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**ETHIOPIA**



# Health Investments within a Constrained Economy

**2021/22**



# KEY MESSAGES

1

**Budget allocation to the health sector has been increasing at an average rate of 18 per cent 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 and increased efficiency in spending.

2

**Although the share of government allocation to the health sector is increasing, reaching 10 per cent in 2021/22, it is still below the 15 per cent spending target of the Abuja Declaration. According to the National Health Survey, the government is covering only 32 per cent of the total health expenditure, while 34 per cent is being covered by donors and 31 per cent from out-of-pocket expenditure.**

Recommendation: The government should continue to progressively increase its allocation to the health sector to meet the 15 per cent spending target. This will alleviate the high donor dependency, as well as high out-of-pocket expenditure. The latter is much higher than the 15 per cent maximum that the WHO recommends when accessing health care services to avoid impoverishment and catastrophe.

3

**A high proportion of donor funds directed to the health sector are off-budget and therefore not easy to accurately quantify.**

Recommendation: 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 put in place a system for systematically documenting off-budget contributions from development partners.

4

**The second Health Sector Transformation Plan (HSTP-II) provides a costed plan for the health sector under different scenarios. The costed plan indicates a financing gap, as the sector is aiming towards reducing the share of out-of-pocket expenditure and external assistance from total health expenditure.**

Recommendation: Implementation of the HSTP-II, along with looking for ways to fill the funding gap through improved efficiency of spending, exploring innovative financing, and implementation of the Health Care Financing Strategy, should be given due attention in both the short and medium terms.

5

**The conflict in northern Ethiopia has negatively affected the delivery of basic health services in Tigray, Amhara and Afar regions. In total, 3,214 health facilities have been completely or partially destroyed, making access to health services impossible for children and the general population in these regions. Malnutrition is also on the rise due to conflict and drought. This is expected to reverse some of the positive gains the sector had achieved in recent decades.**

Recommendation: The government should swiftly mobilize resources to ensure health facilities continue to deliver services and the gains that were achieved in recent decades will not be further compromised.

# 1. INTRODUCTION

## Health sector overview

**The government of Ethiopia is giving the health sector special attention, as the sector has a direct contribution to human capital development.** 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 health care units are at the first tier of the health service and are composed of health posts, health centres and primary hospitals. One health centre is connected to five satellite health posts and provides services to approximately 25,000 people, while primary hospitals offer inpatient and ambulatory services to about 100,000 people. Under the second tier of health care are general hospitals that serve as referral centres for primary hospitals and serve an average of 1 million people. They also serve as training centres for health officers, nurses and emergency surgeons. At the third tier are specialized hospitals, which provides service populations of around 5 million, and serve as referral centres for general hospitals.

**The country is currently implementing the second Health Sector Transformation Plan (HSTP-II) from 2020/21 to 2024/25.** The sector implemented the first Health Sector Transformation Plan (HSTP I) from 2015/16 to 2019/20. HSTP-II aims to incorporate the lessons from HSTP-I and build on its success. Its overall objective is "to improve the health status of the population by accelerating progress towards universal health coverage, protecting populations during health emergencies, transforming woredas, and improving the health system's responsiveness"<sup>1</sup> To achieve this objective, five priority issues are identified for implementation to transform the health system: 1) quality and equity; 2) information revolution; 3) motivated, competent, and compassionate health workforce; 4) health financing; and 5) leadership. Under the health financing pillar, the main priority is reforming public financial management and health financing to improve efficiency and accountability of health spending, while ensuring sustainable domestic resource mobilization for the sector.

**At the heart of primary health care in Ethiopia is the Health Extension Program (HEP).** Introduced in 2003, HEP is the health sector's primary health care delivery platform. It has served as the largest component of the health care system in terms of

improving community access to health care services. It provides a package of primary health care services for family health, disease prevention, hygiene, and environmental sanitation. It is aligned with HSTP in ensuring primary health service delivery, especially to rural areas. Primary health care services, such as maternal and child healthcare, tuberculosis, HIV and family planning, among others, are more accessible to communities through HEP. A new roadmap for optimizing 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 performance, and adjust the service delivery model.

**Community-based health insurance (CBHI) is a vehicle 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. The scheme is one avenue that can be used to transition the country away from donor assistance for health towards domestic resource mobilization. Since its implementation, it has helped to improve access to health services, mobilize community resources, provide financial protection, and empower women.<sup>2</sup> HSTP-II plans to enrol 80 per cent of eligible households into the scheme by 2024/25.

**Public-private partnerships (PPPs) are one of the engagement platforms for enhancing private engagement in health.** At the federal level, there is policy and strategic framework to guide the implementation of PPPs in the health sector. The objective of PPPs is to improve engagement of the private sector with the public health sector and thereby improve the quality of public health services by promoting and facilitating the implementation of privately financed projects. However, this engagement modality with the private sector is new to the health sector, with only few projects in the pipeline.

<sup>1</sup> Ministry of Health. (2021). Health Sector Transformation Plan II: 2020/21–2024/25. Addis Ababa, Ethiopia.

<sup>2</sup> 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. <https://doi.org/10.1186/s12913-022-07889-4>

### Box 1: Policy and strategy documents

- Health Sector Transformation Plan 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 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 (HCFS) 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 (2021–2030))

## Health sector performance

The recent conflict in northern Ethiopia, and the spread of the conflict to Amhara and Afar, has resulted in the destruction of health facilities. Prior to these intensified conflicts, the expansion of health facilities in both the rural and urban parts of the country had resulted in increased access to health services. However, the recent conflict has resulted in the complete or partial destruction of many health facilities in these regions.

