PUBLIC INVESTMENTS IN HEALTH IN THE COVID-19 PANDEMIC ERA

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Ethiopia

Budget Brief 2020/21

KEY MESSAGES

1 **Budget allocation to the health sector has been increasing at an average rate of 18 percent in the past four years. The rate of nominal increase is particularly high in 2020/21 as more budget is flowing into the sector as part of the COVID-19 response. However, the increase is not as high in real terms due to the high level of inflation currently challenging the economy.**

Recommendation: To ensure the value of investment is increasing in the sector, the government should ensure increases in inflation-adjusted budget allocations.

2 **The average per capita expenditure measured in Purchasing Power Parity international dollars, stood at PPP international $15.6 in 2018, which is lower than that of neighbouring countries, and much lower than the sub-Saharan average of PPP international $69.1. It is also far below the USD 86 per capita spending estimated by WHO for required essential health care services in low-income countries.**

Recommendation**:** Increased government spending on the health sector is necessary to provide the required basic health services.

3 **Although the share of government allocation to the health sector is increasing, reaching 10 percent in 2020, it is still below the 15 per cent spending target of the Abuja Declaration.**

Recommendation: The government should continue to progressively increase its spending on the health sector in order to meet the 15 per cent target.

4 **The national health budget is credible with actual expenditure being off the original budget by only four percent in 2018/19. Compared to the recurrent budget, the credibility of capital budget is low. One of the reasons for low credibility is unpredictability of donor funds and the shortage of foreign currency resulting in lower levels of capital spending, as most capital investments require hard currency.**

Recommendation: Health sector capital budget planning should be improved to make the budget more credible.

5 **In addition to the direct impact of the COVID-19 pandemic such as increased illness and mortality due to COVID-19, essential health service delivery has been affected due to a shift of resources to the COVID-19 response. The shifting of resources coupled with the fear of the community to go to health facilities, is likely to affect children the highest.**

Recommendation: The health crisis caused by the pandemic has proved that the country needs to build a resilient health system to overcome similar shocks in the future. This requires increased commitment to heighten investment in the health sector both in the short, medium and long term through increased public budget allocation.

6 **The country received its first batch of COVID-19 vaccines from the COVAX facility in March 2021. Financing from the World Bank totalling USD 207 million was also provided in the form of a grant for vaccine acquisition. Although additional batches of COVID-19 vaccines are being donated to Ethiopia since then, it is not sufficient to reach the population at large.**

Recommendation: In order to accelerate fair and equitable access to COVID-19 vaccines, additional financing needs to be mobilized to vaccinate the most vulnerable members of the population.

1. INTRODUCTION

Health sector overview

The government of Ethiopia is giving strong attention to the health sector, especially over the past fifteen years. The country's health sector is guided by a health policy and health sector strategic plans which are rolled out and implemented every five years. Ethiopia's health sector is organized in a three-tier health service delivery model. The primary healthcare units are at the bottom of the tier model and composed of health centres and community health posts. At the secondary tier are generalized hospitals, while at the top are specialized hospitals.

The guiding framework for the sector is the Health Sector Transformation Plan (HSTP). The HSTP (2015–2020) places a strong emphasis on the quality and equity of services with the aim of building a high performing health system[1]. It has four major pillars: (i) health service delivery; (ii) quality improvement and assurance; (iii) leadership and governance; and (iv) health system capacity. 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. With the expiration of the HSTP (2015–2020), a new medium-term health sector plan HSTP II (2020/21–2024/25) is developed in 2021 as part of the country's ten-year health sector plan.

[1] Federal Ministry of Health, Annual Health Sector Performance Report, 2019/20.

As one of the four transformation agendas within the HSTP I, **the woreda transformation aims to achieve the objective of enabling everyone to have access to high standard services through well performing woredas and primary healthcare services.** This is to be achieved through building resilient health systems as well as creating high performing woredas, high performing primary health care units (PHCUs) and model kebeles. It also involves ensuring transparency and accountability at the primary healthcare unit level, ensuring financial protection of people in accessing health services and creating effective data utilization for decision making at the woreda level.

Substantial achievements in improving health outcomes were realized through the expansion of primary healthcare services according to the Health Extension Programme (HEP). The HEP is a community-based health programme in Ethiopia that provides access to primary healthcare in rural communities through the transfer to households of knowledge and skills on health. It is aligned with the HSTP in ensuring health service delivery especially to rural areas. Primary healthcare services, such as maternal and child healthcare, tuberculosis, HIV and family planning, among others, are more accessible to communities through the HEP.

As of 2019/20 there were more than 41,000 health extension workers deployed in agrarian, pastoral and urban areas of the country[2]. Introduced in 2003, the HEP is the health sector's primary healthcare delivery platform. It has served as the largest component of the healthcare system in terms of improving community access to healthcare services.

