



Federal Democratic
Republic of Ethiopia
Ministry of Health

ETHIOPIA HEALTH ACCOUNTS, 2013/2014

Addis Ababa, August 2017

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FOREWORD

Ethiopia successfully implemented four consecutive Health Sector Development Programs (HSDP) between 1997 and 2015. The most recent of these was HSDP-IV, covering the period 2010/11–2014/15. These health sector programs have been an integral part of the country's development plans. HSDP-IV was also the health sector component of the first Growth and Transformation Plan (GTP-I). Recently, Ethiopia endorsed the Health Sector Transformation Plan (2015/16–2019/20), part of GTP-II (2015/16–2019/20). Ethiopia proudly achieved most of the health-related targets of the Millennium Development Goals. The country has endorsed the United Nations Sustainable Development Goals and is committed to achieve those targets.

Ethiopia has continued to invest in health, focusing on primary health care services that have been scientifically proven to yield high health returns. For example, the Health Extension Program that Ethiopia introduced in the last decade is a bold and innovative initiative to promote primary health care. This very successful flagship program for the health sector has been instrumental in empowering and making communities, households, and individuals the owners of and major players in their own health.

Resources have also been committed and used to expand training, deployment, and retention of key health professionals such as medical doctors, midwives, and nurses in accordance with the Ministry of Health's human resource development strategy. In addition to strengthening the health workforce, the government has continued investing heavily in expanding health infrastructure. In recent years, the government continued construction and operationalization of health posts, health centers, and primary hospitals.

The focus of the health care financing strategy is to generate more resources from all sources to ensure priority and scientifically proven high-impact health interventions. The government has promoted increasing domestic financing for the health sector by increasing its own health budget and providing financial protection to citizens through health insurance with the aim of ensuring both sustainability and equity in health care financing. Based on encouraging results of Community-Based Health Insurance (CBHI) in 13 pilot woredas between 2011 and 2013, the government scaled up CBHI to over 350 woredas, covering over one-fourth of the country's woredas (districts) and about 13 percent of the population. The ministry plans to expand CBHI to 80 percent of woredas and 80 percent of the population by 2020.

The health sector generates and uses evidence on the magnitude and flow of health sector resources using the Health Accounts (HA) methodology. The current sixth round of HA charted Ethiopia's steady progress in increasing health expenditure and expanding understanding of where investments are made. The findings of this HA study provides critical information that the Ministry of Health and partners can use to jointly assess sector performance. This round of HA will be invaluable for examining health expenditures of HSDP IV and will serve as a baseline for the HSTP. The findings will also enable us to clearly see how, where, and for what purposes the health sector funds were spent during the study year. In addition to information on overall health sector expenditure, findings on priority diseases and program areas – HIV/AIDS, Maternal and Child Health, Malaria, Tuberculosis, Nutrition, Non-communicable Diseases, etc. – provide more specific and in-depth information on how resources flow in each of these areas. This report also shows that the burden of out-of-pocket spending is still significant – underlining the need and importance of health insurance.

The Ministry of Health has used the findings of the multiple HA studies to gauge expenditure trends, helping to redirect investments, harmonize efforts with development partners, and foster private sector engagement and contributions to the health sector. Cognizant of HA's importance, the ministry is working to institutionalize the exercise.

The successful completion of this HA study would not have been possible without the committed efforts and vital contributions of a wide range of stakeholders. Special thanks go to all partners who were actively engaged in the process and particularly to the United States Agency for International Development (USAID) and the Bill and Melinda Gates Foundation (BMGF). The technical leadership role played by the Health Accounts Technical Working Group is also highly appreciated.

Finally, I would like to take this opportunity to encourage Ministry of Health directorates and teams, Regional Health Bureaus, other health sector agencies, and the wider stakeholder community to use the evidence contained here in their planning and policy decision processes.

A handwritten signature in black ink, consisting of a large, stylized 'Y' followed by a horizontal line and a vertical line extending downwards.

Professor Yifru Berhan

Minister

Federal Democratic Republic of Ethiopia Ministry of Health

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ACRONYMS AND GLOSSARY

Acronyms

CBHI	Community-based Health Insurance
FMOH	Federal Ministry of Health
GDP	Gross Domestic Product
HA	Health Accounts
HAPT	Health Accounts Production Tool
HAD	Health Development Army
HEP	Health Extension Program
HSDP	Health Sector Development Program
HSTP	Health Sector Transformation Plan
MOFEC	Ministry of Finance and Economic Cooperation
NGO	Nongovernmental Organization
PLHIV	People Living with HIV
SHA	System of Health Accounts
SHI	Social Health Insurance
STD	Sexually Transmitted Disease
THE	Total Health Expenditure
USAID	United States Agency for International Development
WHO	World Health Organization

Glossary

Ancillary services to medical care: These are specialized services such as laboratory tests, diagnosis imaging, and patient transport performed mainly by paramedical or medical technical personnel, with or without the direct supervision of a medical doctor.

Beneficiary Characteristics: the groups that consume, or benefit from, the health care goods and services. Beneficiaries can be grouped in several ways such as disease, gender and age classifications.

Curative Care: Curative care starts with the onset of disease and encompasses health care during which the “principal intent is to relieve symptoms of illness or injury, to reduce the severity of an illness or injury, or to protect against exacerbation and/or complication of an illness and/or injury that could threaten life or normal function” (OECD et al. 2011). It includes inpatient, outpatient, home-based, and day curative care¹. This is expenditure on outpatient and inpatient health services whose principal intent is to relieve symptoms of illness or injury, to reduce the severity of an illness

¹ Across each of these types, it also includes general and specialized curative care.

or injury, or to protect against exacerbation and/or complication of an illness and/or injury that could threaten life or normal function.

Double-Counting: Identification and management of instances when two data sources cover the same health spending. And the rule of thumb is entities/agents closer to the actual consumption of health care services are likely to have more precise information about actual health spending than those a bit far from actual consumption of services. This implies taking spending reported by financing agents than by financing sources.

Financing schemes (HF): The main funding mechanisms by which people obtain health services. Financing schemes categorizes spending according to criteria such as: mode of participation in the scheme (compulsory vs voluntary), the basis for entitlements (contributory vs non-contributory), the method for fund-raising (taxes/compulsory pre-payments vs voluntary payments) and the extent of risk pooling.

Financing agents (FA): These are institutional units that manage health financing schemes. These may include Ministry of Health, insurance companies, NGOs and international organizations.

Factors of Provision (FP): the inputs to the production of health care goods and services by health care providers, such as compensation of employees, health care goods and services and non-health care goods and services.

Financing sources: Institutions or entities that are original sources of resources (funds) that are used in the health system and are managed by (channeled through) financing agents.

Financing agents: Institutions or entities that manage (channel) the funds from financing sources and use those funds to pay for, or purchase, the activities and commodities that are delivered by health services providers within the health accounts boundaries.

General health administration and insurance: Activities of private insurers and central and local authorities, and social security, including the planning, management, policy, regulation, and collection of funds and handling of claims of the health care delivery system.

Gross capital formation: Gross capital formation on health is measured as the total value of assets that providers have acquired during the estimation year and that are used for longer than one year in the provision of health services.

HAPT: A software developed by the WHO and USAID that facilitates the planning and production of Health Accounts. It automates several previously time-consuming procedures like repeat mapping, and incorporates automatic quality checks. Its advantage also lies in providing a repository for HA data and HA tables for future use.

Health care providers (HP): Organizations and actors who provide medical goods and services as their main activity, such as hospitals, health centers, clinics, pharmacies.

Health care functions (HC): The goods and services consumed by end-users. These may include curative care, information, education, and counseling programs, medical goods/pharmaceuticals, and governance and health system administration.

Health care-related functions: Functions related to availing of the health infrastructure, sanitation and water supply programs, research and surveys. These functions include capital formation by health care provider institutions, medical doctors, nurses and other health professionals' pre-service training, health-related research, and nutritional and environmental programs. Often these functions overlap with sectors such as education, overall "social" expenditure, research and development, and infrastructure.

Health expenditures: Expenditures made in the health sector within a defined period (usually one fiscal year) for production of goods and services consumed/used within the period.

Health functions: Health functions are the goods and services produced and used in the specific period (fiscal year) with the primary purpose of restoring, improving, and/or maintaining the health status of individual citizens and the public at large.

Health providers: Entities that receive money in exchange for or in anticipation of producing the goods and services for improving and maintaining health status of individuals and/or the general public. This includes providers of health promotion, preventive and curative health.

Inpatient Care Boundary: Inpatient care involves a formal admission to a health care facility that involves an overnight stay after admission.

Medical diagnostic labs: Comprise establishments that are primarily engaged in providing analytic or diagnostic services directly to outpatients. These institutions may include the Ethiopian Public Health Institute (EPHI) and regional laboratories. These laboratories also provide higher-level diagnostic services for individual patients referred by health facilities when such diagnoses are beyond the capacity of facility laboratory.

National Health Expenditure (NHE): The sum of current health spending, gross capital formation and health care related spending.

Not specified in kind: Activities or transactions that fall within the boundaries of the health accounts but which cannot be definitely allocated to a specific category because of insufficient documentation.

Other institutions providing health-related services: Other entities that provide health care services such as traditional healers, medicine sellers, and religious institutions/leaders.

Outpatient Care Boundary: Outpatient care is delivered from the health care providers' premises but does not involve a formal admission to a health care facility.

Parastatal enterprise: Parastatal/state owned organizations, as defined by the HA exercise, are entities that are at least 50 % owned by the government. These are enterprises or companies fully or partially owned by the government. The major parastatal enterprises include Ethiopian Airlines, Ethio-telecom, Ethiopian Electric Power Corporation, and Commercial Bank of Ethiopia.

Per capita expenditure: Expenditure per person. Computed by dividing the total expenditure by the total population or the population group for which the spending is intended.