Health facilities were also affected in Oromia and Benishangul-Gumuz due to internal conflicts. According to the Ministry of Health, a total of 652 health centres, 42 hospitals and 2,710 health posts have been damaged in Amhara, Afar, Oromia and Benishangul-Gumuz regions as of February 2022. As a result, the provision of basic health services, including primary health care services, immunization, nutrition interventions, as well both preventive and curative hospital services, has been hampered.

**Table 1:**

Number of damaged health facilities due to conflicts

**Data:**

Data from Ministry of Health (2022)

Region	Health centre	Hospital	Health post	Total
Tigray	153	28	514	695
Amhara	472	40	1,832	2,344
Afar	69	2	105	176
Oromia	106	0	683	789
Benishangul-Gumuz	5	0	90	95
Total	805	70	3,224	4,099

**Although the number of health care workers has been increasing over the last decade, it is not adequate given the high population in the country.**

The ratio of health professionals (doctors, nurses, and midwives) to the population is only 1.16 per 1,000,<sup>3</sup> which is lower than the sustainable development goal (SDG)<sup>4</sup> composite threshold ratio of 4.45 needed to ensure coverage of essential health interventions. The HSTP-II target is 2.3 per 1,000 population. The physician (general practitioners and specialists) per 1,000 population ratio is still very low at 0.1 in 2019/20, lower than the sub-Saharan average of 0.2 and much lower than the average for lower-middle-income countries of 0.7.<sup>5</sup>

**In recent years, various health outcome indicators have improved.**

For instance, births attended by skilled health workers increased from 28 per cent in 2016 to 50 per cent in 2019. The under-5 mortality rate reduced from 67 to 55 per 100,000 live births and infant mortality declined from 48 to 43 deaths per 100,000 live births between 2016 and 2019. Despite these progresses, mortality and morbidity rates associated with maternal and child health conditions remain high. Prevention of neonatal mortality has been less successful, with the neonatal mortality rate showing no improvement in recent years, stagnating at 30 per 1,000 between 2016 and 2019.

The nutritional status of children also remains very low, with a high proportion of stunted children (37 per cent). This is concerning, as malnutrition is a major contributor to child mortality. Furthermore, only 43 per cent of children between 12 and 23 months of age had received all required vaccinations in 2019.

**The conflict in northern Ethiopia is likely to result in the regression in health and nutrition indicators.**

COVID-19, along with the conflict in northern Ethiopia and displacements in other parts of the country, has put immense pressure on the health care system. The drought that is affecting more than 8 million people in Somali, Oromia, SNNP and Southwest region is also contributing to poor nutritional outcomes. There is a high rate of malnutrition among internally displaced persons (IDPs) and crisis-affected communities, with little access to primary health care services. The multiple burdens on the health care system could cause a reversal of the crucial gains in the health sector that were achieved over the last 20 years. The health and nutrition outcome indicators are not updated for current years as the Demographic Health Survey (DHS) could not be conducted in 2020/21. Hence, the impact of the conflicts and droughts is not yet fully known.

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 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

**Table 2:**

Selected health and nutrition outcome indicators

**Source:**

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

<sup>3</sup> Ministry of Health. (2021). Annual Performance Report: 2020/21. Ethiopia.

<sup>4</sup> 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>

<sup>5</sup> <https://data.worldbank.org/indicator/SH.MED.PHYS.ZS>

**Source:**

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

Key indicators	2011	2016	2019
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

**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.** In 2020/21, the COVID-19 pandemic continued to put pressure on the health system in Ethiopia. There was 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, has affected children the most. To overcome the impact of the pandemic, the government increased its allocation to the health sector in 2020/21. As it currently stands, the sector is highly dependent on donor financing. With the pandemic affecting the whole world and negatively impacting the economies of donor countries, the need to build sustainable financing for the sector with increased domestic resource mobilization has become imperative. Hence, one of the prominent lessons from the pandemic is the need to build a resilient and sustainable health care system that is equipped to respond to similar public health shocks.

**The number of woredas providing health care through CBHI has increased from 743 in 2019/20 to 834 in 2020/21.** This number does not include Tigray, as a status report is not available for 2020/21. In these woredas, around 8.7 million households are enrolled into CBHI, of which 7 million are paying members, while 1.7 million are indigents who receive a subsidy from the government.<sup>6</sup> In the woredas that are providing CBHI, around 61 per cent of eligible households are enrolled in the programme. Although membership in the scheme is increasing, the target set by the sector to have 80 per cent of eligible households into the programme by 2020 did not materialize. A study by Biset et al. (2022) showed that household willingness is an important determinant for the implementation of the programme.<sup>7</sup> Low household willingness could lead to low CBHI utilization and high dropout rates, making it difficult to achieve the HSTP-II target. Building the capacity of the Ethiopian Health Insurance Agency (EHIA), the institution that is responsible for managing the CBHI and conducting social mobilization and awareness-creation activities, should be given due focus.<sup>8</sup>

6 Ministry of Health. (2021). Annual Performance Report: 2020/21. Ethiopia.

7 Biset W. G., Tadesse A. W., and Ambaye G. Y. (2022). Willingness to Join Community-based Health Insurance among Households in South Wollo, Northeast Ethiopia: A Community-based Cross-sectional Study. PLoS ONE 17(2): e0261642. <https://doi.org/10.1371/journal.pone.0261642>