To make the HEP relevant for the changing demographic, epidemiological and socio-economic landscape in the country, a new road map for optimizing the Ethiopian HEP (2020–2035) was launched in March 2021. The roadmap is designed to provide structured guidance to an evolving HEP, address socio-economic changes and respond to epidemiological shifts. It also attempts to address the need to expand essential services and achieve universal health care, improve and sustain the HEP performance and adjust the HEP service delivery model.

Community based health insurance (CBHI) is one of the vehicles used by the government to ensure universal health access to all people, especially the poorest and most vulnerable groups of society. The programme was launched in 2012 as a voluntary health insurance scheme where members pool premium payments into a collective fund and cover basic healthcare costs at local health centres 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 Ethiopian fiscal year (EFY) 2019/20, a total of 743 woredas have started providing healthcare via the CBHI with 6.7 million members enrolled into the programme. The scheme is being implemented in all regions of the country except the Afar and Somali regions.

Box 1: Policy and strategy documents

- 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 Social Protection Action Plan 2017–2021, (2017)
- National Social Protection Strategy 2016-2019, (2016)
- National Nutrition Programme II 2016-2020, which provides for linkages with other sectors
- Health Sector Transformation Plan 2015–2020, which builds on four former Health Sector Development Plans (HSDPs) implemented between 1997/98 and 2014/15
- National Strategy for Newborn and Child Survival in Ethiopia 2015/16-2019/20, (2015)
- 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 Care Financing Strategy 2015–2035
- National Nutrition Strategy (2008)
- National Health Insurance Strategy (2008)
- National Health Policy (1994)
- National Health Accounts (used to monitor the national health care financing strategy)

[2] Federal Ministry of Health, Annual Health Sector Performance Report, 2019/20.

Health sector performance

Health outcomes in Ethiopia have been improving considerably over the years. With the expansion of health facilities in both the rural and urban parts of the country, access to health services has increased. The number of public hospitals, health posts and health centres has increased by nine per cent, eight per cent and 14 per cent in the past five years, respectively. The number of health professionals (doctors, health officers, nurses and midwives) is also increasing over the years. However, the health professional to population ratio is only 1.2 which is lower than the minimum of 2.3 doctor, nurse and midwife per 1000 population ratio needed to ensure coverage of essential health interventions[3] and far behind the sustainable development goal (SDG) composite threshold of 4.5 doctors, nurses and midwives per 1000 population[4]. The physician (general practitioners and specialists) per 1000 population ratio is still very low at 0.1 in 2019/20, much lower than the sub-Saharan average of 0.2 and much lower than the average for lower-middle income countries of 0.7[5].

Table 1: Number of functional health facilities

	2015/16	2019/20
Health posts	16,440	17,975
Health centres	3,547	3,831
Public Hospitals	311	353
Health professional per 1000 individuals in population	0.7	1.2

Source: Ministry of Health.

Infant and under-five child mortality rates and other child health indicators have improved while some indicators are lagging behind (*see Table 2*). Under-five mortality declined from 88 per 1000 population in 2000 to 55 per 1000 in 2019. The percentage of women who gave birth in the presence of a skilled birth attendant 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 health indicators have stagnated. For instance, the neonatal mortality rate has not shown improvement in recent years, stagnating at 30 per 1000 population and the maternal mortality rate is also still high (412 deaths per 100,000 population). Furthermore, the nutritional status of children is still very low with a high percentage of children (37 per cent) being stunted. Only 43 per cent of children between 12 and 23 months of age had received all required vaccinations in 2019.

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.

[3] Ministry of Health (2015). Health Sector Transformation Plan (2015/16-2019/20) retrieved from https://ehia.gov.et/sites/default/files/Resources/HSTP%20Final%20Print%202015-11-27%20Print%20size.pdf
[4] World Health Organization (2016). *Health Workforce Requirements for Universal Health Coverage and the Sustainable Development Goals*. Human Resources for Health Observer Series No 17. Retrieved from https://apps.who.int/iris/bitstream/handle/10665/250330/9789241511407-eng.pdf
[5] https://data.worldbank.org/indicator/SH.MED.PHYS.ZS

Since the discovery of the first case of COVID-19 in the country in March 2020, the number of infections has been increasing considerably and putting additional pressure on the health system. There is widespread community transmission of the virus affecting all parts of the country. In addition to the direct impact of the pandemic, such as increased illness and mortality due to COVID-19, essential health service delivery has been affected due to a shift of resources to the COVID-19 response. The shift of resources, coupled with the community's fear of visiting health facilities, is likely to affect children the most. The other impact on children is related to nutrition. There is also a possible impact on the treatment of moderate and severe wasting and on preventive nutrition services as there could be a shift in the health workers' attention to the COVID-19 response. The health crisis caused by the pandemic has proved that the country needs to build a resilient healthcare system to overcome similar shocks in the future. The government has shown its financial commitment to the health sector response by increasing the budget allocation for the sector in recent years. However, more financial resources, through both domestic resource mobilization and foreign assistance/loan, is needed to build a robust, resilient and sustainable healthcare system in the country.