Pharmaceuticals: Mainly focused on drugs and medical supplies that are obtained from independent (standalone) drug retail outlets (private and public pharmacies or drug stores). In case of inpatient and outpatient care services, pharmaceuticals/medical goods are not usually identified separately due to aggregation problems and considered as part of inpatient and outpatient curative care expenditures.

Pharmacies: Comprise establishments that are primarily engaged in the retail sale of medicinal preparations which are compounded or prepared and dispensed or sold to the public.

Prevention: Prevention interventions start with an individual in a healthy condition and the aim is to enhance health status and to maintain a condition of low risk of diseases, disorders or injuries. Preventive interventions also cover individuals at specific risk and those who have either no symptoms of the disease or early signs or symptoms, where early case detection will assist in reducing the potential damage by enabling a more successful intervention² (OECD et al. 2011).

Public health programs: Services designed to enhance the health status of the population, in contrast to curative services. These services are provided outside of health facilities that provide outpatient and inpatient health care services. Typically, this includes preventive health programs implemented by government agencies and non-government organizations, health promotion and sensitization programs, and campaigns to promote use of specific health care services.

² Take the examples of breast and prostate cancer, where age and sex affect the risk; certain lifestyle choices increase the risks, as smoking does for lung cancer.

Providers of occupational health: According to SHA 2011, occupational health comprises a wide variety of health services such as surveillance of employee health (routine medical check-ups) and therapeutic care (including emergency health care services) on or off business premises (including government and NPISH). And this item is referring to such providers which are engaged in the provision of such health services.

Providers of health care system administration and financing: This item comprises establishments that are primarily engaged in the regulation of the activities of agencies that provide health care and in the overall administration of the health care sector, including the administration of health financing.

Rest of the economy: According to the SHA 2011 providers' classifications, these entities basically include households as providers of home health care and all other industries as secondary providers of health care. In addition, this category also includes those establishments that are outside the health care provider universe but specialized in health-related activities such as:

i) long-term care (social) and ii) health promotion with a multi-sectoral approach.

Rest of the world (ROW): All international/foreign-based institutions that play a role in the financing and/or transactions of resources in the country's health system. The ROW includes bilateral and multilateral donors and international NGOs.

Revenues of financing schemes (FS): These are types of revenues received or collected by financing schemes. Examples include: transfers from the Ministry of Finance and Economic Cooperation to governmental agencies, direct foreign financial transfers (e.g. external donors providing funds to NGOs); and voluntary prepayment from employers.

Total Health Expenditure (THE): The sum of current health spending and gross capital formation.

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EXECUTIVE SUMMARY

Health Accounts tracks total health expenditure flows of a health system from financing sources to purposes of spending and end users, for a given time period. Ethiopia's sixth round of Health Accounts covered fiscal year 2013/14 (July 8, 2013 through July 7, 2014). This was the first time that Ethiopia conducted a Health Accounts exercise using the World Health Organization's (WHO's) Systems of Health Accounts 2011 framework.

This Health Accounts exercise, like its predecessors, aimed to answer the following specific policy questions regarding Ethiopia's health care sector: What is the magnitude of health financing and how much was spent on per capita basis? Who finances health sector? Where do government resources go in the health sector? How are health care funds managed and distributed? Who are the health service providers and how much is spent at each level of the health system? For what purposes are these resources used? Which diseases and health conditions does Ethiopia spend on? What is the burden of financing on households? What is the role of the private sector in health?

Methods

Health expenditure data were collected from the Ministry of Finance and Economic Cooperation, 26 universities, 38 bilateral and multilateral donors, samples of 236 nongovernmental organizations (NGOs) (129 international and 107 local), 331 employers (33 parastatals and 298 private), 17 insurance companies, and 5 line ministries; in addition, a general health care utilization and expenditure survey collected data from 10,000 households and a survey of people living with HIV collected utilization and expenditure data from 4,200 citizens clinically diagnosed as HIV positive. All collected data were entered and analyzed in the Health Accounts Production Tool (HAPT) software, which was developed by the WHO and USAID's Health System 20/20 project.

Findings

The exercise estimated total health expenditure in Ethiopia in 2013/14 at 49.6 billion Ethiopian Birr, representing 4.73 percent of gross domestic product (GDP). Over 86 percent of the spending was on recurrent expenditures (delivery of health services, provision of health commodities and supplies, and operationalization of the health system), 10 percent was on capital formation, and 3 percent on training and research. While Ethiopia's per capita health expenditure on essential health services is very low compared with peer countries and WHO's recommendation of US\$60 (by year 2015), it has grown significantly over the past two decades, from US\$4.5 in 1995/96 to of US\$28.65 in 2013/14. The share of domestic health financing has increased from 50 percent to 64 percent (30 percent from government, 33 percent from households, and 1 percent from private employers and others) in the same period. The share of spending by "the rest of the world" (bilateral and multilateral donors, and private philanthropists) has fallen from 50 percent in 2010/11 to 36 percent in 2013/14. The government manages the largest proportion of health spending, although its share has declined slightly, from 48.9 percent in 2010/11 to 44 percent in 2013/14; the second largest manager is households, at 33 percent. Households spend – and thus manage – most of their funds directly at providers; there is no significant pooling of household resources in the form of health insurance. NGOs manage close to one-fifth of the resource (19 percent). Donors, insurance entities, and the private sector play a lesser role, each managing only 2 percent of spending.

Regarding health service provision, 36 percent of the spending occurs at the level of health centers, clinics, and health posts, and 28 percent at hospitals. Providers of preventive health care and providers that were not identified each accounts for 11 percent of the total spending. The share of spending going to health administration is low (4 percent), and spending on training and research institutions, on the rest of the economy (sectors other than health), and on independent pharmacies each accounts for 3 percent of the total spending. Thirty-four percent of total government spending on health goes to health centers and health posts and 32 percent goes to hospitals. Health administration accounts for 13 percent of the government spending, and training and research institutions for 13 percent. The balance went to providers of preventive care services (7 percent) and others (1 percent).

Looking at what health funding is spent on, curative health care services account for almost half (49 percent) of total spending, of which 45 percent goes to for outpatient services and 4 percent to inpatient care; preventive care services account for 28 percent. Capital formation together with training and research account for 13 percent. The remaining 10 percent is spent on health governance and administration (5 percent), medical goods (3 percent), and ancillary services (2 percent).

By type of disease, the significant share of spending (49 percent) goes to prevention, management, and treatment of infectious and parasitic diseases, of which nearly one-tenth (10 percent) goes to HIV/AIDS, malaria to 9 percent, 2 percent to tuberculosis, and 7 percent to vaccine-preventable diseases; 20 percent goes to all other infections. Nutritional deficiencies, non-communicable diseases, and reproductive health services account for 13 percent, 12 percent, and 9 percent of the total spending, respectively.

Major policy implications and recommendations

Increase the magnitude and per capita spending on health with emphasis on domestic financing: Ethiopia needs to continue increasing spending significantly with emphasis on domestic health financing so that it will be able to adequately provide essential health services to all citizens. Spending levels should be closer to resource needs and to the globally recommended amount and regional commitment.

Expand financial protection to reduce the financial burden that health spending imposes on households and to increase health service utilization by citizens: Ethiopia needs to expedite its effort to expand financial protection through the various health insurance programs, mainly the community-based health insurance (CBHI) program, to provide financial protection for citizens in the small farming/ rural economy and informal sector in urban settings.

Provide financial protection for the poor and needy segments of the population: The country needs to expand coverage of the poor through the fee waiver system and expand financial protection through health insurance so that households can access health care without incurring an undue financial burden. Equally important is to strengthen the exemption system so that services that have public health nature can be provided for free to all.

Institutionalize health accounts and regular generation of evidence for policy decision making: More than ever before, the Federal Ministry of Health owned and led this round of health accounts. Establishment and operationalization of the Health Economics and Financing Analysis (HEFA) Case team was instrumental for this development. However, the HEFA team is new and has limited capacity; it needs to be strengthened so that it can generate health accounts data routinely. The HEFA team also needs to conduct other research related to health care financing, efficiency, and effectiveness, and further analysis to help evidence-based health financing policy decision making. Finally, health accounts also need to be a financed mandate with budget code in the government's chart of accounts.

I. INTRODUCTION

In a rapidly changing health care environment, policymakers need reliable national information on the sources and use of funds for health to enhance health system performance. Health Accounts (HA) estimations provide such information. HA is an internationally recognized methodology used to track expenditures in a health system for a specified period of time. It summarizes in table form different aspects of countries' health expenditure.

1.1 Background

Ethiopia is the most populous country in Eastern Africa and second most populous in all of Africa. Projections from the 2007 population and housing census estimated the total population in fiscal year 2013/14 to be 87,952,991 (CSA 2010). During the first Growth and Transformation (GTP I) period (2010/11–2014/15), Ethiopia achieved significant economic and social progress. Real gross domestic product (GDP) has grown at an average annual rate of 10.8 percent since 2004/05 (ADB 2011). As a result, Ethiopia is among the few countries in sub-Saharan Africa to achieve nearly all Millennium Development Goals, including all health targets: it reduced under-five mortality by two-thirds by 2012, made significant progress in reducing the maternal mortality ratio (MMR) by implementing low-cost, high-impact interventions; and reduced malaria incidence by 50 percent between 2000 and 2012.³ New HIV infections have dropped by 90 percent and adult mortality has been cut by more than 50 percent. Besides, Ethiopia is one of the few sub-Saharan African countries with a “rapid decline” in mother-to-child transmission of HIV, with a reduction by 50 percent of new HIV infections among children between 2009 and 2012. Similarly the country has achieved the targets set for tuberculosis prevention and control. Mortality from and prevalence of tuberculosis has declined by more than 50 percent and the incidence rate has fallen significantly (FMOH 2015). To ensure healthy lives and promote well-being for all ages (Sustainable Development Goal 3) and achieve the goals different targets by 2030, the country has designed different strategies for the health sector.