8 Ministry of Health (2021). Annual Performance Report: 2020/21. Ethiopia.

## Key takeaways

- The country is currently implementing the second Health Sector Transformation Plan (HSTP-II) from 2020/21 to 2024/25, which is fully costed. Under the health financing pillar, the main priority is reforming public financial management and health financing to improve efficiency and accountability of health spending, while ensuring sustainable domestic resource mobilization for the sector.
- The high neonatal mortality rate, poor nutritional status of children and low vaccination rates continue to challenge the health sector. The recent multiple shocks may result in the worsening of these health outcomes. The government should swiftly mobilize resources to ensure health facilities continue to deliver services so that the gains that were achieved in the past are not reversed.
- Conflict in the country has left numerous health facilities damaged and unable to provide health services to the population. In addition to the conflicts, the recent drought and increased internal displacements are leading to deteriorating health and nutrition outcomes. The multiple burdens on the health care system could cause a reversal of the crucial gains in the health sector that were achieved over the past 20 years
- 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 health care system in the country.

## 2. NATIONAL HEALTH BUDGET

Ethiopia's total health sector expenditure is financed by 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 allocated for the health sector for the periods under consideration.

**Government budget allocation to the health sector has been increasing over the years.** The nominal budget has been increasing at an average

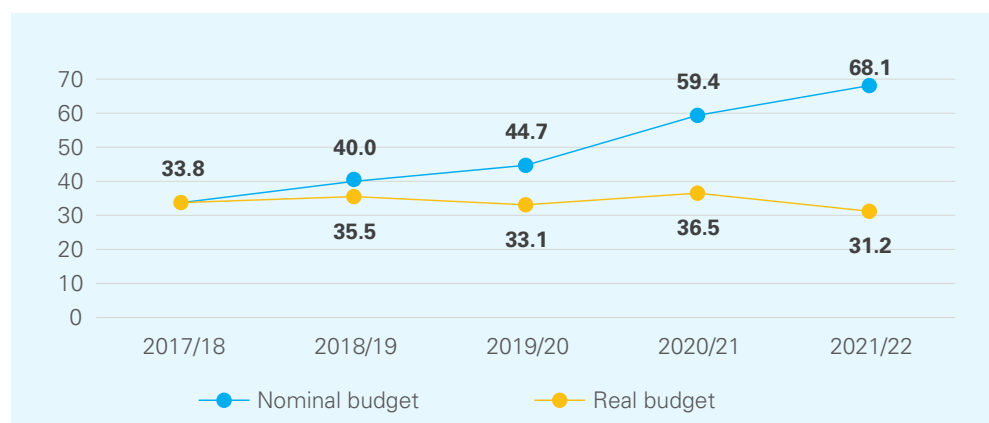
rate of 19 per cent between 2017/18 and 2021/22 (Figure 1). It increased by 14.6 per cent in 2021/22 compared to 2020/21. There was a significant increase in government budget after 2019/20, mainly to meet the COVID-19 response. However, in real terms, the budget declined by 14.5 per cent between 2020/21 and 2021/22. The high inflation rate, projected at 34.5 per cent for 2022,<sup>9</sup> is putting significant pressure on the value of government budget allocation and undermining the level of investment that is going into the sector.

**Figure 1:**

Nominal and real health sector budget (in billion ETB)

**Source:**

Data from Ministry of Finance (2017/18–2021/22)



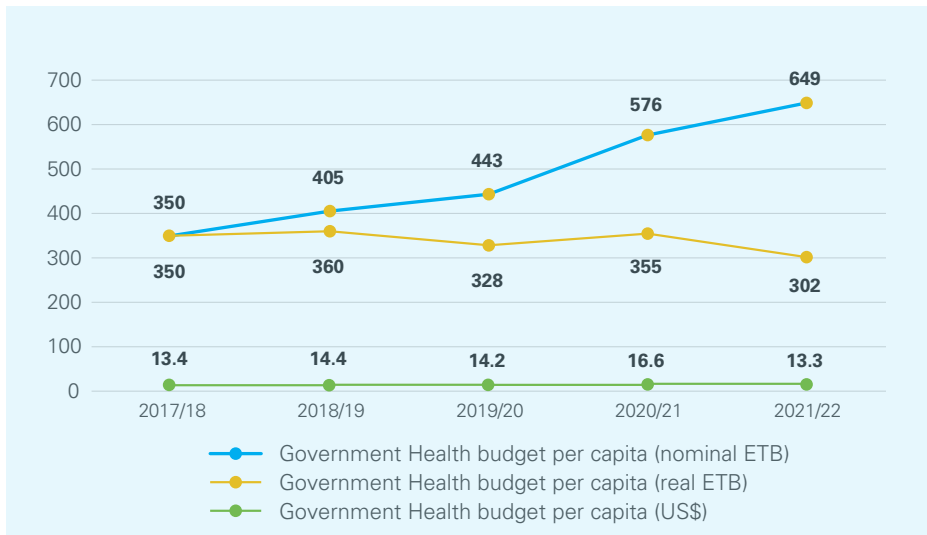
**Nominal per capita government budget has also increased between 2017/18 and 2021/22.** It increased from ETB 350 in 2016/17 to ETB 649 in 2021/22 (Figure 2). However, in US\$ terms, the per capita allocation has not improved much. This is due to the depreciation of the Ethiopian Birr in recent years.<sup>10</sup> The real value of the per capita budget has also declined significantly due to high inflation. This indicates increasing budget allocations can lead to improvement in real value of investment only when

the overall macro environment of the economy is stable. The high inflation rate, along with shortage of foreign currency, which is resulting in the depreciation of the ETB, will continue to undermine the growing government budget allocation. The effect of the foreign currency crunch is particularly significant for the health sector, as most health commodities, such as medicines and vaccines, as well as medical equipment, are imported using hard currency.