The ten-year national development plan (2021–30) that was launched in 2020 aims to improve the major impediments in the health sector to bring about an improved human resource development in the country. As it relates to the health sector, the plan aims to build an effective healthcare system based on prevention and control methods, mitigation of maternal and child mortalities, prevention of communicable and non-communicable diseases and protection of citizens from fatal health incidents. The specific targets under the plan include reducing maternal mortality, under-five mortality, stunting, incidence of death due to TB and HIV/AIDS, and anaemia prevalence in women in reproductive age. It also includes the targets of increasing the ratio of primary hospitals per 100,000, as well as increasing community health insurance coverage and average life expectancy.

Table 3: Ten-year development plan targets related to the health sector

Indicators	Baseline	Target
Maternal mortality	401/100,000	140/100,000
Under-5 mortality	59/1,000	25/1,000
Stunting	37%	7%
Incidence of death due to TB	22/100,000	4/100,000
Incidence of death due to HIV/AIDS	1.2/100,000	0.45/100,000
Anaemia prevalence in women in reproductive age	24%	12%
Ratio of primary hospitals per 100,000	0.3	0.85
Community health insurance coverage	49%	95%
Average life expectancy (in years)	65.5	70

Source: Planning and Development Commission, Ten Year Development Plan (2021-2030).

Currently, COVID-19, along with the conflict in northern Ethiopia and displacements in other parts of the country, is putting immense pressure on the healthcare system. There is a high rate of malnutrition among internally displaced persons (IDPs) and crisis affected communities, with little access to primary healthcare services. The multiple burdens on the healthcare system could cause a reversal of the crucial gains in the health sector that were achieved over the last twenty years.

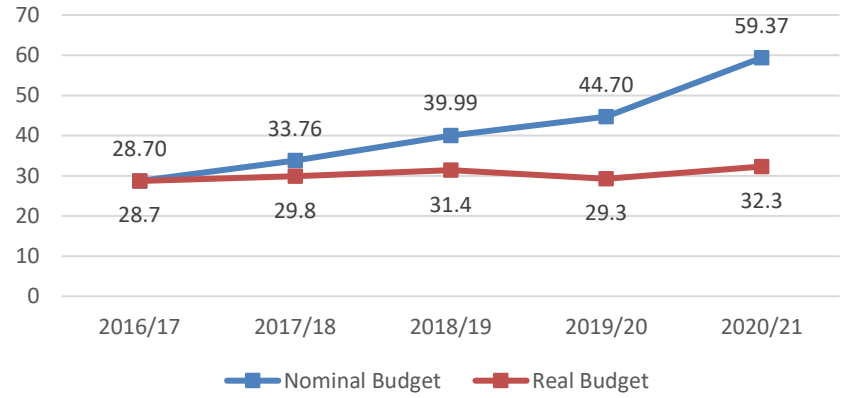
Key Takeaways:

- The ten-year national development plan (2021–30) that was launched in 2020 aims to improve the major impediments in the health sector in order to bring about an improved human resource development in the country. This requires the design and implementation of a medium-term health sector plan to make the national plan actionable.
- High neonatal mortality rate, poor nutritional status of children and low vaccination rates continue to challenge the health sector. Additional burdens from COVID-19, the conflict in northern Ethiopia and displacements in other parts of the country could cause a reversal of the crucial gains in the health sector that were achieved over the last twenty years. This calls for the strengthening of primary healthcare services, with an emphasis on children, and reinforcing of the primary healthcare package.
- The health crisis caused by the COVID-19 pandemic has proved that the country needs to build a resilient healthcare system to overcome similar shocks in the future. More financial resources, through both domestic resource mobilization and foreign assistance/loans, is needed to build a robust, resilient, and sustainable healthcare system in the country.

2. NATIONAL HEALTH BUDGET

The allocation for the health sector has been increasing over the past years. The nominal budget has been increasing at an average rate of 18 per cent between 2016/17 and 2020/21 (*see Figure 1*). However, the greatest increase came in 2020/21 when the budget increased by 32 per cent from its value in 2019/20. This is mainly due to additional financing that is flowing into the sector for the COVID-19 response. In real terms, the increase is 18 per cent. The high inflation rate, especially in the current year, is putting significant pressure on the value of the investment going into the sector.