The 20-year National Health Sector Development Program (HSDP), implemented in four five-year plans, began in 1997 and was successfully completed in 2015. Implementation of the Health Sector Transformation Plan (HSTP) began in 2015/16, with ambitious goals to improve equity, coverage, and utilization of essential health services; improve quality of health care; and enhance the implementation capacity of the health sector at all levels of the system (FMOH 2015).

³ https://www.google.com.et/?gws_rd=cr,ssl&ei=bM-JVPbbPIKLsAGizKKYBw#q=Analysis+of+the+Common+African+Position+on+the+post-2015+Development+Agenda

Ethiopia implemented a Health Care Financing Strategy over the past two decades. The strategy made an unprecedented contribution by mobilizing financial resources for improving access to health services and health outcomes. A revised strategy, for 2017–2025 (FMOH 2017), builds upon the successes and challenges of its predecessor in accelerating progress toward Ethiopia attaining Universal Health Coverage through Primary Health Care. It is intended to pave the way to sustainable health financing that will enable the provision of proven essential health services to all segments of the population, without them incurring financial hardship in accessing the service.

1.2 Health Accounts in Ethiopia

This report presents the findings of Ethiopia’s HA estimation for fiscal year 2013/14 (July 8, 2013 through July 7, 2014). The estimation was conducted between October 2015 and October 2016. It was Ethiopia’s sixth round of HA (prior rounds covered selected fiscal years between 1995/96 and 2010/11) and the first to use the Systems of Health Accounts (SHA) 2011 framework, a tool developed by the World Health Organization (WHO). The prior HA studies have been critical to setting baselines and health financing targets as well as to measuring progress over the phases of the HSDP and improving health financing policy decisions and planning processes.

As noted above, the HA methodology measures how a country’s total health expenditure (THE) flows from financing sources to purposes of spending and end users of spending on health. The SHA 2011 framework breaks down spending into the standard classifications defined by financing sources, financing schemes, financing agent, and spending by level and type of provider, health function, and disease/ health condition. Ethiopia’s HA financing sources are government, external donors, international and national nongovernmental organizations (NGOs), employers, and households.

1.3 Policy Questions and Objectives

The ultimate goal of HA is to inform health care policy making. HA helps policymakers determine if existing sufficient resources are being spent on health care, are being used in the most equitable, effective, and sustainable way, are appropriately allocated, and, if not, could be reallocated to achieve more value-for-money and improve the overall coverage and quality of health services. In Ethiopia, the health expenditure data were tracked in a way that would help answer the following policy questions:

- What is the magnitude of health spending on an overall and a per capita basis?
- Who finances health sector?
- To which providers and what level of health service the government resources go?
- How are health care funds managed and distributed?
- Who is the health service provider in Ethiopia and how much is spent on each level and group of providers?
- For what services do health spending used?
- Which diseases and health conditions does Ethiopia spend on?
- What is the burden of financing on households?
- What is the role of the private sector in health?

The objective of this sixth round of HA is to generate up-to-date empirical evidence on health care spending in order to inform formulation and development of health financing policy, including gauging financing performance of HSDP-IV and a baseline for the HSTP.

The specific objectives were:

- To generate evidence on the relation between health sector priorities and spending on health care by level and types of health care services.
- To quantify the resource spent on health and to determine the contribution of each stakeholder in financing health care.
- To generate evidence on financing sources and levels for selected areas, diseases, and health service needy groups through the generation of expenditures by disease category and programs.
- To produce health expenditure data that will be internationally comparable and useful for global comparison
- To understand the magnitude and role of health expenditures in a broader macroeconomic context, and
- To make conclusion and draw policy implications arising from the overall analysis

This report highlights major policy implications of the findings.

1.4 Methodology

As noted above, WHO revised the SHA framework in 2011 to help countries use similar, standard methods regardless of their level of economic development and income. The SHA 2011 is now the international standard for national-level HA estimations and is what Ethiopia used for its latest round of HA. The country also employed the Health Account Production Tool (HAPT), software developed by WHO and USAID's Health System 20/20 project, to facilitate HA planning and production. The HAPT automates several previously time-consuming procedures, such as data collection and repeat mapping, and incorporates automatic quality checks. It facilitates the removal of double-counting and weighting for non-surveyed data. In addition, distribution keys and mapping decisions from previous years can be used to facilitate data analysis in subsequent years.

1.4.1 Data Sources

To gather primary data, a wide range of sources were surveyed:

- The Federal Ministry of Finance and Economic Cooperation (MOFEC), which provided audited data (for EFY 2006) on government spending in the health sector at all levels of government (federal, regional, and woreda), and by various types of provider;
- Line ministries/agencies with health-related activities⁴ and 26 universities⁵ whose data are not captured in the disaggregated MOFEC data;

⁴ The HA team approached about 10 line ministries and agencies but obtained information or responses from only five including the ministries of Women and Children Affairs, of Labor and Social Affairs, and of Education, and the Pharmaceutical Fund and Supply Agency (PFSA).

⁵ Mekele, Adigrat, Axum, Semera, Debre Tabor, Gonder, Woldiya, Debre Markos, DebreBirhan, Bahir Dar, Wolega, Jimma, Mettu, Ambo, Arsi, Haromaya, AAU, Arba Minch, Wolkitie, Wachamo, Dilla, Hawassa, WolaitaSodo, MizanTepi, Dire Dawa, Jigjiga. Only two universities (Wollo and Meda Wollabu) did not provide information.

- All bilateral and multilateral donors⁶ working in Ethiopia’s health sector, to estimate the magnitude, flow, and purpose of donors spending in the health sector;
- 236 NGOs (129 international and 107 local), to understand flows of health resources through these entities;
- 331 employers (33 parastatals and 298 private employers), to understand the extent to which employers provide medical insurance to their employees;
- All 17 insurance companies (1 public and 16 private) operating in the country during the study period, to estimate the amount of health resources managed by these entities; and
- Households and people living with HIV (PLHIV): 10,000 households were surveyed to better understand their health-seeking behavior and health services utilization, and to estimate and track household expenditure on general health and disease categories/priority areas. In addition, a separate HIV/AIDS targeted sample survey of 4,200 PLHIV was conducted to estimate and track the health expenditures of PLHIV in Ethiopia.

Secondary data were collected from the following sources:

- Federal Ministry of Health (FMOH) health service utilization, health, and health-related indicators and annual reports (FMOH n.d.): The health services utilization data generated from the health management information system (HMIS) database in particular were used to develop/estimate distribution keys for this HA exercise.
- FMOH unit cost study: Unit cost figures also were used to produce/estimate distribution keys, which in turn were used to disaggregate government spending to the different disease categories/programs at various levels of care.
- MOFEC macroeconomic reports: For the GDP estimates.
- Central Statistical Agency Population and Housing Census 2007: These data were used to estimate per capita health spending of the country.
- Annual reports of the National Bank of Ethiopia: Exchange rate figures were used to convert the different foreign currencies into Ethiopian birr and U.S. dollars.

1.4.2 Data Analysis

The HAPT software was employed by the health accounts team to do the analysis. All data collected were imported into the HAPT and mapped in line with the SHA 2011 classifications. The HA technical working group (TWG) used all the six modules⁷ of the HAPT in entering general information and data, customizing codes, mapping expenditures, checking for double-counting, creating/applying rules, and validating the data up to the generation of HA tables, graphs, and reports.

⁶ All 39 donors (except one) taken as a census for the institutional survey provided the requested information.

⁷The six modules are: Home, Customization, Data Sources, Data Import, Mapping, and Validation.

1.4.3 Limitations and Challenges

This HA estimation is a significant accomplishment for the FMOH. The estimation was far reaching and the first to employ the new SHA 2011 framework. Nevertheless, it was not without limitations. Several challenges were encountered during the estimation process.

Government budget and expenditure reports do not directly match the SHA 2011 classifications. Therefore, as in previous HA rounds, distribution keys⁸ were used to disaggregate government expenditure figures between outpatient and inpatient health and into the various disease categories/programs at the different levels of care. Hence, these figures are not actual ones but rather are estimates.

Different institutions keep information in different formats. This also made it difficult to obtain data according to HA categories. For instance, the survey questionnaires requested detailed information about expenditures on the different intervention areas or disease categories. However, most organizations do not keep information at that level of detail and, if they do, the formats are different.

HA does not track community in-kind contributions. The HA TWG tried to estimate the health expenditure contributions of communities participating in the health development army (HDA) and malaria control initiatives through the health extension program (HEP) platform.⁹ Communities also have helped to build and operationalize waiting centers near health facilities for expectant mothers nearing full term, and to make ambulance services available. HA estimates do not capture the value of these volunteer efforts however, as the HA methodology defines health expenditure in terms of financial transactions.

⁸The distribution keys are estimated based on the health services utilization data and unit cost study reports obtained from the FMOH, and are used as per the SHA 2011 recommendations.

⁹ The community-based health delivery platform creates a network between five households and one model family; they influence one another in practicing a healthy life style, and work to empower the community to generate its own health.

2. HEALTH EXPENDITURE FINDINGS AND ANALYSIS

2.1 Health Spending: Who Finances Health Care, and How Much Do They Contribute?

As noted above, this was the sixth round of HA since the FMOH started doing estimations in 2000 (for health expenditure in 1995/96, i.e. EFY 1988). In this round (for 2013/14), Ethiopia's THE was estimated at Birr nearly 50 billion (over US\$2.5 billion).¹⁰ This is 4.73 percent¹¹ of the country's GDP, a decline from 5.2 percent in 2010/11, and much less than the \$8.83 billion annual investment needed under the HSDP-IV base scenario. The lion's share of health spending, over 86 percent, is on recurrent expenditures, i.e., for delivery of health care services, provision of health commodities and supplies, and general health system operation. Capital investments account for the next largest share of spending, 10 percent. The remaining 3 percent of spending is on pre-service training and research, which includes education of health professionals in higher learning institutions and conducting research.