<sup>9</sup> International Monetary Fund, 2022. *World Economic Outlook: War Sets Back the Global Recovery*. Washington, DC, April.

<sup>10</sup> The exchange rate used for 2021/22 is US\$1=ETB 48.6, which is the average exchange rate from July 2021 to April 2022.





**Figure 2:**

Per capita government health allocation

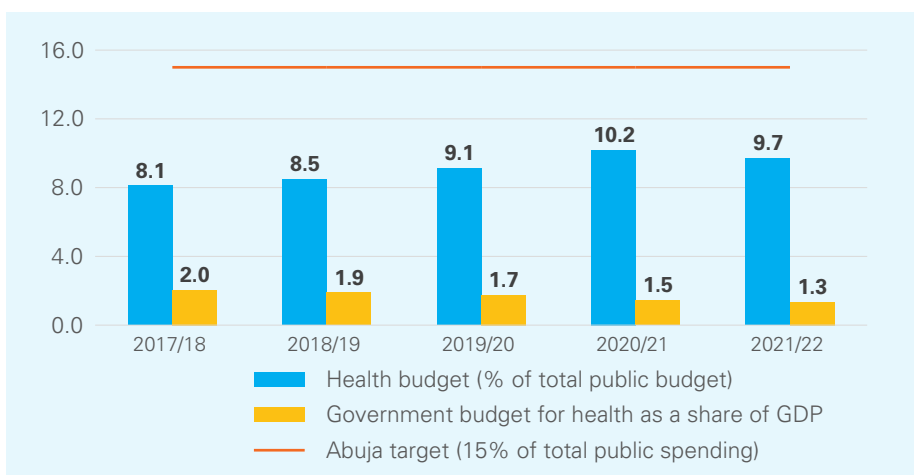
**Source:**

Data from Ministry of Finance (2017/18–2021/2022)

**The share of health spending as a 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.<sup>11</sup> 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.

The sector ranks third in terms of government allocation priority, next to education and road construction. Although the government is increasing its allocation 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). When considering the share of government budget for health to GDP, it is only 1.3 per cent and declining over time. Of course, this is only reflective of what the government is spending on health from its public budget and does not represent the total spending on health, which includes donor support (a portion which is not captured by the budget), private sector investment, and out-of-pocket expenditure (OOP). The government budget is around a third of the total health expenditure and hence the total health expenditure as a share of GDP is around 3.24 per cent.<sup>12</sup>

**The share of government budget allocation to the health sector has been increasing for the past five years.** In 2021/22, the share of government allocation to public health stood at 9.7 per cent, having increased from 8.1 per cent in 2017/18 (Figure3).



**Figure 3:**

Public health budget (percentage share of total national budget)

**Source:**

Data from Ministry of Finance (2017/18–2021/22)

<sup>11</sup> <https://data.worldbank.org/indicator/SH.XPD.GHED.PP.CD?locations=ET>  
<sup>12</sup> Ibid.

## Key takeaways

- The budget allocation for the health sector has been increasing. However, in real terms, the budget is declining and thus undermining the level of investment that is going to the sector. The government should prioritize stabilizing the rate inflation to ensure the value of investment to health and other sectors is not compromised.
- Although the share of government budget going to the health sector is increasing over time, the proportion of spending is lower than the Abuja target of 15 per cent. Increasing the proportion of allocation, along with improvements in internal efficiency, should be given due attention to ensure health care services are adequately provided.

### Box 2: Summary of selected key findings from the eighth Ethiopia National Health Accounts (2019/20)

According to the eighth round of the Ethiopia National Health Account (ENHA) data analysis, Ethiopia's estimated total health expenditure (THE) was ETB 127.47 billion (US\$3.63 billion) in 2019/20. Compared to 2016/17 (the seventh round NHA), it has increased by 76 per cent in nominal terms, while the increase was only 16 per cent in real terms. The per capita health expenditure, including COVID-19 spending, was US\$36.40 in 2019/20 (Figure A), which is much lower than the WHO-recommended US\$86 per capita spending for the delivery of essential health services.