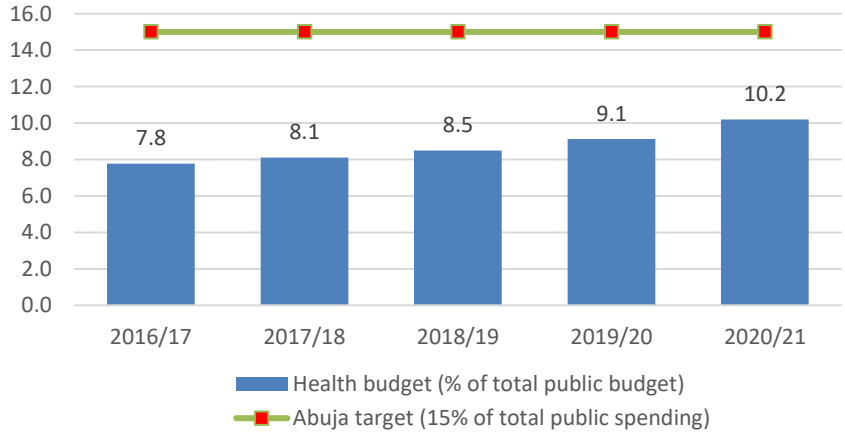
Figure 1: Nominal and real health sector budget (in billion ETB)



Source: Data from Ministry of Finance. (2016/17–2020/21).

The share of government allocation to the health sector has been increasing for the past five years. In 2020/21, the share of government allocation to public health stood at 10.2 per cent, having increased from 7.8 per cent in 2016/17 (*see Figure 2*). The sector ranks third in terms of government allocation priority, next to education and road construction. Although the government is increasing its attention regarding 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).

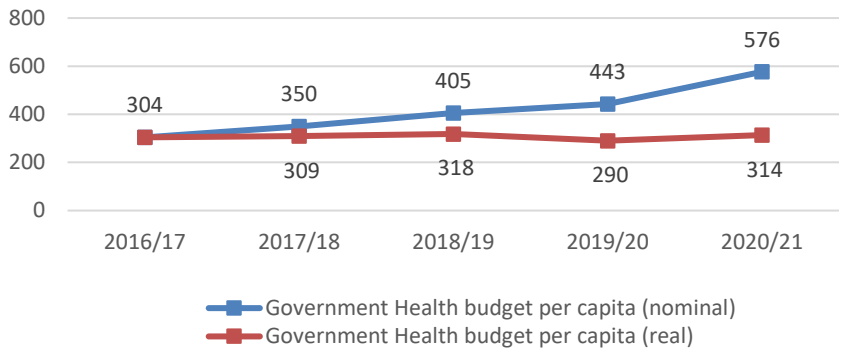
Figure 2: Public health expenditure (percentage share of GDP and total national expenditure)



Source: Data from Ministry of Finance (2016/17-2020/21).

The nominal per capita public health allocation increased from ETB 304 (USD 13.6) in 2016/17 to ETB 576 (USD 16.2) in 2020/21. The highest percentage of annual increase was observed in 2020/21 when the real per capita allocation increased by just eight per cent. However, the increase in inflation rate continues to undermine the growing per capita allocation.

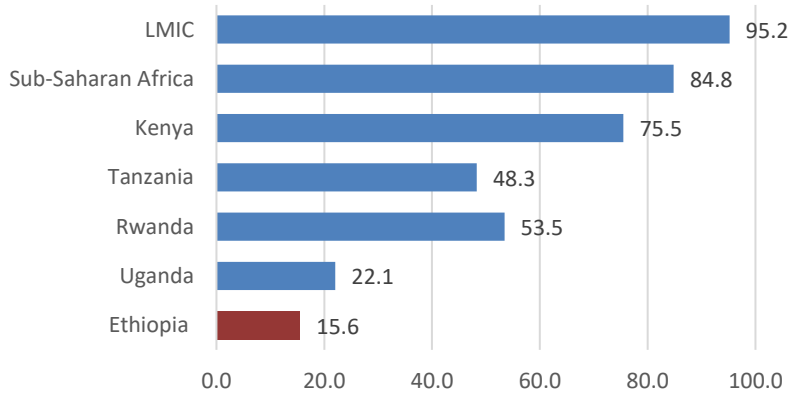
Figure 3: Per capita government health allocation (in ETB)



Source: Data from Ministry of Finance(2016/17–2020/21).

Per capita government expenditure in Ethiopia is much lower than that of other comparable African countries. The average per capita expenditure measured in Purchasing Power Parity (PPP) international dollars, stands at PPP international $15.6, which is lower than that of neighbouring countries and much lower than the sub-Saharan average of PPP international $69.1 (*see Figure 4*). Moreover, the country's per capita government health expenditure is only a fifth 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 to be required for essential healthcare services in low-income countries.

Figure 4: General domestic government health expenditure per capita, in PPP (current international $), 2018



Source: World Bank, 2018[6]

Key Takeaways:

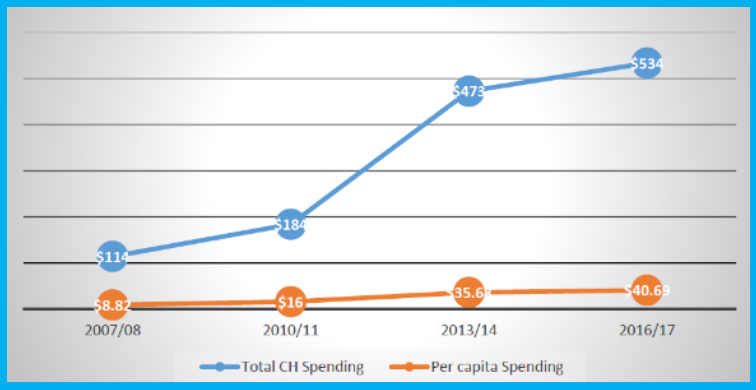
- The budget allocation for the health sector has been increasing. However, the increase is not as high in real terms due to the high level of inflation currently challenging the economy. High priority should be given to control high inflation in order to maintain the real value of public investment in the health sector.
- Although the share of government allocation to the health sector is increasing, it still falls short of the international target of 15 per cent and needs to be increased to build a robust and sustainable healthcare system.

