Health Budget Brief

Updated with 2017/18 national data

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Ethiopia

Key Messages

1. **The share of total national government spending on the health sector was 8.8 per cent in 2017/18, which is way below the 15 per cent target of the Abuja Declaration set by the African Union Member States.** The government should continue to progressively increase its spending on the health sector in order to meet the 15 per cent target.
2. **The per capita public health spending in 2017/18 was USD 13.5, which is an 11 per cent increase from 2016/17. However, this is far lower than the sub-Saharan average and much lower than USD 86 per capita spending estimated by WHO as a requirement for essential health care services available in low-income countries.** *Expansion of the fiscal space for health and increased government spending on the health sector is necessary to provide the required basic health services.*
3. **A high proportion of donor funds directed to the health sector are off-budget and therefore not easy to accurately track and measure.** *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 health care services. There is also a need for the government to apply enforcements or improve existing systems to systematically document off-budget sector contributions from development partners in the final Government Accounts of the Ministry of Finance.*
4. **A major discrepancy between the capital budget and capital expenditure was observed resulting in a 35 per cent overspend in total health expenditure compared to the initial total health budget for 2017/18. High donor dependence in the health sector can make the budget unpredictable as all donor commitments may not be obtained at the beginning of the year.** *Health sector capital budget planning should be improved to make the budget more credible.*
5. **COVID-19 health responses are likely to crowd out funding to other crucial health services. This situation is likely to lead to an insurgence of illnesses that are related to poverty, decreased immunization and increased malnutrition.** *Alongside the COVID-19 responses, provision of child related health services such as immunization and nutrition interventions should be given due attention.*
6. **With the COVID-19 related economic crisis expected to put pressure on incomes, households may face higher challenges to meet out-of-pocket health expenses.** *The Community Based Health Insurance (CBHI) could be expanded for vulnerable communities in the rural and urban areas to lift the health spending burden from poorer households. Expanding CBHI coverage is also imperative for covering costs of childhood illness such as pneumonia which in principle should be exempted from all costs at public health facilities but is not being implemented uniformly.*
7. **Due to combined effects of the desert locust and the secondary impact of COVID-19, a 24 per cent increase in the wasting caseload is anticipated. This will significantly increase the number of children to be treated and will require additional funding of USD 3.8 million for the procurement of Ready to Use Therapeutic Food (RUTF).** *Advocacy with donors needs to be done swiftly to meet the funding gap and ensure nutrition outcomes of children are not compromised.*

1. Introduction

Health Sector Performance

Health outcomes in Ethiopian have improved over the past two decades. In the past five years the number of health posts and health centres have increased by 5.6 per cent and 10.2 per cent from 2013/14 to 2018/19, respectively. The number of public hospitals has doubled from 156 to 314 between 2013/14 and 2018/19, albeit from a very low base. However, the health sector still faces some serious constraints. For instance, the number of physicians per 1,000 people was only 0.1 in 2017 lower than the sub-Saharan average of 0.2 and much lower than the average for lower middle-income countries of 0.7[1].

Table 1: Number of functional health facilities

	2013/14	2018/19
Health Posts	16,251	17,162
Health Centres	3,335	3,678
Public Hospitals	156	314

Source: Ministry of Health

Infant and under-5 child mortality rates, and several other child health indicators have also improved (Table 2). The percentage of women who gave birth in the presence of skilled birth attendants increased from 28 per cent in 2016 to 48 per cent in 2019. The percentage of births that occurred in health facilities also increased from 62 per cent in 2016 to 74 in 2019.

However, some areas have lagged. For instance, the neonatal mortality rate has not shown improvement in recent years, stagnating at 30 per 1000, and the maternal mortality rate is also still high (412 deaths per 100,000). Furthermore, the nutritional status of children is still very low with high percentage of children (37 percent) being stunted. Only 43 per cent of children between 12 and 23 months of age had received all required vaccinations in 2019.