The health sector has multiple financing sources, including the government treasury, bilateral and multilateral donors, household out-of-pocket expenditure, CBHI (voluntary prepayment), and private employers. Data from previous rounds of the NHA on the contribution of financing sources to the health sector indicate an increasing share of government treasury, from 16 per cent in 2010/11 to 32 per cent in 2019/20 (FigureB)

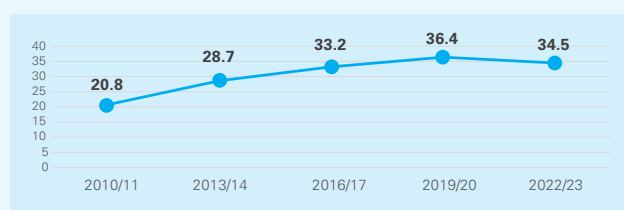
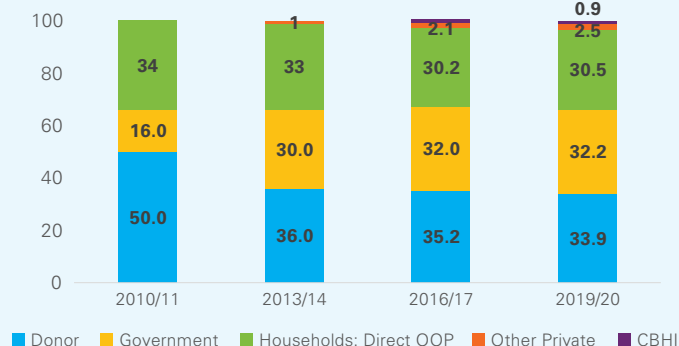


Figure A: Per capita health expenditure (in US\$)

On the other hand, the share of donor contribution has slightly declined, from 35.2 per cent in 2010/11 to 33.9 per cent in 2019/20. Household contributions or out-of-pocket (OOP) contributions remained at about 30 per cent in 2019/20. The contribution of private employers and others was minimal, at 2.5 per cent, while CBHI's contribution was only 0.9 per cent. Given the relatively low government expenditure, OOP contributions play a significant role in financing health in Ethiopia. The share of OOP as a proportion of total health expenditure is higher than the global average of 21 per cent and the WHO-suggested 15 per cent to avoid impoverishment and financial catastrophe due to accessing health care services.

**Box 2:**



**Figure B:** Total health expenditure by source of financing  
**Source:** Ministry of Health. (2022). Ethiopia National Health Accounts Report 2019/20. April 2022. Ethiopia

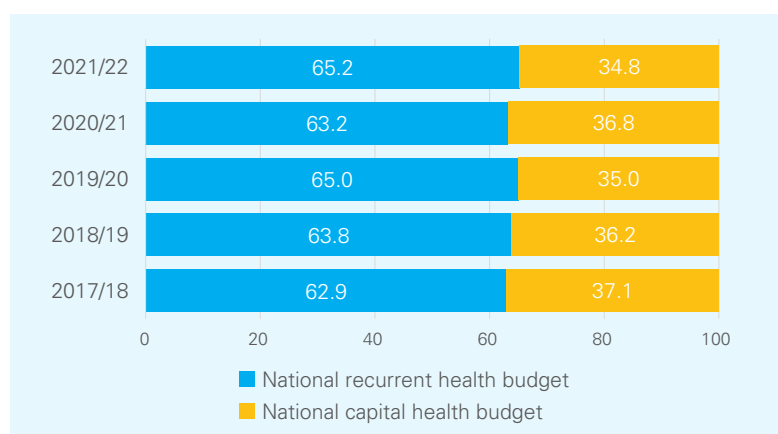
In terms of spending by the different levels of health service providers, the highest share of spending went to health centres and health posts (30 per cent), followed by government health administration (20 per cent). The total expenditure to primary health care units (health posts, health centres and primary hospitals) was 44 per cent of total health expenditure, while the share of spending on general and tertiary public hospitals was 10.7 per cent. As indicated in the health sector strategy, the focus on primary health care delivery units is well reflected in the expenditure allocation.

## 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 65 per cent of the total expenditure in 2021/22 (Figure 4). 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 shifted, with more allocation on recurrent expenditure. This is to be expected, as newly established health facilities require a sustained operational cost financing 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, more than half of the government’s recurrent expenditure (56 per cent) goes to curative care. The share of preventive care, which was 30 per cent in 2016/17, declined to 19 per cent in 2019/2020, while the share of spending on governance and health system and financing administration almost doubled, from over 10% in 2016/17 to 20% in 2019/2020.<sup>13</sup> The decline in the share of preventive care is contrary to the country’s health policy, which puts more emphasis on preventive care at primary health care units.



**Figure 4:**

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

**Source:**

Data from Ministry of Finance (2017/18–2021/22)

<sup>13</sup> Ministry of Health. (2022). Ethiopia National Health Accounts Report 2019/20. April 2022. Ethiopia.



## Decentralization and health sector budget

**In line with devolving fiscal structure, an increasing share of public health budget is allocated by regional governments.** The share of budget allocated by regional governments is 70 per cent in 2021/22 (Figure 5). Health budget allocation by regions is much higher because much of the health expenditure at the lower tier of health service delivery is covered by regional governments. However, when considering the composition of the budget, 77 per cent of the federal-level budget allocation goes to capital expenditure while only 17 per cent is allocated for capital investments at the regional level in 2021/22 (Figure 6). The federal government is mainly tasked with building health infrastructure throughout the country and purchasing