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

Box 2: Child Health Spending in Ethiopia

Although identifying child health spending from government budgets is not a straightforward task and there is no readily available data for this purpose, the results from the 2016/17 National Health Accounts (NHA) present estimates on under-five child health spending in Ethiopia. The under-five child health spending in the NHA includes government spending, household's out-of-pocket payment and financing by donors. Accordingly, the study indicated that in 2016/17 the country spent ETB 12.4 billion (USD 534 million) on under-five child health care, which is a 13 percent nominal increase from 2013/14. The under-five per capita spending also increased form USD 35.7 in 2013/14 to USD 40 in 2016/17.

Figure A: Trends in under-five child health (CH) (in USD millions) and under-five per capita spending (in USD)



Source: Ministry of Health, 2020

Out-of-pocket payment for under-five child health care spending accounted for 53 per cent indicating that households bear the greatest burden of financing under-five child health care. Government spending and funding from external sources accounted for 22 percent and 23 percent of the total under-five child health spending, respectively. The high share of spending being financed through external funds makes the child health spending in the country unsustainable in the event there is a decline of funds from donors. The NHA analysis also indicated that 59 percent of spending on under-five child health care went to child curative care services, while 40 percent went to child preventive care in 2016/17. The spending composition appears not to be in line with the country's overall health policy which gives stronger emphasis on preventive care.

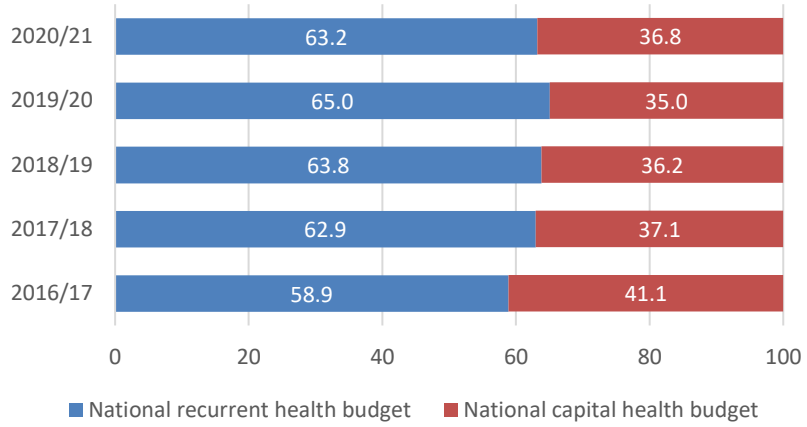
Source: *Ministry of Health, 2020. Child Health Programme Financing. Child health financing in Ethiopia: results from the 2016/17 National Health Account Study.*

Composition of the health sector budget

The composition of government health spending indicates a higher share of allocation on recurrent expenditure compared to capital expenditure. The recurrent budget allocation accounted for 63 per cent of the total expenditure in 2020/21, while the remainder was accounted for capital expenditures (*see Figure 5*). Prior to 2014/15, the government was focused mainly on building health infrastructure that led to a 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 in order to ensure a 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. According to the Ethiopian National Health Accounts, a significant proportion of recurrent resources managed by the government went to preventive care (51 per cent), followed by curative care (32 per cent) and governance of health system finance administration in 2016/17[7].

[7] Federal Ministry of Health (2019). Ethiopia Health Accounts: 2016/17. Addis Ababa, Ethiopia.

Figure 5: Recurrent versus capital public health expenditure (percentage share of total public health expenditure)

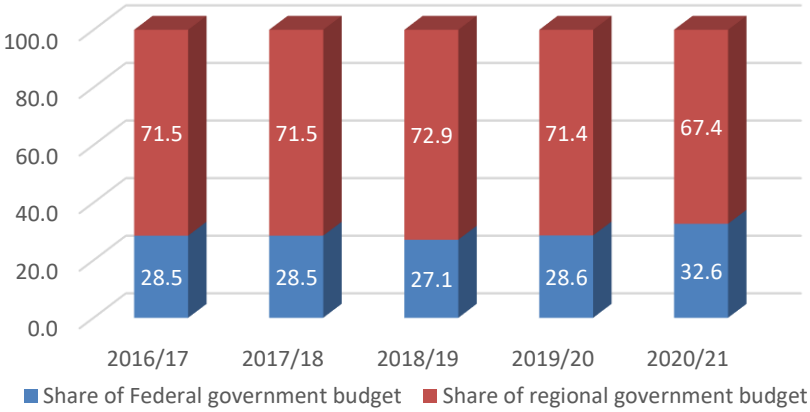


Source: Data from Ministry of Finance (2016/17-2020/21).