The Health Sector Transformation Plan (2015-2020) is the guiding framework for the health sector. The HSTP places more emphasis on quality and equity of services. The overall objective of the HSTP is to ensure equitable and quality health care through woreda transformation. This plan has four major pillars: (i) Health Service Delivery; (ii) Quality Improvement and Assurance; (iii) Leadership and Governance; and (iv) Health System Capacity. The total cost of the Health Sector Transformation Plan (HSTP 2015/16 to 2019/20) is USD 15.6 Billion of which 36 per cent of the total cost is for human resource development and management; 25 per cent is for medicines, commodities and supplies; and 24 per cent is for infrastructure.

By bringing together the planning and implementation of the four pillars of the HSTP at the woreda level, the Ministry of Health has been following an integrated approach to woreda transformation. The woreda transformation is to be achieved through building resilient health systems and creating high performing woredas, high performing primary health care units (PHCUs), and model kebeles. It also involves ensuring transparency and accountability at the primary health care unit level, ensuring financial protection of people in accessing health services and creating effective data utilization for decision making at woreda level.

Table 2: Selected health and nutrition outcome indicators

Key indicators	2011	2016	2019
Neonatal mortality rate (per 1,000)	37	29	30
Infant mortality (per 1,000)	59	48	43
Under-5 mortality (per 1,000)	88	67	55
Child mortality (per 1,000)	31	20	12
Maternal mortality rate (per 100,000)	676	412	-
Use of modern contraceptive (%)	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.

The country's Health Extension Program (HEP) has been the most important component of the health system in terms of contributing towards universal health coverage and achieving improved health outcomes. The Health Extension

[1] https://data.worldbank.org/indicator/SH.MED.PHYS.ZS

Program is a community-based health programme in Ethiopia that provides access to primary health care in rural communities through transfer of health knowledge and skills to households. It is aligned to the HSTP in ensuring health service delivery especially to the rural areas. Primary health care services, such as maternal and child health care, tuberculosis, HIV, and family planning, among others, are more accessible to communities through the HEP. Although national directives outline the abolition of user fees for health posts and for some services at health centres, its applicability has been different across regions. Generally, however, maternal health care, immunization, and emergency child health services are universally provided free of charge through these government health services.

There are around 40,000 health extension workers deployed in agrarian, pastoral and urban areas of the country[2]. The HEP has thus contributed to improving the equity and efficiency of health care services. However, the program has not been transformative over time due to changing and increasing community needs. Changes in demographic trends, socio-economic status of the population and increased urbanization has created the need to modify the existing HEP. Accordingly, the government has designed a second-generation HEP to address the missing elements in the earlier program.

The second-generation HEP is designed to respond to the changing reality and address the equity and quality issues in the health service delivery. The second-generation rural HEP includes upgrading health extension workers, amending the content and improving the quality of existing health extension packages, and improving the infrastructure and organization of the health posts. To further strengthen the HEP and ensure the gains from the program are sustained with in the community, the government has launched the Health Development Army also referred to as Women Development Army (WDA). As an inclusive engagement of women network, the WDA helps disseminate health information to the community by working in synergy with HEWs.

To ensure universal health access by all people, especially the poorest and vulnerable, the government introduced the Community Based Health Insurance (CBHI) in 2012. The CBHI is a voluntary health insurance scheme where members pool premium payments into a collective fund and cover basic health care costs at local health centers that would otherwise be covered through out-of-pocket spending. The government covers the premium cost of the 10 per cent indigent population. As of the end of the EFY 2018/19 a total of 657 woredas have started implementing the scheme with 4.9 million households being enrolled into the program. The scheme is being implemented in all regions of the country except Afar and Somali regions.