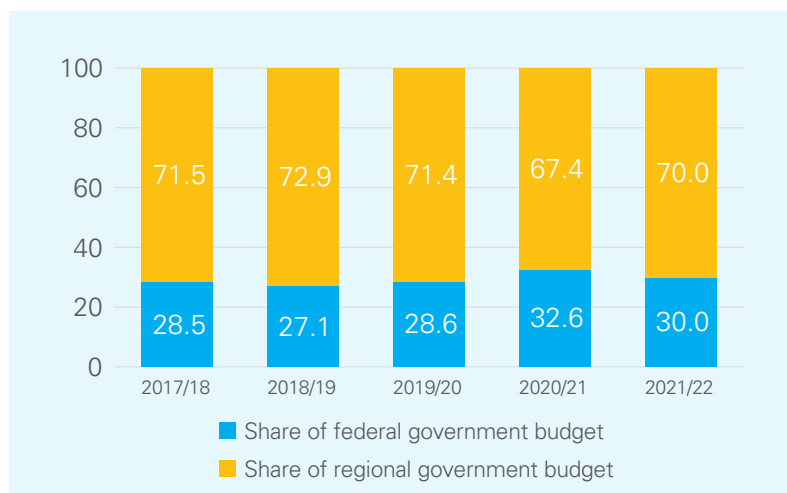
machinery and medical and transport equipment. The recurrent expenditure at the federal level is very minimal, pertaining to tertiary-level staff hiring and operational expenditure for service delivery. On the other hand, recurrent expenditure accounted for 83 per cent of the regional spending in 2021/22. This leaves little for regional governments to invest in capital equipment for health facilities in their respective regions. The resources left for health-related investments is close to non-existent at the woreda level, with almost all of the budget allocated to cover salary expenses. Often, the budget is not even enough to cover the operational costs involved in the day-to-day administration of health facilities.

**Figure 5:**

Share of federal and regional government budgets

**Source:**

Data from Ministry of Finance (2017/18–2021/22)

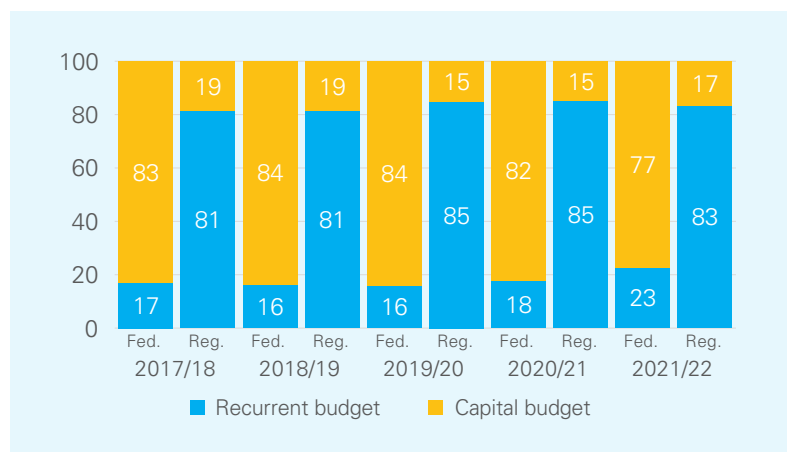


**Figure 6:**

Share of recurrent and capital allocations for federal and regional budgets

**Source:**

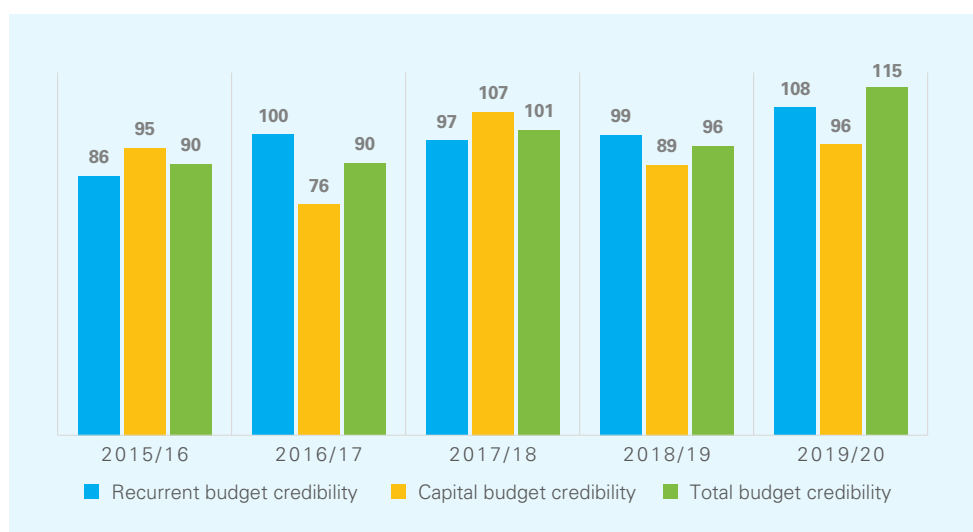
Data from Ministry of Finance (2017/18–2021/22)



## 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 8 per cent in 2019/20. When assessing the budget components, a relatively higher level of discrepancy is observed in the recurrent budget.

The capital budget credibility is 96 per cent, with a 4 per cent underspend in 2019/20 (Figure 7). The capital budget improvement has improved from its value of 89 per cent in 2018/19. On the other hand, there was a 15 per cent overspend with the recurrent budget.



**Figure 7:**

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

**Source:**

Data from Ministry of Finance (2015/16–2019/20)

### Note:

Actual expenditure data is presented based on Ministry of Finance's (MoF) Government Accounts data available until 2018/19 (2019). The next best estimate MoF data is used for 2019/20 (2020), as MoF's Government Accounts actual expenditure data is not yet available.