Decentralization and health sector budget

In line with devolving fiscal decision-making to lower tiers of administration, an increasing share of the public health budget is allocated by regional governments. Although the share allocated to the regional governments has slightly declined by four percentage points from 2019/20 to 2020/21, the amount allocated to regional governments has increased by 25 per cent in absolute terms, albeit at a much lower rate of increase when compared to the federal budget which increased by 50 per cent (*see Figure 6*). The higher rate of increase in the federal budget could be explained by the higher COVID-19 related expenditure, involving procurement of equipment and drugs which is carried out at the federal level.

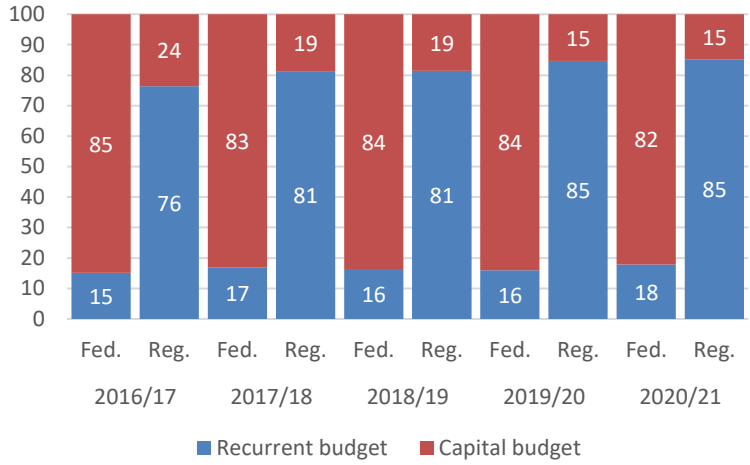
Figure 6: Federal versus regional health budget (percentage share of total health expenditure)



Source: Data from Ministry of Finance (2016/17-2020/21).

Eighty-two per cent of the federal level budget allocation goes to capital expenditure while only 15 per cent is allocated for capital investments at the regional level in 2020/21 (*see Figure 7*). The federal government is mainly tasked with building health infrastructure throughout the country and purchasing machinery and medical and transport equipment. The recurrent expenditure at the federal level is very minimal, pertaining to tertiary level staff hiring and operational expenditure for service delivery. On the other hand, recurrent expenditure accounted for 85 per cent of the regional spending in 2020/21. This leaves little for regional governments to invest in capital equipment for health facilities in their respective regions. The amount of resources left for health-related investments is close to non-existent at the woreda level, with almost all of the budget allocated for covering salary expenses. Often, the budget is not even enough for covering the operational costs involved in the day-to-day administration of health facilities.

Figure 7: Composition of health budget at federal and regional levels (percentage share)

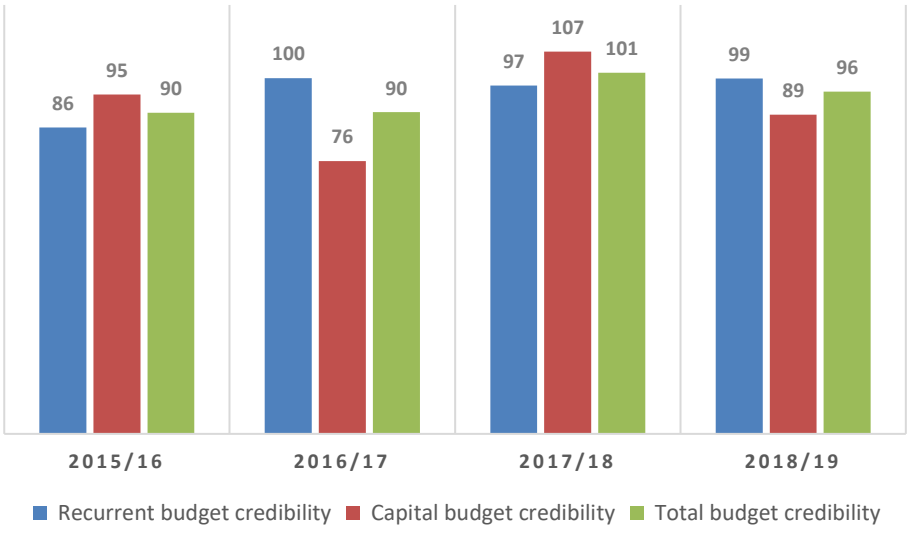


Source: Data from Ministry of Finance (2016/17-2020/21).