Box 1: Policy and strategy documents

- The Second Growth and Transformation Plan, GTP-II, (2015/16–2019/20), which builds on former national development plans such as GTP-I (2010/11–2014/15)
- National Health Policy, 1994
- Health Sector Transformation Plan (2015–2020), which builds on four former Health Sector Development Plans (HSDPs) implemented between 1997/98 and 2014/15
- National Health Care Financing Strategy, 2015–2035
- National Health Accounts (used to monitor the national health care financing strategy)
- National Nutrition Strategy, 2008
- National Nutrition Programme II (2016–2020), which provides for linkages with other sectors
- Food and Nutrition Policy, 2018
- National Health Insurance Strategy, 2008
- National Social Protection Strategy, 2016 (2016–2019)
- National Social Protection Action Plan, 2017 (2017–

Takeaways:

- ***The Health Sector Transformation Plan (2015-2020) serves as a guiding framework of the sector with an objective of ensuring equitable and quality health care through woreda transformation.***
- ***The country's health outcomes such as infant and under-5 mortality rates, and the number of women giving birth in health facilities have improved over the past decade.***
- ***On the other hand, the high neonatal mortality rate, poor nutritional status of children and low vaccination rates continue to challenge the health sector.***

[2] Federal Ministry of Health, Annual Health Sector Performance Report, 2018/19.

Box 2: Possible impact of COVID-19 pandemic on the health sector in Ethiopia.

Increased COVID-19 illness is expected to put pressure on the quality of health care in Ethiopia with potential service saturations and severe limitations for poorer households in terms of affordability and accessibility. Its impact on women and children are going to be even more pronounced. For instance, in 2018, about 17 per cent of child deaths (32,000) were due to pneumonia, making it one of the leading killers of children under-five years. There is risk that some resources may be diverted from treatment of pneumonia and other diseases to COVID-19. Moreover, twelve per cent of children under this age group had diarrhea two weeks before the 2016 Ethiopia Demographic and Health Survey, showing a high prevalence of diarrhea, another child killer estimated to be responsible for 8-9 per cent of under-five child deaths. Primary health care services must continue or more children will die of these preventable causes than of COVID-19.

If the pandemic spreads in the country, health services to non-COVID-19 related needs would diminish as more health service providers will be mobilized to respond to COVID-19. Due to Covid-19 the provision of essential services has been disrupted with measles and polio campaigns planned for March/April 2020 postponed. The number of children (0-59 months) due for polio vaccination is 17,116,378 and for measles (9 - 59 months) is 14,699,948. This means that the vaccination of these children has been delayed and they are vulnerable to these infections. There are also other outbreaks such as yellow fever and cholera that also stress the system which already has few assets.

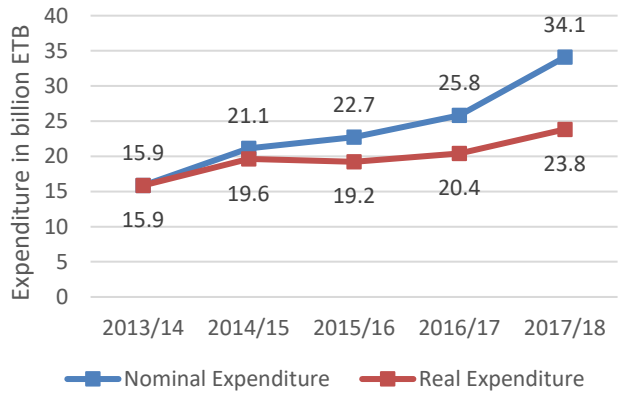
Its other impact is on nutrition. Currently, there are three-underlying causes of malnutrition and COVID-19 will have impact through these causes: (1) household food insecurity due to loss of income particularly among the lower wealth quintile households with children under 5; there is therefore a need to advocate for expansion of the Productive Safety Net Programme (PSNP); (2) caring practices for children and women are likely to go down as livelihoods are affected; and (3) access to health services for common child illnesses, for treatment of moderate and severe wasting, and preventive nutrition services maybe be disrupted due to health workers' attention shift to COVID-19 response, lack of motivation or fear of infection. These three underlying causes along with the current locust infestation in the country is expected to increase rates of malnutrition. UNICEF has estimated a 24 per cent increase in the wasting caseload in Ethiopia as a result of the spread of COVID-19. This will have implications on the number of children to be treated and will require advocacy with donors for additional USD 3.8 million funding to procure Ready to Use Therapeutic Food (RUTF).

Source: UNICEF Ethiopia (2020) Socio-economic impacts of COVID-19 in Ethiopia.