Table 1: Total Health Expenditure by Source of Financing and Spending Categories, 2013/14 (Birr Billion)

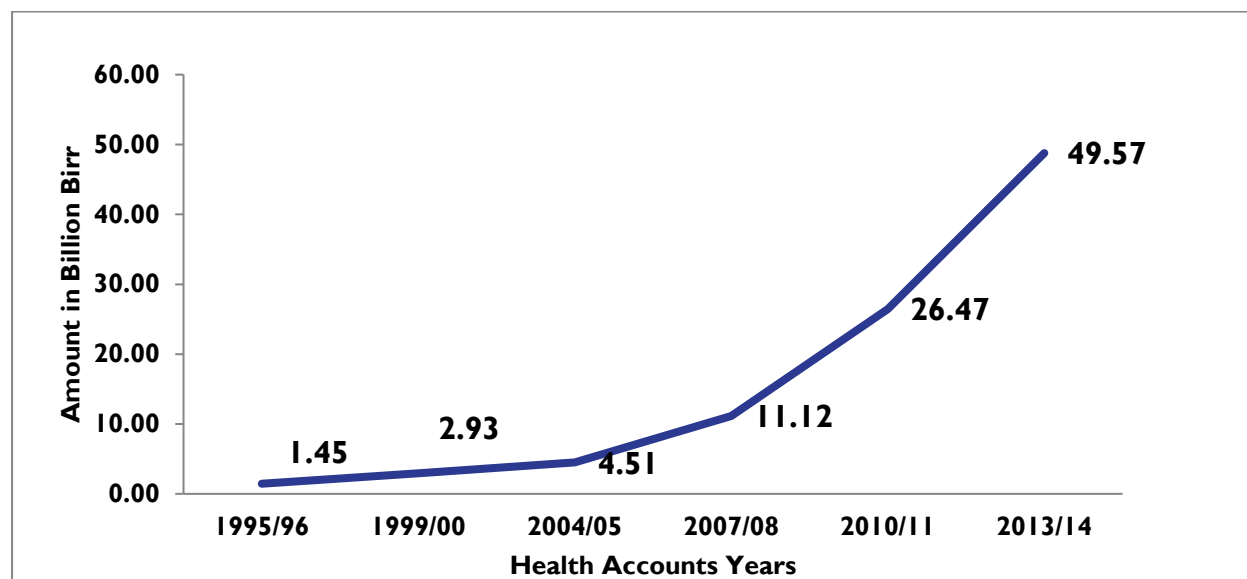
Source of Financing	Health Spending Categories			
	Recurrent	Capital	Training and Research	Total
Government including parastatals	9.93	3.16	1.62	14.72
Private employers, NGOs, and others	0.68	0.05		0.73
Households	16.49			16.49
Donors	15.68	1.95		17.63
Total	42.79	5.16	1.62	49.57
Share in %	86.3%	10.4%	3.3%	100%

¹⁰ In 2013/14, the annual average exchange rate was US\$1 = Birr 19.675. The HA exercise used this rate to convert spending in Birr to US dollars, and vice versa. All dollar amounts used henceforth in this report are U.S. dollars.

¹¹ Total GDP of Ethiopia in 2013/14 was estimated to be Birr 1,047,392,800,000 (MoFED: Brief Notes). Accordingly, health spending was 4.73 percent of GDP.

THE has grown steadily and significantly since 1995/96. In nominal terms, it grew by 87 percent, i.e., from Birr 26.5 billion in 2010/11 to Birr 49.6 billion in 2013/14. In real terms, it grew by 17 percent, i.e., Birr 31,080,368,313¹².

Figure 1: Total Health Expenditure, 1995/96–2013/14



Source: FMOH, HA 1-5 reports, and current HA data

The growth in THE came from different financing sources. In nominal terms, government spending more than tripled since 2010/11; in real terms, it grew by 124 percent, which is still substantial. However, government spending on health represents only 6.65 percent of the general government expenditure¹³; while this is higher than the 5.6 percent share in 2010/11, it is far less than the Abuja target and the government's own commitment to direct 15 percent of its total spending to health. In the same 2010/11 to 2013/14 period, household spending on health almost doubled in nominal terms and "rest of the world" (bilateral and multilateral donors, and private philanthropists) spending grew by 34 percent. In real terms, household spending increased by 16 percent, and donor spending declined by 16 percent.

Table 2: Total Health Expenditure by Source of Financing, 2004/05–2013/14

Source of Financing	HA III 2004/05 (Birr)	HA IV 2007/08 (Birr)	HA V 2010/11 (Birr)	HA VI 2013/14 (Birr)	Change, HA V to HA VI (%)
Government including parastatals	1,376,331,696	2,476,381,390	4,126,681,043	14,718,750,380	257%
Households	1,382,770,265	4,125,367,110	8,926,754,560	16,491,438,560	85%
Rest of the world	1,661,413,034	4,364,465,742	13,193,919,360	17,633,708,800	34%
All others	87,228,590	156,807,872	217,511,290	729,771,260	236%
National Health Expenditure (NHE)	4,507,743,585	11,123,022,114	26,464,866,253	49,573,669,000	87%

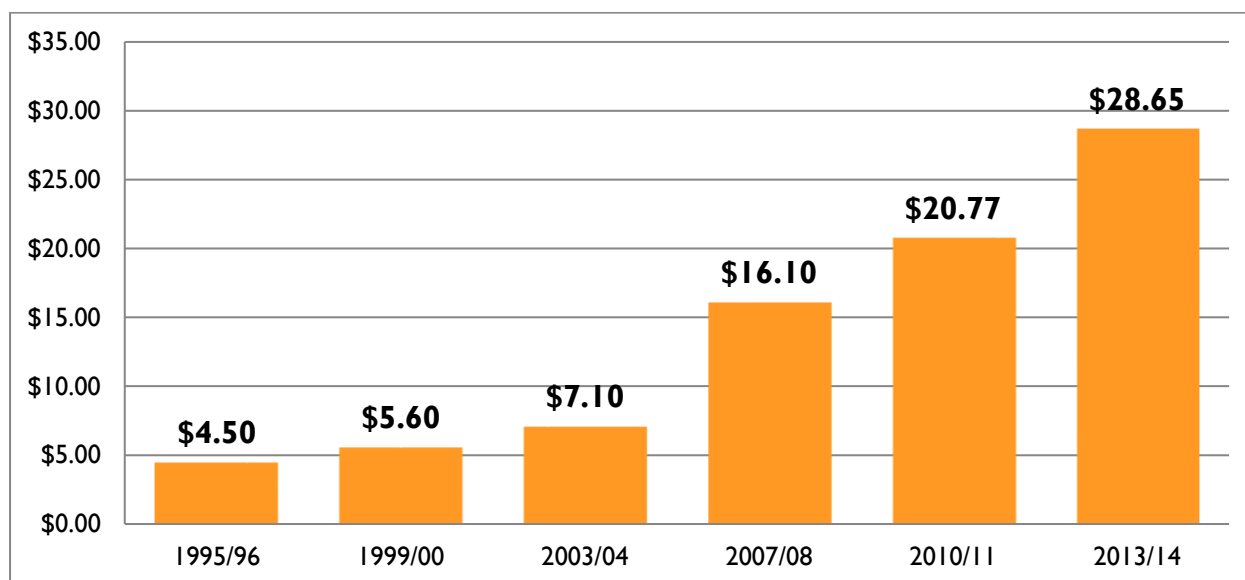
Source: FMOH, HA 1-5 reports, and current HA data

¹² The real spending is calculated by deflating the total spending of the current health account year (2013/14) to the previous health accounts year (2010/11).

¹³ The National Bank of Ethiopia's 2013/14 Annual Report stated that total government expenditure in 2013/14 was Birr 185,471,780,000. This HA estimated that total government health spending from the Treasury (not including spending by parastatal organizations) was Birr 12,332,340,000. Accordingly, the share of government spending on health was estimated to be 6.65 percent.

Ethiopia’s per capita health expenditure has grown steadily over the past two decades, from \$4.50 in 1995/96 to \$28.65 in 2013/14.¹⁴ Though this growth is encouraging, the amount is still very low compared with \$37.7 for low-income African countries,¹⁵ and it is far less than the \$60 per capita spending the WHO recommended for delivery of essential health services by 2015 (Jowett et al. 2016).

Figure 2: Per Capita Health Expenditure, 1995/96–2013/14



Source: FMOH, HA I-5 reports, and current HA data

2.1.1 Making Ethiopia’s Health System Financially Sustainable: What Is the Trend Toward Domestic Resource Mobilization?

The share of THE coming from domestic sources has increased substantially since the previous HA exercise, from accounting for around 50 percent of THE in 2010/11 to close to 64 percent in 2013/14. The proportion of financing coming from government almost doubled, from 16 percent to 30 percent (25 percent from the Treasury and 5 percent from parastatals). This is mainly because of accelerated expansion of health care services, which saw the opening of 1,839 health facilities (health posts, health centers, and hospitals) and concomitant increases in staffing and operational budgets. Additionally, health worker salaries were increased after the previous HA, and this also had substantial budgetary implications. Household out-of-pocket spending remains a major domestic source of financing for the health sector; as has been mentioned, it almost doubled in absolute terms and its share of THE has remained essentially the same, declining only slightly from 34 percent in 2010/11 to 33 percent in 2013/14.¹⁶ Similar to previous HA estimations, the share contributed by other sources, including the private sector as employers, NGOs, and others, remained insignificant, at only about 1 percent of THE. In contrast, rest-of-the-world spending on the Ethiopian health sector fell, from around half (50 percent) to 36 percent of THE. The significant increase in domestic financing and its share of overall spending on health is encouraging, as it pushes the Ethiopian health sector toward financial sustainability.