National health budget credibility

The national health budget credibility indicates that the health sector budget is credible, with actual expenditure straying off the original budget by only four per cent in 2018/19. When assessing the budget components, a relatively higher level of discrepancy is observed in the capital budget. The recurrent budget credibility is almost 100 per cent in 2018/19 (*see Figure 8*). The relatively better budget credibility of recurrent expenditure is mainly due to recurrent expenses being spent on salary and operational costs which are better accounted for at the beginning of the year. With regards to capital expenditure, the formation of capital in the health sector is highly donor dependent. This makes the planning process rather unpredictable as all donor commitments may not be obtained at the beginning of the year. Another reason is the shortage of foreign currency, especially in recent years, resulting in a lower level of spending as most capital investments require hard currency.

Figure 8: National capital and recurrent health budget credibility (health expenditure as a percentage of the health budget)



Source: Data from Ministry of Finance (2015/16-2020/21).

Key Takeaways:

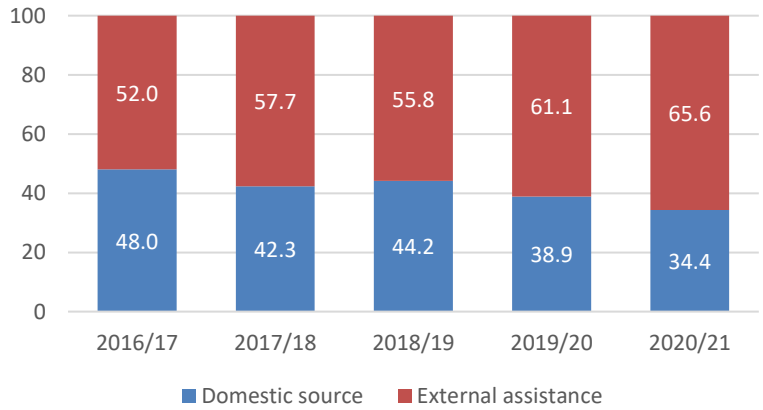
- A higher share of government allocation to the health sector goes into recurrent spending. The share of capital expenditure available for sub-national regions is very low with the majority of resources available at lower levels of government being used to cover salaries and leaving very little capital resource for improved service delivery.
- The share of the health budget allocated to regional governments has slightly declined between 2019/20 and 2020/21 (though the amount allocated has increased in absolute terms), mainly due to the increase in federal budget needed to cover COVID-19 related expenditure involving the procurement of equipment and drugs which is carried out at the federal level. The increase in financial resources for the COVID-19 response should come from new financing sources and not by taking resources away from other health programmes.

3. HEALTH SECTOR FINANCING

Ethiopia's health sector financing has three major sources: the state budget, private sector investments and household contributions, and external funds from bilateral and multilateral donors. **Although the state budget includes capital funds from donors, a sizable portion of external financing to the health sector is directed through off-budget channels.** According to the Ethiopia Health Accounts[8], government contribution to total health expenditure was 32 per cent in 2016/17, while donor financing and households' out-of-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[9].

In 2020/21, 66 per cent of the health sector's capital budget is planned to be financed by external assistance. The resource for capital budget allocation for the health sector has increased from ETB 15.6 billion in 2019/20 to 21.8 billion in 2020/21 (*see Figure 9*). The share of external assistance has also increased by four percentage points between 2019/20 to 2020/21. Compared to other sectors, the health sector is largely financed by external grants from multilateral organizations, bilateral governments and other philanthropic organizations. This is particularly the case with the budget for 2020/21, where the share of external assistance was the highest at 66 per cent. Part of the reason is an increased budget for the COVID-19 response which is mainly financed by donors.

Figure 9: Sources of funds for national capital health budget (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 strategy includes targets such as the need to increase financing from domestic sources, allow fee exemption for key services and reduce out-of-pocket

[8] Federal Ministry of Health (2019). Ethiopia Health Accounts: 2016/17. Addis Ababa. Ethiopia.
[9] ibid.

(OOP) expenditure through health insurance schemes. Ethiopia's national health care financing strategy also has the objective of increasing financial resources for healthcare services. The strategy directs resource mobilization for the health sector from various sources, including the government, development partners and households, and requires swift implementation in order to see results in the short and medium-term.

Enhanced private sector contributions and specific initiatives aiming to strengthen the collection and utilization 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 the treasury) at local public health facilities, with the aim of improving the quality of healthcare 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 healthcare 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.

The recently launched HEP optimization roadmap is estimated to cost USD 12.6 billion over the 15 year implementation period. The total cost of implementation includes costs of human resources, infrastructure, medicine and medical supplies as well as health system costs. The roadmap indicates a financing gap ranging from 28 to 53 per cent in the first five years for the different scenarios, with an expected decline in the subsequent periods of the programme. The financing gap is expected to be reconciled through the introduction of innovative financing mechanisms, including the introduction of user fees at health centres and mobilization of resources through prepayment schemes such as the CBHI. Such recommendations should, however, be given further consideration as they could further increase out-of-pocket expenditures which are already high and burdensome on poorer households. Recent developments, particularly related to the COVID-19 pandemic and the conflict in the country, will result in a surge in financing needs requiring additional financing.