2. National Health Care Spending

The public health expenditure has increased from 25.8 billion in 2016/17 to 34.1 billion in 2017/18. This amounts to a 34.5 per cent nominal increase, which is nearly double the increase in total government health spending between 2013/14 and 2016/17 (figure 1). However, in real terms the increase is relatively modest at 15 per cent due to the high inflation rate of 16.7 per cent during 2017/18.

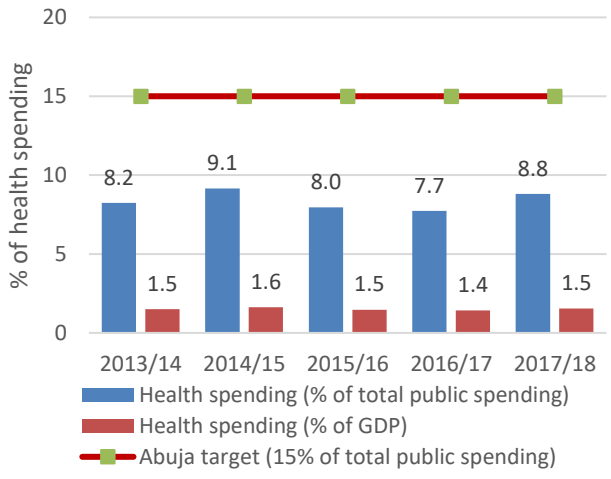
Figure 1: Nominal and real health spending (in billion ETB)



Source: Data from Ministry of Finance. (2013/14-2017/18)

The health sector is increasingly becoming a top spending priority of the government. In 2016/17 the share of health spending stood at the fourth place next to education, road construction, and agriculture development and food security (Figure 2). However, in 2017/18 health was the second priority sector having the highest share of public expenditure allocated to it next to education. The percentage of public spending that went to the sector in 2017/18 was around 8.8 increasing by 1 per cent from its share in 2016/17. Although the government is increasing its attention to the health sector, the share of public expenditure going to the sector is still way below the 15 per cent target set by the African Union under the Abuja Declaration (2001). The share of public health spending as a percentage of GDP is also very low at only 1.5 per cent.

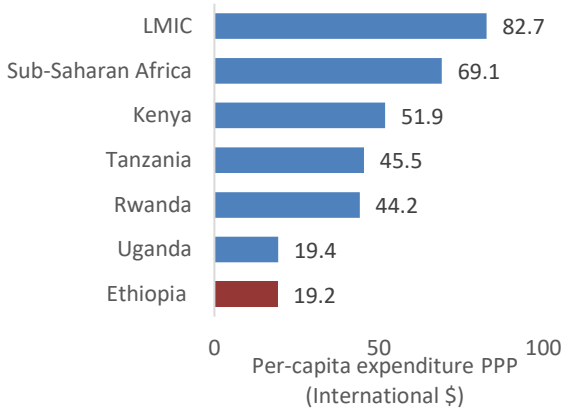
Figure 2: Public health expenditure (percentage share from GDP and total national expenditure)



Source: Data from Ministry of Finance (2013/14-2017/18)

The nominal per capita public health spending in 2017/18 is ETB 353 showing a 29.1 per cent increase compared to 2016/17. However, the real per capita spending is ETB 266 and increased by a relatively lower margin at 14.3 percent. The per capita government expenditure in Ethiopia measured in Purchasing Power Parity international dollars stands at PPP international $19.2 which is lower than neighbouring countries and much lower than the sub-Saharan average of PPP international $69.1 (Figure 3). Moreover, the country's per capita government health expenditure is only a fourth of the average per capita government expenditure of lower middle-income countries. It is also far below the USD 86 per capita spending estimated by WHO for required essential health care services in low-income countries.