¹⁴ The Central Statistical Agency-projected total population of 87,952,991 was used to project household spending for the HA year and for the per capita estimation.

¹⁵ WHO global health expenditure database: <http://apps.who.int/nha/database>, accessed on April 27, 2017.

¹⁶ While Ethiopia is looking to increase domestic funding of health, doing so through household out-of-pocket spending is a challenge that the country is trying to resolve, as discussed elsewhere in this report.

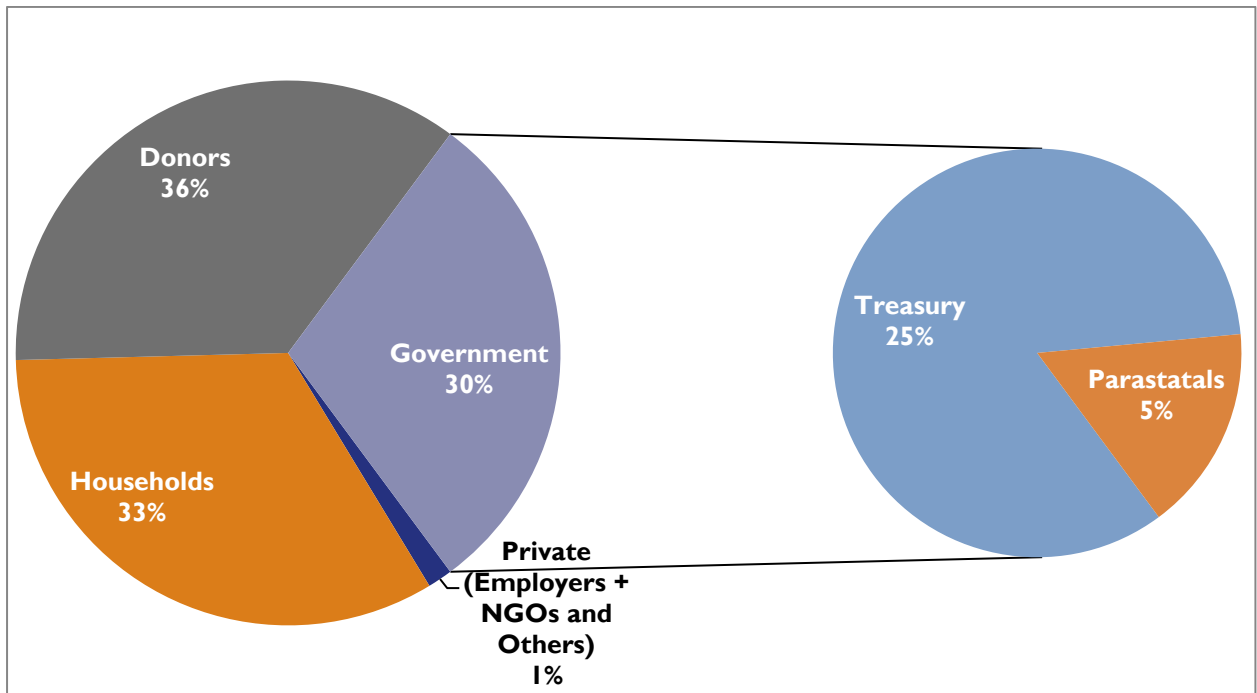
Table 3: Total Health Expenditure by Source of Financing, 2010/11 and 2013/14 (%)

Source of Financing	Share (%)	
	2010/11	2013/14
Government including parastatals	16%	30%
Private employers and others	1%	1%
Households	34%	33%
Rest of world	50%	36%
Total	100%	100%

Source: FMOH, HA 1-5 reports, and current HA data

Within the government share of spending on health, the bulk (84 percent) comes from the Treasury, and the remaining 16 percent is from parastatals.¹⁷

Figure 3: Total Health Expenditure by Source of Financing, 2013/14



¹⁷ Parastatals include all government fully or partially owned strategic business organizations; they include Ethiopian Airlines, Ethiopian Telecommunications, Electricity and Power Company, government-owned banks, the Ethiopian insurance companies, sugar plantations, and other public enterprises.

2.1.2 COMMUNITY OWNERSHIP AND ENGAGEMENT: AN IMPORTANT PILLAR FOR SUSTAINABILITY

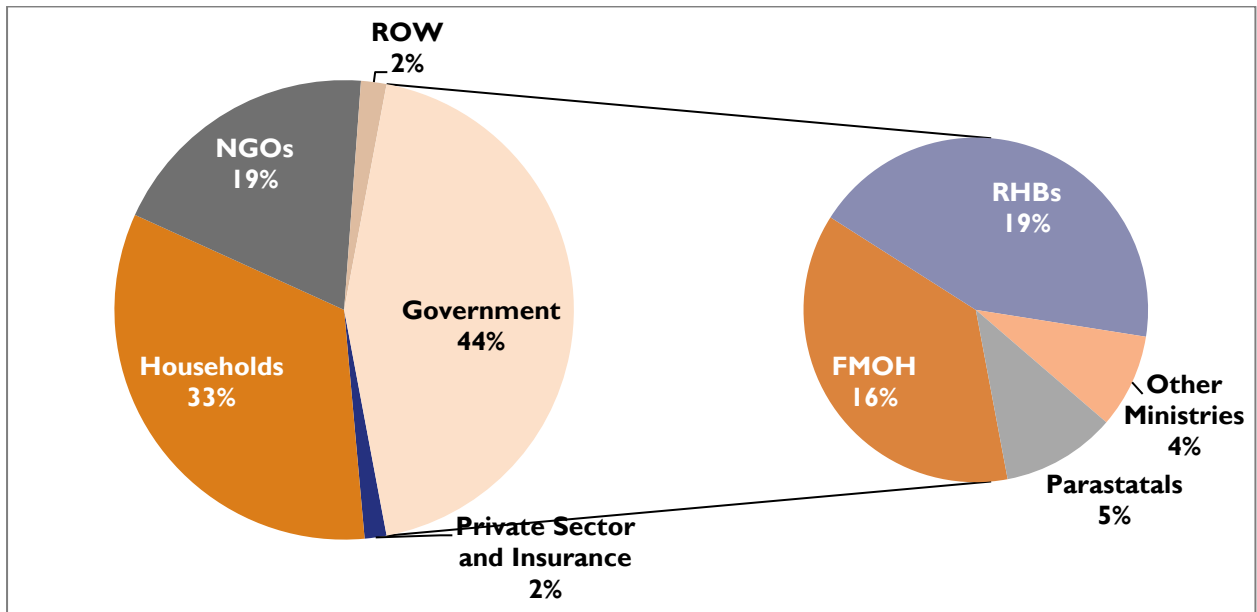
One of the great successes of the Ethiopian health system is working at community and household levels to engage and empower the community to own their health. This is being realized through the HEP, the health sector's flagship program, and the HDA. These complementary programs enabled the health sector to reach communities and households in promoting health care and prevention programs. The health sector was also able to mobilize resources from households and communities, both in kind and in cash, for construction of health posts, for the environment health campaign such as drainage of water ponds, for indoor residual spraying operations and distribution of insecticide-treated nets to combat malaria, and for other public works that promote health and prevent diseases. The household survey conducted for this round of HA estimated that the community contribution through the HDA and through malaria control programs was about Ethiopian Birr 2.87 billion in 2015/16, the household survey year. Though community contribution and engagement is difficult to account for in the HA framework, one can understand how significant it is to the Ethiopian health system, and how critical it is for citizens' ownership of health care and for health system sustainability.

2.2 Who Manages Health Resources?

In health financing, managerial responsibility of health resources is critical because it decides where, for what purposes, and how expenditures are made. Government has traditionally played the largest role in managing health resources; that said, its share declined slightly between 2010/11 and 2013/14, from 48.9 percent to 44 percent. Households account for the next largest share, 33 percent, of managing health spending; they make their management decisions in the form of out-of-pocket spending at the time of seeking health care – as HA estimations have shown, there is no significant pooling of household resources in the form of health insurance. NGOs managed almost one-fifth (19 percent) of THE. Donors, and insurance companies and other private sector actors played a lesser role in managing health resources, each accounting only 2 percent of health spending.

Within the government system, regional health bureaus and the FMOH managed 19 percent and 16 percent of THE, respectively. Four percent was managed by other ministries and government agencies, mainly the Ministry of Education, as most training and research are handled by universities under the ministry. Parastatals managed almost all the resources that they contribute to the sector, which is another indication of the low level of risk pooling.