Key Takeaways:

- The sector's capital expenditure is financed mainly through external assistance. Given a low domestic resource mobilization performance, it seems that the sector will remain dependent on foreign financing for service delivery, at least in the short run. However, sustainability of health financing should be a priority in the medium- and long-term.
- Ethiopia has endorsed a national health care financing strategy (2015–2035) with the objective of increasing financial resources for healthcare services through increased financing from domestic resources. It also includes fee exemption for key services and reduction of OOP expenditure through health insurance schemes which requires a strong follow-up for implementation.
- The recently launched HEP optimization roadmap indicates a financing gap ranging from 28 to 53 per cent. A specific plan that addresses this gap should be outlined to ensure the successful implementation of the roadmap.

4. KEY POLICY ISSUES

- **As it currently stands, the 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 using line-item budgeting. This calls for the reform of the chart of accounts and budget templates in order to make sure health programmes are identifiable in the budget and expenditure data. This will allow for better tracking and monitoring in order to measure and advocate for increased investment in specific programmes.

- **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 in order to better plan, execute and monitor how much is being spent on healthcare services.

- **With almost three million children being added to the population every year, immunization and child-related health and nutrition expenditures are increasing significantly.** Currently, the financing of immunization and other health commodities is heavily dependent on donors, making the sustainability of health commodity financing a major concern. The government's allocation for health expenditure needs to improve further through increased domestic resource mobilization.

- **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 and personal out-of-pocket healthcare costs that are burdening poorer households.

- **The current COVID-19 related crisis is putting additional pressure on the health system.** This highlights the need for more commitment to increasing investment in the health sector in the short-, medium- and long-term through further increases in public budget allocation.

Annex 1: Ethiopia national health sector on-budget records 2016/17–2020/21

Gregorian calendar fiscal year	2016/17	2017/18	2018/19	2019/20	2020/21
Ethiopian fiscal year	**2009**	**2010**	**2011**	**2012**	**2013**
Population (in million)	94.40	96.50	98.67	100.83	103.00
GDP at current market price (in million ETB)	1,806,656	2,202,373	2,696,223		
General inflation rate (CPI growth rate)	7.20	13.10	12.6	19.9	20.4
Exchange rate (period-weighted average)	22.40	26.10	28.1	31.20	35.47
Budget (in ETB million)					
Total National Budget	**369,704.23**	**416,120.77**	**471,195.85**	**490,325.67**	**582,257.93**
Total national recurrent budget	192,634.16	227,108.00	273,441.91	271,054.19	323,934.98
Total national capital budget	177,070.07	189,012.78	197,753.94	219,271.48	258,322.94
Total national health budget	**28,704.17**	**33,757.44**	**39,988.24**	**44,697.47**	**59,369.33**
Total national recurrent health budget	16,898.52	21,249.00	25,517.31	29,071.12	37,521.03
Total national capital health budget	11,805.65	12,508.44	14,470.93	15,626.35	21,848.30
Total federal government health budget	8,188.56	9,626.72	10,842.72	12,785.68	19,377.46
Federal government recurrent health budget	1,236.44	1,629.03	1,780.00	2,044.60	3,463.33
Federal government capital health budget	6,952.12	7,997.69	9,062.72	10741.08	15914.13
Total regional government health budget	20,515.61	24,130.71	29,145.53	31,911.79	39,991.86
Regional government recurrent health budget	15,662.08	19,619.97	23,737.31	27,026.52	34,057.70
Regional government capital health budget	4,853.53	4,510.75	5,408.22	4,885.27	5,934.16
Source of funds for national government capital health budget (in ETB million)					
Domestic source	5,669.37	5,289.59	6,398.79	6,073.60	7,512.25
External assistance	6,136.28	7,215.69	8,069.00	9,549.60	14,332.58
External loan	0.00	3.16	3.15	3.15	4.15
National government health original budget and actual expenditure (in ETB million)					
National recurrent health budget and expenditure:					
Original budget	16,898.52	21,249.00	25,517.31		
Actual spending	16,821.30	20,714.80	25,362.52		
National capital health budget and expenditure:					
Original budget	11,805.65	12,508.44	14,470.93		
Actual spending	9,007.00	13,381.10	12,927.77		
National total health budget and expenditure:					
Original budget	28,704.17	33,757.44	39,988.24		
Actual spending	25,828.20	34,095.90	38,290.29		

Source: Data from Ministry of Finance (2016/17-2020/21).

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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 (BoH) and district-level Woreda Health Offices. The report was reviewed by Bob Muchabaiwa from the Regional Office. UNICEF's work on Public Finance for Children is undertaken under the leadership of Samson Muradzikwa. Coordination with the MoH and the wider health sector is facilitated by Yejimmawork Ayalew.

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