Figure 3: Domestic general government health expenditure per capita, PPP (current international $)- 2016

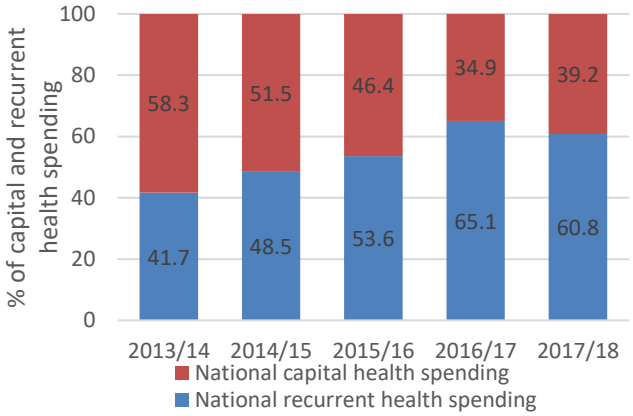


Source: World Bank, 2016[3]

Composition of Health Spending

The composition of government health spending indicates higher share of spending on recurrent expenditure compared to capital expenditure in recent years. Capital expenditure accounted for 61 per cent of the total expenditure in 2017/18 while the remaining 39 per cent went to financing recurrent expenditure (Figure 4). Prior to 2014/15 the focus was mainly on building health infrastructure that led to higher share of capital spending. However, after 2014/15 the share is reversing with more allocation on recurrent expenditure. This is expected as the newly established health facilities require a sustained operational cost financing to ensure smooth service delivery to the public. Although the share of capital health investment is showing a declining trend, the amount of expenditure has continued to increase in absolute terms.

Figure 4: Recurrent versus capital public health expenditure (percentage share from total public health expenditure)

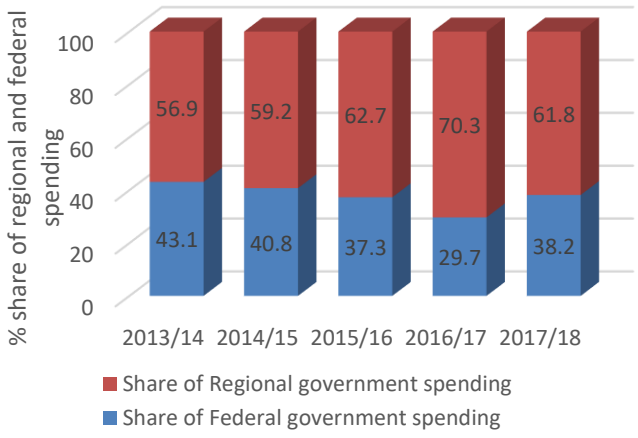


Source: Data from Ministry of Finance (2013/14-2017/18).

Decentralization and Health Spending

In line with devolving fiscal decision-making to lower tiers of administration, the government designed a fiscal decentralization strategy with the specific objective of promoting health care services to citizens. An increasing share of the public health budget has been spent by regional governments from 2013/14 to 2016/17 showing a slight dip in 2017/18 (Figure 5). Although the share allocated to the regional governments has declined by 8 percentage points from 2016/17 to 2017/18, the amount allocated to regional governments has increased by 16 per cent in absolute terms, albeit at a much lower rate of increase when compared to the federal budget which increased by 70 percent. Commodities and drugs used in the regions are procured centrally by the federal government. Hence, most of the funds executed by both the federal and regional government finance health expenditure at the regional level.

Figure 5: Federal versus regional health spending (Percentage share from total health expenditure)

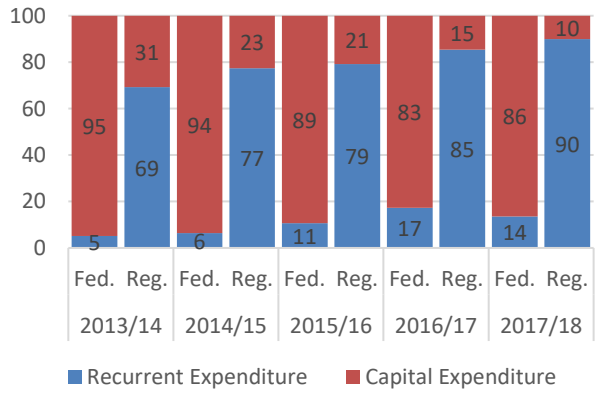


Source: Data from Ministry of Finance (2013/14-2017/18).