Figure 4: Total Health Expenditure by Financing Agent



Note: ROW=rest of the world, RHB=regional health bureau

2.3 Pooling of Health Resources

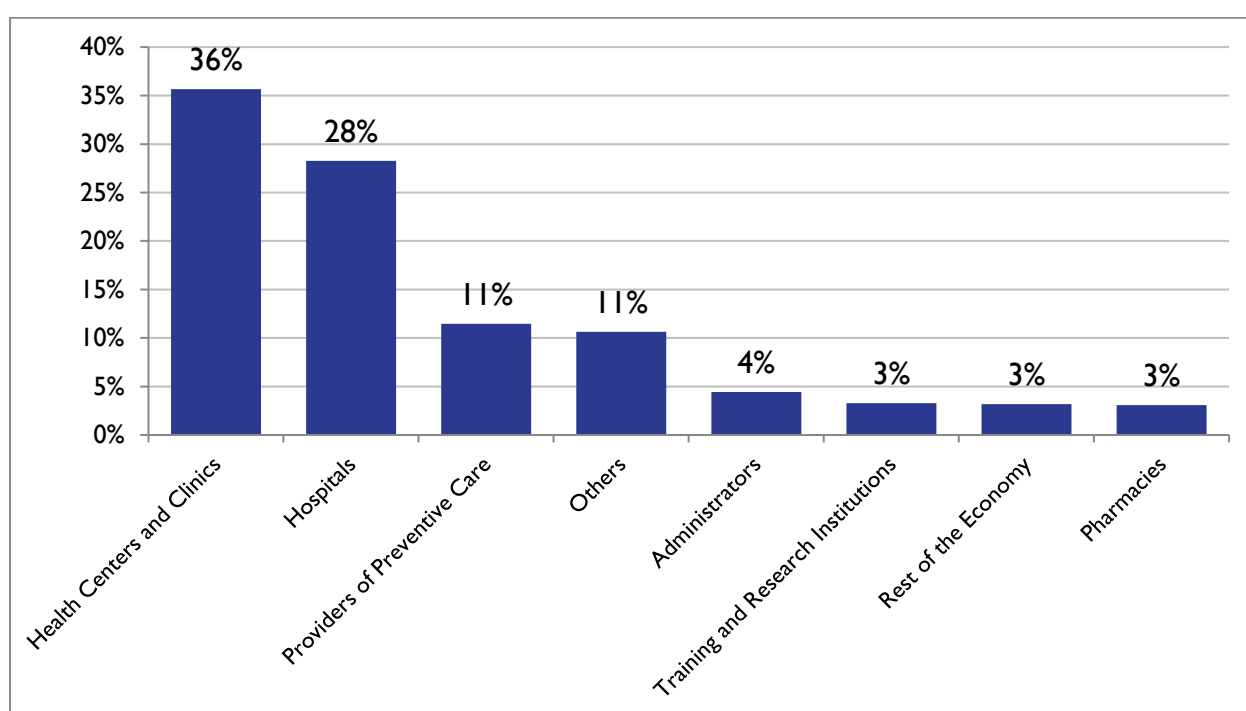
As mentioned above, government manages the largest share (44 percent) of health resources, making for a significant pool. However, the remaining 56 percent of health spending – over half – is managed by other financing agents. As noted above, 16 percent of the health resources managed by government (5 percent of THE) was managed by parastatal organizations acting individually; their funds were not pooled into one system. As also noted, households manage 33 percent, through out-of-pocket spending at time of sickness – almost no household spending is pooled. Such spending can be a burden for many households, preventing them from seeking health care at all or proving to be financially catastrophic for some who choose to seek care. In view of this, the government’s policy to establish health insurance programs is a step in the right direction.

However, the current HA estimation looks at 2013/14, too soon for the Ethiopian Health Insurance Agency to show a significant contribution in managing health resources. At that time, community-based health insurance (CBHI) had been piloted in only 13 woredas, in the four largest regions, and preparation of the social health insurance (SHI) program was just starting. Under the 13 pilot CBHI schemes, 152,000 households, with beneficiaries totaling around 700,000, were registered as scheme members. Total spending in the form of reimbursement to health facilities that provided services to members was estimated to be Ethiopian Birr 16.9 million (EHIA 2015).

2.4 Who Provides Health Services to Ethiopians, and How Much Is Spent on Each Level and Types of Health Service Providers?

Where, and at what level of the health system, spending occurs has significant implications for provision of services and who accesses and uses health services and commodities. In 2013/14, more than one-third (36 percent) of THE occurred at the health center, clinic, and health post level. Hospitals also received a significant amount, (28 percent). Providers of preventive health care received 11 percent of THE, providers that were not identified received almost that percentage. Health administration consumed relatively little of THE, 4 percent. Training and research institutions and the rest of the economy (other sectors) each accounted for 3 percent of THE, as did independent pharmacies.

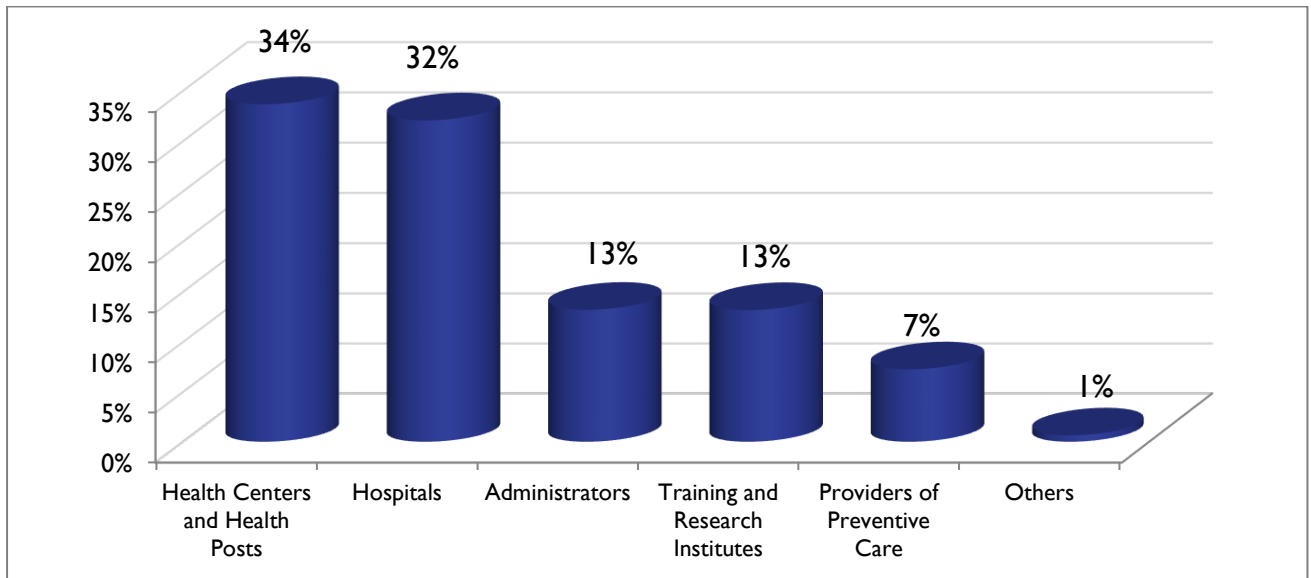
Figure 5: Total Health Expenditure by Provider



2.5 Government Spending: Where in the Health System Are Government Resources Going?

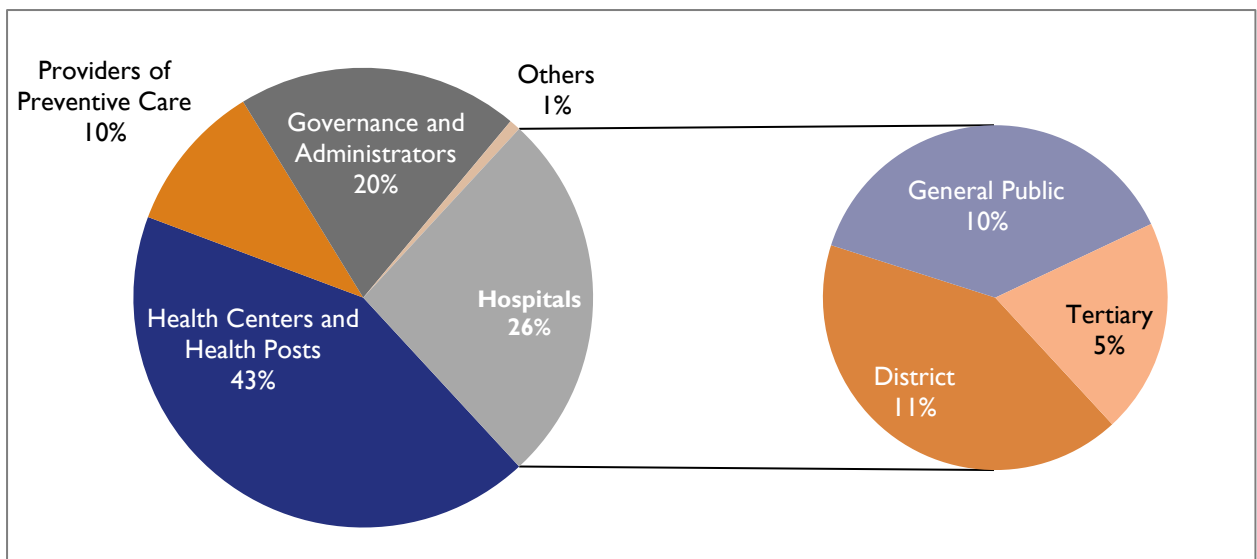
When one examines to which health service providers government resources (from the Treasury) went, the breakdown is not much different from the overall health spending. Thirty-four percent of total government health spending went to health centers and health posts and 32 percent went to public hospitals. A moderately higher proportion of government resources (compared with the total spending from all sources) went to health administration, and to training and research institutions; each received 13 percent. Providers of preventive health care services received 7 percent.

Figure 6: Total Government Health Spending by Health Provider (Recurrent and Capital)



Regarding the flow of government recurrent spending to providers of health care services, 43 percent went to health centers and health posts, followed by 26 percent to hospitals. Governance and administration the health system consumed 20 percent, and providers of preventive care services received 10 percent. Breaking down the 26 percent that was hospital-level recurrent expenditure, district hospitals accounted for 11 percent, general public hospitals for 10 percent, and tertiary hospitals for 5 percent. Primary health care providers including district hospitals, health centers, and health posts together received more than half (54 percent) of total government recurrent expenditure. This is in line with the Ethiopian government’s health policy, which is focused on prevention and promotive services provided at the primary health care level.