### 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 most resources available at lower levels of government being used to cover salaries and leaving very little capital resource for improved service delivery.
- Health budget allocation by regions is much higher because much of the health expenditure at the lower tier of health service delivery is covered by regional governments. However, when considering the composition of the budget, 77 per cent of the federal-level budget allocation goes to capital expenditure while only 17 per cent is allocated for capital investments at the regional level in 2021/22. The budget for the lower tier of government administration does not go far beyond covering salary costs. There needs to be earmarked budget at regional and woreda levels that is specifically available for capital investment.

### 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 National Health Accounts Report 2019/20,<sup>14</sup> government contribution to total health expenditure was 32.2 per cent in 2019/20, while donor financing and households’ out-of-pocket expenditure accounted for 33.9 per cent and 30 per cent of the total health expenditure, respectively. The share of private employers and other sources accounted for only around 2.5% of the total health expenditure. 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 15 per cent threshold suggested by WHO to minimize financial catastrophe and impoverishment due to accessing health care services.

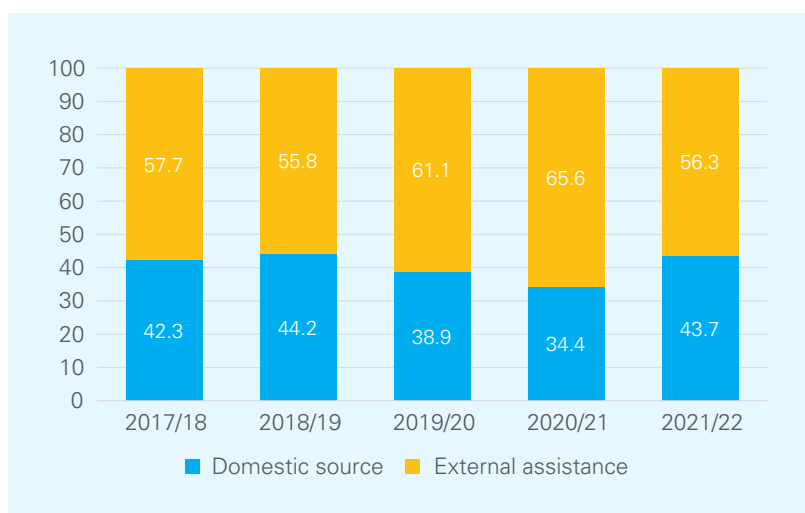
**In 2021/22, 56 per cent of the health sector’s capital budget is planned to be financed by external assistance** (Figure 8). The resource for capital budget allocation for the health sector has increased from ETB 21.8 billion in 2019/20 to ETB 23.7 billion in 2021/22, showing an 8 per cent increase. When compared to the previous fiscal year (2020/21), the share of domestic resources has increased by 9 percentage points, while the share of external assistance has declined in 2021/22. 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, mainly due to an increased budget for the COVID-19 response, largely financed by donors. The increase in the share of domestic financing for 2021/22 is encouraging, as it shows an increased commitment to move towards a more sustainable financing source for the sector.

**Figure 8:**

Sources of funds for national capital health budget (in ETB billion)

**Source:**

Data from Ministry of Finance (2017/18–2021/22)



**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 (OOP) expenditure through health insurance schemes. Ethiopia’s Health Care Financing Strategy

(HCFS) also 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, and requires swift implementation in order to see results in the short and medium term.

<sup>14</sup> Ministry of Health (2022). Ethiopia National Health Accounts Report 2019/20. April 2022. Ethiopia.



**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 health care services. The 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.

**The recently launched HEP optimization roadmap is estimated to cost US\$12.6 billion over the 15-year implementation period.**

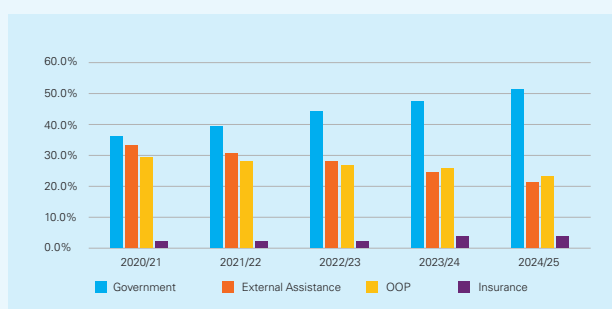
The total cost of implementation includes costs of human resources, infrastructure, medicine, and medical supplies, as well as health system costs. The roadmap indicates a financing gap ranging from 28 to 53 per cent in the first five years for the different scenarios, with an expected decline in the 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 require additional financing.

**Box 2: Costing HSTP-II**

HSTP-II has cost estimates for the five years of its implementation. The estimates are for base-case and high-case scenarios depending on the targets for impact, outcome indicators and input assumptions. Accordingly, it estimates the cost of implementation over the five years to be US\$21.9 billion based on the base-case scenario, and US\$27.6 billion based on the high-case scenario. For the base-case scenario, 50 per cent of the cost is to be used for the procurement of medicine and medical equipment, 19 per cent for human resources, 13 per cent for health infrastructure (including construction, rehabilitation, and maintenance of health facilities) and 8 per cent for health service programme management cost. The remaining 11 per cent is allocated for health care financing, health information systems, regulatory, and governance. In terms of composition of the cost, 94 per cent of the estimated cost is allocated to recurrent expenditure, while only 6.4 per cent is for capital expenditure. The cost estimated by service delivery levels indicates 58.8 per cent is allocated to primary health care-level interventions (household/community level, health posts, health centres and primary hospitals), 31 per cent to secondary and tertiary levels of care at general and specialized hospitals. The remaining cost is allocated for national and sub-national level program support such as for trainings, workshops, and supportive supervision.