3 https://data.worldbank.org/indicator/SH.XPD.GHED.PP.CD?locations=ET

In terms of budget composition by the federal and regional governments, the lion's share of government budget at the federal level goes to capital expenditure and the share has been increasing from 85 per cent in 2016/17 to 90 per cent in 2017/18. The federal government is mainly tasked with building health infrastructures throughout the country and purchase of machinery and equipment (both medical and transport equipment). The recurrent expenditure at the federal level is very minimal pertaining to the higher staff hiring and operational expenditure at the point of service delivery which lies within the responsibility of regional governments. Around 86 of the regional expenditure was spent on recurrent expenditure. This leaves little to regional governments to invest on capital equipment for health facilities in their respective regions. In addition to operational costs of health facilities, salaries of HEWs are covered at the regional level.

Figure 6: Composition of health expenditure at federal and regional levels (percentage share).



Source: Data from Ministry of Finance (2013/14-2017/18).

Regional and woreda level health expenditure are mainly focused on financing recurrent expenditure, leaving little room for capital investment at lower level of government. Different modalities, such as providing ear marked capital budgets at regional and woreda level governments should be pursued to ensure resources are available at lower government administrations for capital investments.

Health Budget Credibility

The federal health budget credibility indicates the spending on the sector is much higher than the amount budgeted at the beginning of the year. The actual spending at the end of the year was 35 per cent higher than the originally approved budget (Table 3). In assessing the budget components, a higher level of discrepancy is observed in the capital budget. The recurrent budget credibility is in a relatively better position as recurrent expenditure in the sector is mainly spent on salary and operational costs which are better accounted for at the beginning of the year. With regards to capital expenditure, the capital formation in the health sector is highly donor dependent. This could make the planning process rather unpredictable as all donor commitments may not be obtained at the beginning of the year.

Table 3: Federal and regional capital and recurrent health spending (percentage share from total capital and recurrent health spending)

Indicator	2014/15	2015/16	2016/17	2017/18
Recurrent budget credibility	135.5	110.8	107.1	108.0
Capital budget credibility	169.8	136.2	91.3	140.7
Total budget credibility	167.1	133.0	93.7	135.2

Source: Data from Ministry of Finance (2013/14-2017/18). (information for sub-national levels of government has not been made available)

Takeaways:

- ***Government expenditure on health has increased by 15 per cent from 2016/17 to 2017/18 in real terms.***
- ***Although the government is increasing its spending on the sector, the share of public expenditure going to the health sector was 8.8 per cent in 2017/18 and is below the 15 per cent international target.***
- ***The per capita spending on health was USD 13.5 in 2017/18 which is lower than other African countries and much lower than the WHO's estimate of USD 86 per capita spending for essential health care services in low-income countries.***
- ***In 2017/18, 39 per cent of the health expenditure was spent on capital expenditure. The share of capital expenditure to total government health spending is declining over the years with more resource going to recurrent expenditure to finance the operational costs of the newly built infrastructures.***
- ***In 2017/18, 62 per cent of the health expenditure was spent by the regions. As much of the spending at the regional level is on recurrent expenditure, there is little resource left for regions to invest on capital equipment for health facilities.***
- ***The health sector budget credibility is poor. Actual expenditure at the end of the year was 35 per cent higher than budget at the beginning of the year.***

3. Health Sector Financing

Ethiopia's health sector financing has three major sources: the state budget, private sector investments and household contributions, as well as external funds from bilateral and multilateral donors. Although the state budget includes capital funds from donors, the amount is only partially captured. Comparing the capital expenditure between the state budget and the National Health Accounts[4], while the recurrent expenditure and capital expenditure from the treasury from the two sources are very similar, there is a huge discrepancy in terms of data on donor capital expenditure (Table 4). This indicates that there is a significant proportion of donor capital that is off-budget and not captured in the state budget.

