total national recurrent budget	323,935	395,113	590,290	706,928	1,171,609
Total national capital budget	258,323	309,918	392,826	493,548	806,406
Total national health budget	**59,369**	**68,115**	**79,442**	**100,172**	**143,433**
National recurrent health budget	37,521	44,424	55,878	67,567	84,471
National capital health budget	21,848	23,692	23,564	32,605	58,962
Total federal government health budget	**19,377**	**20,429**	**19,332**	**22,566**	**50,041**
Federal recurrent health budget	3,463	4,636	5,483	5,808	9,898
Federal capital health budget	15,914	15,793	13,849	16,758	40,143
Total regional government health budget	**39,992**	**47,686**	**60,110**	**77,606**	**93,392**
Regional recurrent health budget	34,058	39,787	50,395	61,759	74,573
Regional capital health budget	5,934	7,899	9,715	15,847	18,819
Sources of finance for national government capital health budget (in million ETB)					
Domestic source	7,512	10,363	12,877	19,127	26,767
External assistance	14,333	13,326	10,687	13,478	32,196
External loan	4	3	-	-	-
National government health original budget and actual expenditure (in million ETB)					
National recurrent health budget and expenditure					
Original budget	37,521	44,424	55,878	67,567	-
Actual spending	40,665	47,267	53,596	61,651	-
National capital health budget and expenditure					
Original budget	21,848	23,692	23,564	32,605	-
Actual spending	22,299	21,138	19,099	27,193	-
Total national health budget and expenditure					
Original budget	59,369	68,115	79,442	100,172	-
Actual spending	62,965	68,404	72,695	88,843	-

Source: Data from Ministry of Finance (2020/21–2024/25)

Notes: ** The inflation rate used for reporting on real budget for 2024/25 fiscal year is 17.3 per cent, which is the average inflation rate between July 2024 and January 2025.*

This national-level health budget brief was produced by Fanaye Tadesse Techane ftechane@unicef.org with guidance and contributions provided by Zeleka Paulos zpaulos@unicef.org. The main objective of this budget brief is to synthesize complex budget and expenditure information so that it is easily understood by stakeholders, to foster discourse, and to inform policy and financial decision-making processes. The analysis presents budget and expenditure that are recorded on-budget for the Federal Ministry of Health (MoH) and its affiliated sub-national-level Bureaus of Health (BoHs) and district-level Woreda Health Offices. UNICEF's work on Social Policy is undertaken under the leadership of Daniel Kumitz.

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