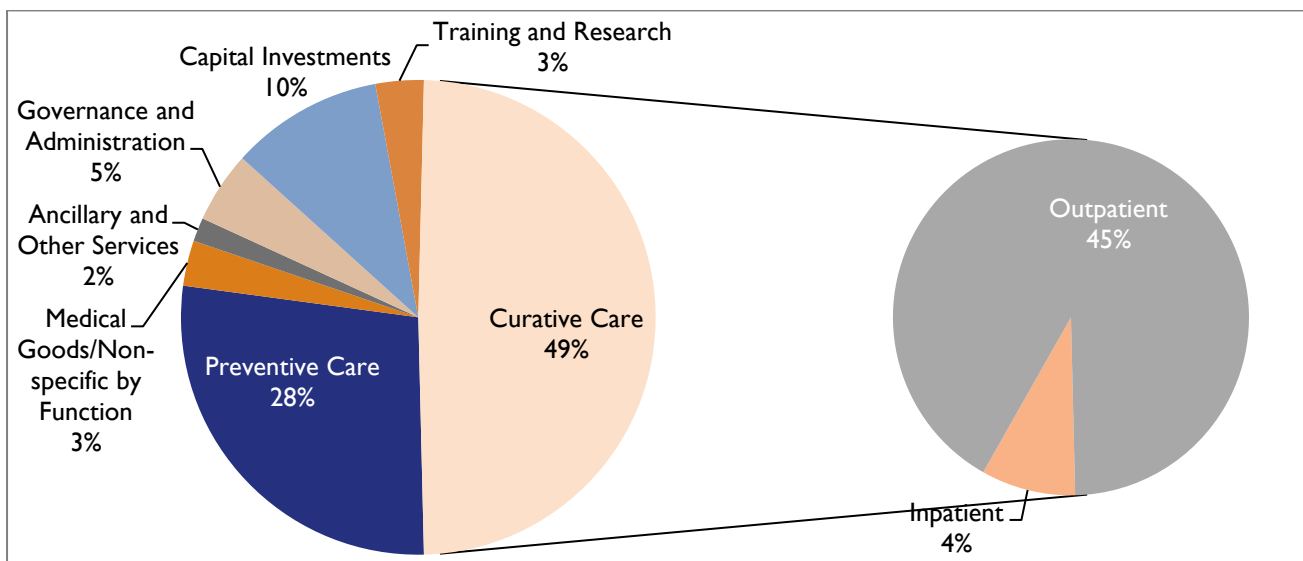
Figure 7: Recurrent Government Health Spending by Type of Provider



2.6 For What Purpose Are Health Resources Used?

Almost half of health spending (49 percent) is on curative health care services. This is followed by preventive care services, which accounted for 28 percent of THE in 2012/14. Capital formation together with training and research accounted for 13 percent. Governance and administration accounted for 5 percent. Out of the 49 percent of the total spending on curative care, 45 percent was for outpatient services and only 4 percent of the total spending was for inpatient care. Over half (55 percent) of the curative care spending paid for services at primary health care providers (again, district hospitals, health centers, clinics, and health posts), 39 percent went to services at general and referral hospitals (both public and private hospitals), and the remaining 6 percent went to services at all other providers.

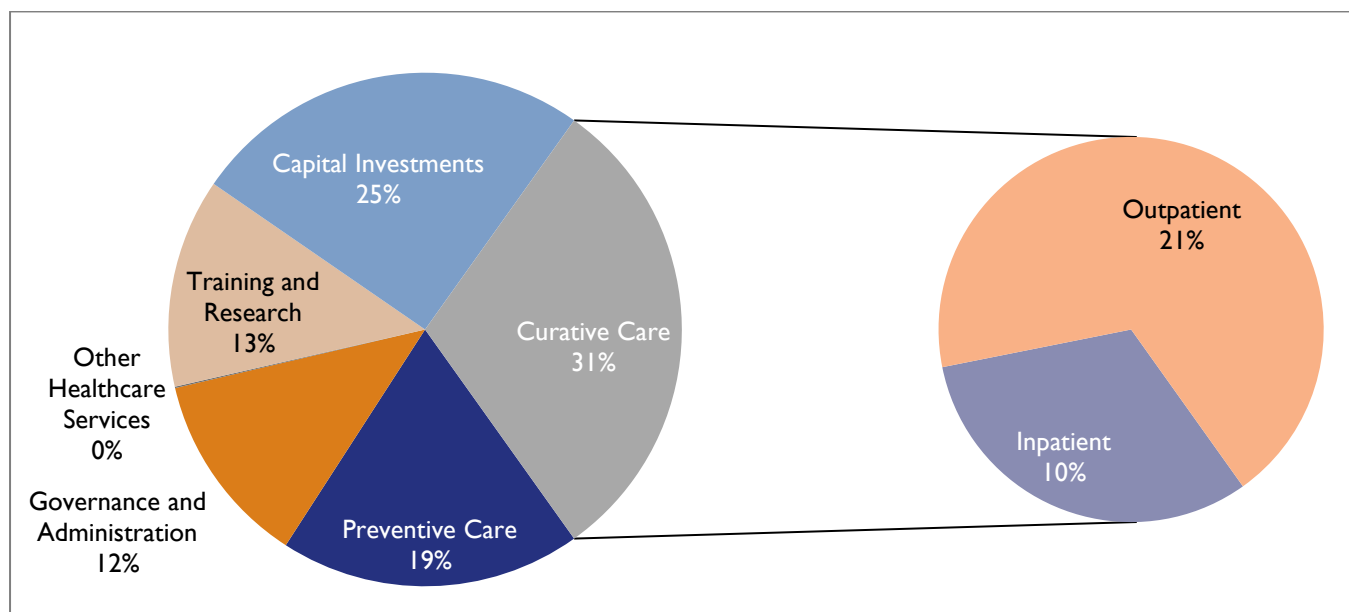
Figure 8: Total Health Expenditure by Type of Health Care Service



2.7 How Are Government Resources Spent and Does the Spending Align with Government Priorities?

Are government resources spent differently from overall health spending? How are government resources for health spent? Is spending in line with government policy? The 2013/14 HA findings showed that the largest share of government spending (31 percent) is on curative health care services. Over 54 percent of curative care spending was made at the primary health care level (district hospitals and health centers, clinics, and posts). Only 39 percent of the curative care spending occurred in general, specialized, and referral hospitals (both public and private). The second largest share was capital investment, which accounted for one-fourth of total government spending. The third share was preventive care, at 19 percent. Training and research accounted for 13 percent of the government spending, and governance and administration of the health system accounted for 12 percent. The major distinction between overall spending and government spending is that the latter spent a higher proportion on capital investment, training, and research.

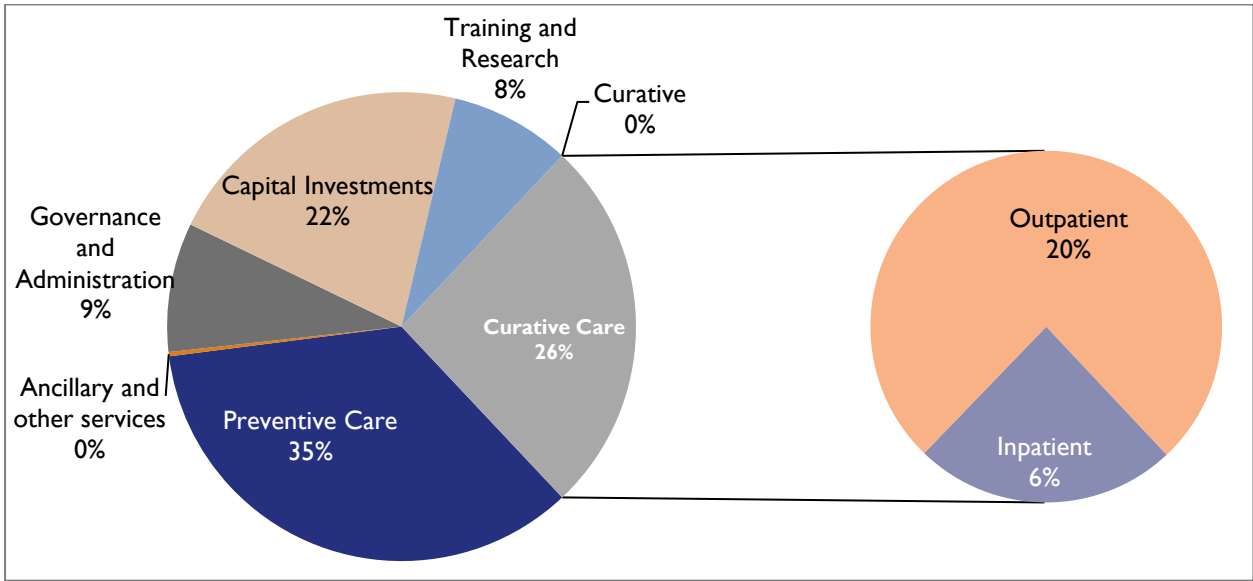
Figure 9: Programmatic Use of Government Resources (Recurrent and Capital)



Examining spending of treasury resources on health gives detailed evidence about government spending on priority services and a better understanding of where curative services are provided by government. In 2013/14, the Ethiopian government spent over Birr 12.3 billion of treasury resources on health care; around 62 percent of this was on recurrent expenditure, and the remaining 38 percent was on capital investments, training, and research. Out of the recurrent spending, 30 percent (Birr 3.73 billion) was on curative care services, 71 percent of which occurred at the primary health care level: 50 percent at health centers and health posts and 21 percent at district hospitals. Only 29 percent of curative care of treasury resources was spent at general and referral hospitals level.

Looking at spending of all resources managed by the government (including resources from other sources that flow through the government), the greatest proportion went to preventive care (35 percent). This is because some of the resources coming through the Global Fund and other sources are earmarked for preventive services. Following this were curative care (26 percent) and capital investments (22 percent). The share of these resources going to health governance and administration was lower (9 percent) than the 12 percent of the government's own resources. This implies that the government has the capacity to manage additional resources and programs without raising the administrative cost of managing them.