Table 4: Comparison of Expenditure record by the State budget and National Health accounts (2016/17 in ETB Billion)

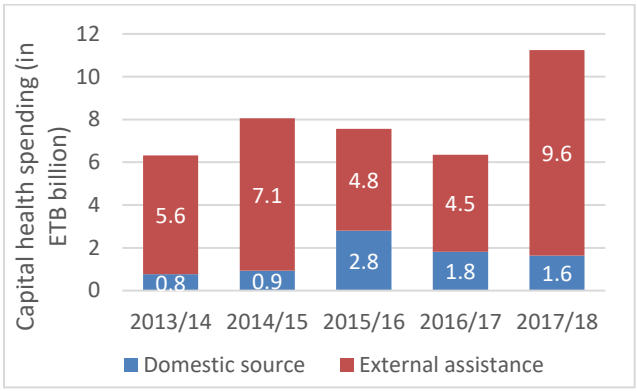
	Recurrent	Treasury Capital	Donor Capital
State Budget	16.83	3.54	5.37
National Health Accounts	17.19	3.37	25.35

Source: Data from Ministry of Finance and NHA (2016/17)

A sizeable portion of external financing to the health sector is directed through off-budget channels, the amounts of which are challenging to track. Since this budget brief analyses finances only reflected in the state budget, it also does not capture private sector investments and citizens' contributions. On the other hand, the National Health Accounts (NHA) reports on all of these categories. According to the National Health Accounts (NHA)[5], government contribution to the total health expenditure was 32 in 2016/17 while donor financing and households' out-pocket expenditure accounted for 35 per cent and 31 per cent of the total health expenditure, respectively. The relatively lower government expenditure has forced the out-of-pocket payments to play a greater role in financing health expenditures at a level much higher than the 20 per cent threshold suggested by WHO to minimize financial catastrophe and impoverishment as a result of accessing health care services[6].

The majority of the federal capital expenditure is financed by external assistance. The resource for the federal capital health spending has significantly increased from 6.3 billion in 2016/17 to 11.2 billion in 2017/18 (Figure 7). The share of external assistance is especially much higher in 2017/18 increasing from 75 per cent in 2016/17 to 85 per cent in 2017/18. Compared to other sectors, health is largely financed by external grants from multilateral organizations, bilateral governments, and other philanthropic organizations.

Figure 7: Sources of finance for federal capital health spending (In ETB billion)



Source: Data from Ministry of Finance (2013/14-2017/18).

Ethiopia has endorsed a National Health Care Financing Strategy (2015–2035). The strategies include the need to increase financing from domestic sources, fee exemption for key services, and reducing OOP expenditure through health insurance schemes. Ethiopia's National Health Care Financing Strategy has the objective of increasing financial resources for health care services. The strategy directs resource mobilization for the health sector from various sources, including the government, development partners and households.

Enhanced private sector contributions and specific initiatives to strengthen the collection and use of user fees by health facilities are also part of the financing strategy. Accordingly, a system has been established for retaining revenue in the form of user fees (in addition to the budget allocated from treasury) at local public health facilities, with the aim of improving the quality of health care services. Establishment of private wings and outsourcing for better efficiency are also part of the health financing strategy. Decentralization of revenue collection and retention of this revenue by health care providing institutions is to stimulate a greater sense of community ownership and contribute towards the system's long-term sustainability. However, this will depend on capability, budget and quality of management.

Takeaways:

- ***The share of external assistance to the total health financing resource is 85 per cent, indicating high donor dependence.***
- ***Ethiopia has endorsed a National Health Care Financing Strategy (2015–2035) with the objective of increasing financial resources for health care services.***

[4] Ministry of Health, 2019. Ethiopia Health Accounts 2016/17.

[5] ibid.

[6] ibid.

4. Key Policy Issues

- **Currently, the health sector expenditure classification system lacks disaggregation. There is no disaggregated data on health expenditure to track expenditure on chid related health expenditures or nutrition specific interventions.** The management information system should be strengthened to increase access and availability of such information with ease. This will allow better tracking and monitoring purposes to measure and advocate for increased investment in specific programs.

- **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 health care services.