The costing analysis indicates maintaining the existing health achievements and improving poor performance areas requires increased public health expenditure, as external financing is likely to decline in the future. As it currently stands, the Ethiopian health system is highly dependent on donor assistance and without sufficient preparation to increase domestic financing, the health care system will deteriorate if external assistance declines. The Ethiopia HCFS includes innovative financing options to bridge the funding gap and ensure sustainable financing. It outlines the potential of innovative financing options for health resource mobilization, such as airline levies, sin-taxes, airtime levies, private contributions (complemented by corporate social responsibilities), mobilization of more philanthropists and public-private partnerships.

The total resource forecast considers various sources of finance to the health sector: low-, medium- and high-case scenarios. The medium-case scenario projection assumes the share of government health expenditure from general expenditure to increase from 8 per cent to 10 per cent in five years. It also assumes that the government will cover half of the expenditure, while out-of-pocket expenditure will moderately decline due to increased CBHI coverage and social health insurance (SHI). External assistance is assumed to moderately decline as the Ministry of Health has a plan to increase mobilization of resources both from domestic sources and external assistance.



**Source:** Ministry of Health (2021) Health Sector Transformation Plan II: 2020/21–2024/25

The cost of HSTP-II, under all scenarios, will result in a funding gap. The resource deficit is due to the sector's initiatives to reduce the OOP share from total expenditure from 31 per cent to 20 per cent and the share of external assistance from 35 per cent to 20 per cent in 10 years. The projections indicate that higher resources will only be available if the government reprioritizes health and increases the share of health expenditure from total government expenditure. By 2024/25, under the medium-case scenario, the current rate of 8 per cent will need to be increased to 10 per cent if external assistance decreases to 25% of total health expenditure; and under the high-case scenario, the rate will need to increase to 12 per cent if external assistance decreases to 30 per cent of total health expenditure.

## Key takeaways

- The sector's capital expenditure is financed mainly through external assistance. Given the low domestic resource mobilization performance, it appears that the sector will remain dependent on foreign financing for service delivery, at least in the short run. However, the sustainability of health financing should be a priority in the medium and long term.
- Ethiopia has endorsed the 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 a 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 expenditure.** 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 3 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, in both 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 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 2017/18–2021/22

Gregorian calendar fiscal year	2017/18	2018/19	2019/20	2020/21	2021/22
Ethiopian fiscal year	2010	2011	2012	2013	2014
Population (in million)	96.50	98.67	100.83	103.00	105.17
GDP at current market price (in million ETB)	2,202,373	2,696,223	3,374,349	4,341,387	
General inflation rate (CPI growth rate)	13.10	12.6	19.9	20.40	34.5*
Exchange rate (period weighted average)	26.10	28.1	31.20	39.02	48.60**
<b>Budget (in million ETB)</b>					
<b>Total national budget</b>	<b>416,120.78</b>	<b>471,195.85</b>	<b>490,325.67</b>	<b>582,257.92</b>	<b>705,030.48</b>
Total national recurrent budget	227,108.00	273,441.91	271,054.19	323,934.98	395,112.63
Total national capital budget	189,012.78	197,753.94	219,271.48	258,322.94	309,917.85
<b>Total national health budget</b>	<b>33,757.44</b>	<b>39,988.24</b>	<b>44,697.47</b>	<b>59,369.33</b>	<b>68,115.48</b>
National recurrent health budget	21,249.00	25,517.31	29,071.12	37,521.03	44,423.55
National capital health budget	12,508.44	14,470.93	15,626.35	21,848.30	23,691.93
<b>Total federal government health budget</b>	<b>9,626.72</b>	<b>10,842.72</b>	<b>12,785.68</b>	<b>19,377.46</b>	<b>20,429.41</b>
Federal recurrent health budget	1,629.03	1,780.00	2,044.60	3,463.33	4,636.11
Federal capital health budget	7,997.69	9,062.72	10,741.08	15,914.13	15,793.30
<b>Total regional government health budget</b>	<b>24,130.72</b>	<b>29,145.53</b>	<b>31,911.79</b>	<b>39,991.86</b>	<b>47,686.07</b>
Regional recurrent health budget	19,619.97	23,737.31	27,026.52	34,057.70	39,787.44
Regional capital health budget	4,510.75	5,408.22	4,885.27	5,934.16	7,898.63
<b>Source of finance for national government capital health budget (in million ETB)</b>					
Domestic source	5,289.59	6,398.79	6,073.60	7,512.25	10,362.56
External assistance	7,215.69	8,069.00	9,549.60	14,332.58	13,325.90
External loan	3.16	3.15	3.15	4.15	3.47

## Source:

Data from Ministry of Finance (2017/18–2021/22)

## Note:

\* Inflation forecast for 2021/22 is taken from: IMF. (2022). World Economic Outlook: War Sets Back the Global Recovery, Washington, DC, April.

\*\* The exchange rate used for 2021/22 is US\$ 1=ETB 48.6, which is the average exchange rate from July 2021 to April 2022





This national-level health budget brief was produced by Fanaye Tadesse Techane [ftechane@unicef.org](mailto:ftechane@unicef.org) with guidance and contributions provided by Zeleka Paulos [zpaulos@unicef.org](mailto: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 Public Finance for Children is undertaken under the leadership of Samson Muradzikwa.

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