- **Ethiopia's health sector is heavily dependent on donor financing hence the sustainability of health financing is of serious concern.** The government's allocation to health expenditure needs to improve further through increased domestic resource mobilization. The recently introduced excise tax on 'unhealthy' foods and beverages is a commendable effort in mobilizing domestic resource. However, there needs to be strict implementation of the policy in terms of allocating the mobilized resource to finance the health sector.

- **Households are currently burdened with shouldering a significant proportion of the country's health expenditure.** Insurance schemes both for the formal and informal sectors should be expanded to reduce the high personal out of pocket health care charges that are burdening poorer households.

- **The current COVID-19 related crisis could put pressure on the already struggling health system of the country.** This highlights the need for increased commitment by government to heighten investment in the health sector both in the short, medium and long term through increased public budget allocation.

- **With the COVID-19 pandemic expected to put pressure on the health system, households may face higher out-of-pocket spending for health-related expenses.** The CBHI could be expanded for vulnerable communities in the rural and urban areas to lift the health expenditure burden from poorer households. The expansion of the CBHI could also improve child related health outcomes as some child illnesses which should be exempted from all costs are not cost free in practice.

Annex 1: Ethiopia National Health Sector On-budget Records 2013/14–2017/18

Gregorian calendar Fiscal Year	2013/14	2014/15	2015/16	2016/17	2017/18
Ethiopian Fiscal Year	**2006**	**2007**	**2008**	**2009**	**2010**
Population (in million)	87.00	89.10	91.20	94.40	95.50
GDP at Current Market Price (in million ETB)	1,060,825	1,297,961	1,541,277	1,806,656	2,202,373
General Inflation Rate (CPI growth rate)	8.10	7.70	9.70	7.20	13.10
Exchange Rate (period weighted average)	19.90	20.10	21.10	22.40	26.10
Expenditure (in million ETB)					
Total national Spending	**192,674**	**231,016**	**285,471**	**334,177**	**387,050**
Total national recurrent spending	78,631	112,685	154,747	183,667	217,863
Total national capital spending	114,043	118,330	130,724	150,510	169,186
Total national health spending	**15,865**	**21,124**	**22,706**	**25,828**	**34,096**
National recurrent health spending	6,611	10,241	12,170	16,821	20,715
National capital health spending	9,255	10,882	10,537	9,007	13,381
Total federal government health spending	**6,845**	**8,613**	**8,476**	**7,673**	**13,015**
Federal recurrent health spending	357	555	906	1,324	1,760
Federal capital health spending	6,489	8,058	7,570	6,349	11,255
Total regional government health spending	**9,020**	**12,510**	**14,230**	**18,155**	**21,081**
Regional recurrent health spending	6,254	9,686	11,264	15,497	18,955
Regional capital health spending	2,766	2,824	2,966	2,659	2,126
Source of Finance for Federal Government Capital Health Expenditure (in million ETB)					
Domestic source	773	934	2,803	1,814	1,638
External assistance	5,554	7,124	4,765	4,534	9,607
External loan	162		2		10
Federal Government Health Original Budget, Adjusted Budget, and Actual Expenditure (in million ETB)					
Federal recurrent health:					
Original budget	302	410	818	1,236	1,629
Adjusted budget	336	581	977	1,466	2,001
Actual spending	357	555	906	1,324	1,760
Federal capital health:					
Original budget	4,297	4,746	5,557	6,952	7,998
Adjusted budget	8,545	7,159	10,545	10,390	14,833
Actual spending	6,489	8,058	7,570	6,349	11,255
Total federal health:					
Original budget	4,599	5,155	6,375	8,189	9,627
Adjusted budget	8,881	7,740	11,522	11,856	16,834
Actual spending	6,845	8,613	8,476	7,673	13,015

Source: Data from Ministry of Finance

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This health budget brief, which is complemented by three other briefs on education, social protection and a national overview, analyses budget and expenditure that are recorded on-budget for the Federal Ministry of Health (FMoH) and its affiliated sub-national-level Bureaus of Health and district-level Woreda Health Offices. 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.