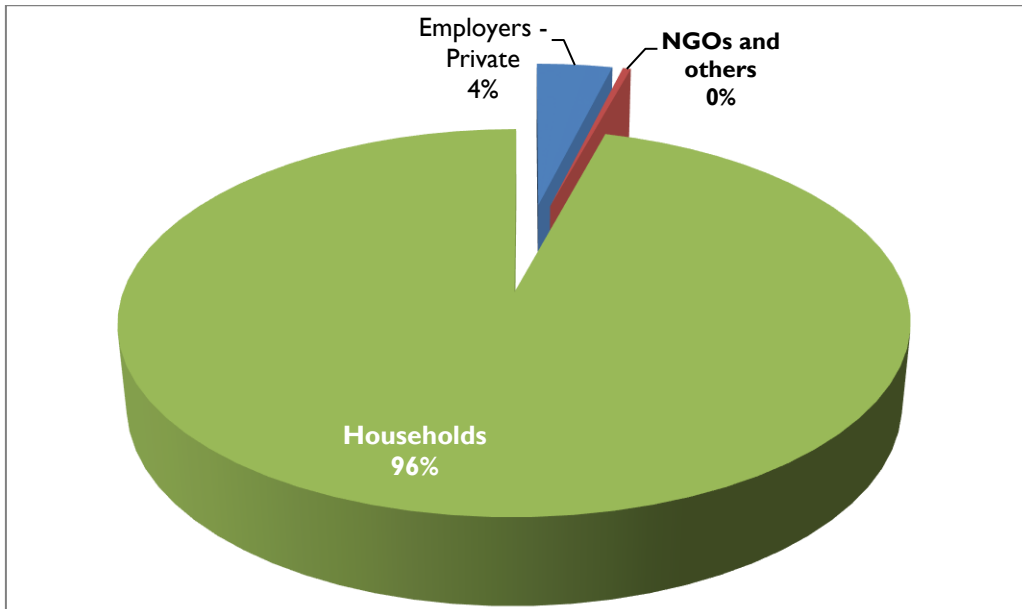
Figure 10: Programmatic Use of Resources Managed by Government



2.8 Role of the Private Sector in Health Financing: What Are the Sources of Private Spending?

Private sector actors (households and all others) contributed Birr 17.22 billion, 35 percent of THE in 2013/14. Households contributed the lion's share (96 percent) and private employers contributed 4 percent. NGOs and other private sector sources contributed only 0.15 percent.

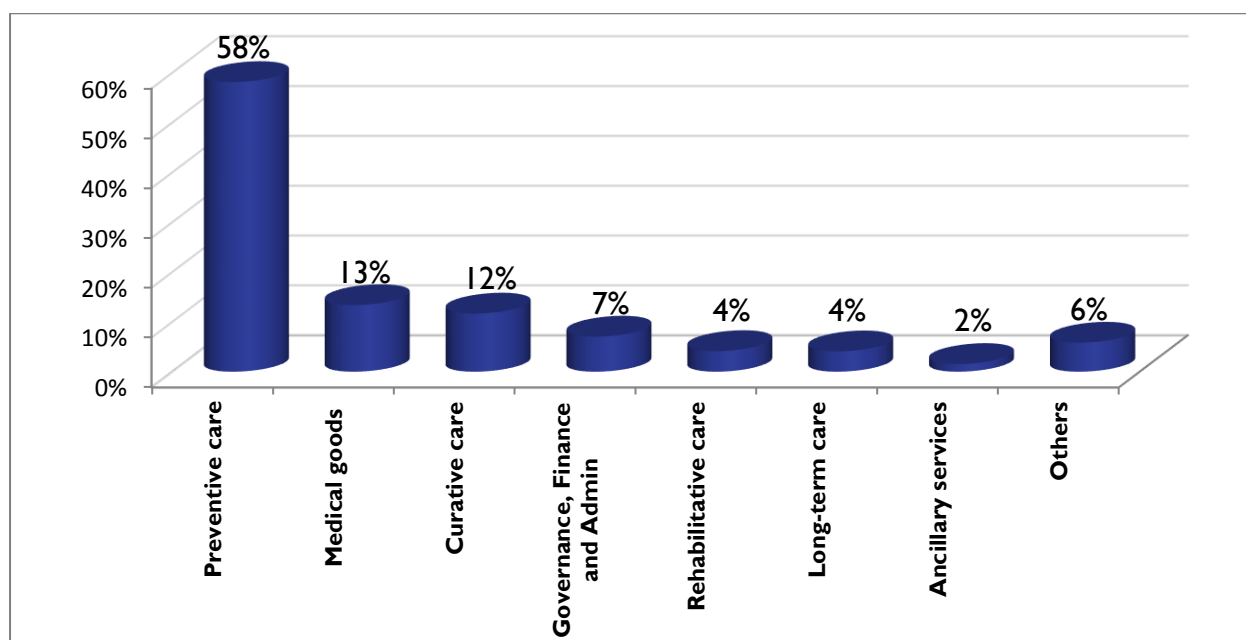
Figure 11: Distribution of Private Sector Health Financing



2.9 How Were NGO-managed Health Resources Spent?

NGOs managed Birr 8.74 billion (19 percent) of total recurrent health spending. Of this amount, 58 percent was spent on preventive health care, followed by 13 percent on medical goods, 12 percent on curative care, and 7 percent on health governance, finance, and administration. NGOs also spent 4 percent each on rehabilitative and long-term care. All other services and ancillary services accounted for 6 percent and 2 percent of the total NGO-managed spending, respectively.

Figure 12: Programmatic Use of Resources Managed by NGOs



2.10 Which Diseases and Health Conditions does Ethiopia Spend On?

A significant share, 49 percent, of Ethiopia's health spending goes to prevention, management, and treatment of infectious and parasitic diseases. This is in line with the country's disease burden. Of this, nearly 10 percent was spent on HIV/AIDS and other sexually transmitted diseases (STDs). This was followed by spending on malaria, vaccine-preventable diseases, and tuberculosis, which get 9 percent, 7 percent, and 2 percent of THE, respectively. All other infectious diseases together received about 15 percent of the spending. Nutritional deficiencies and non-communicable diseases accounted for 13 percent and 12 percent of total spending, respectively, reproductive health services (including both maternal and family planning services) accounted for 9 percent.

Figure 13: Spending on Major Diseases and Health Conditions

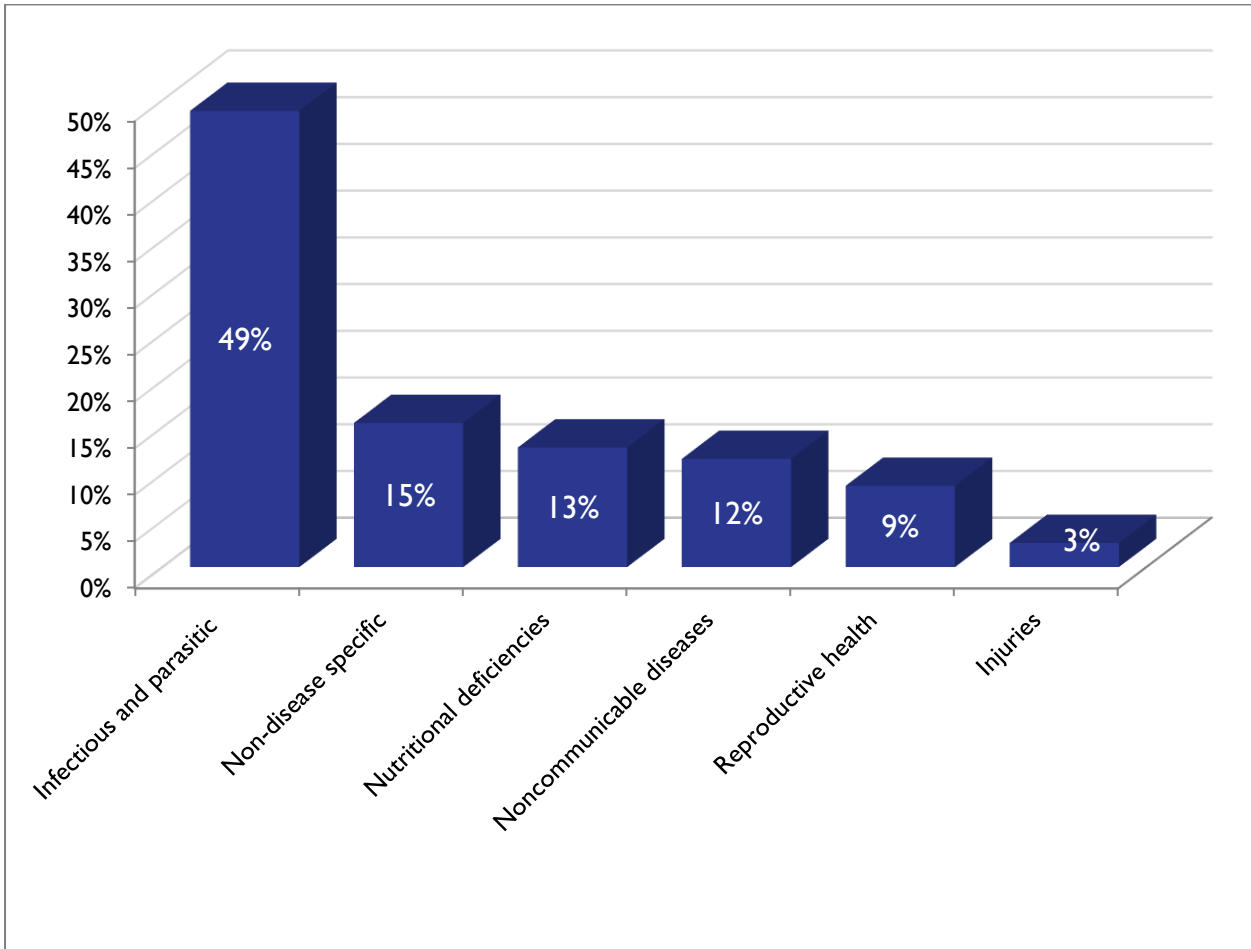
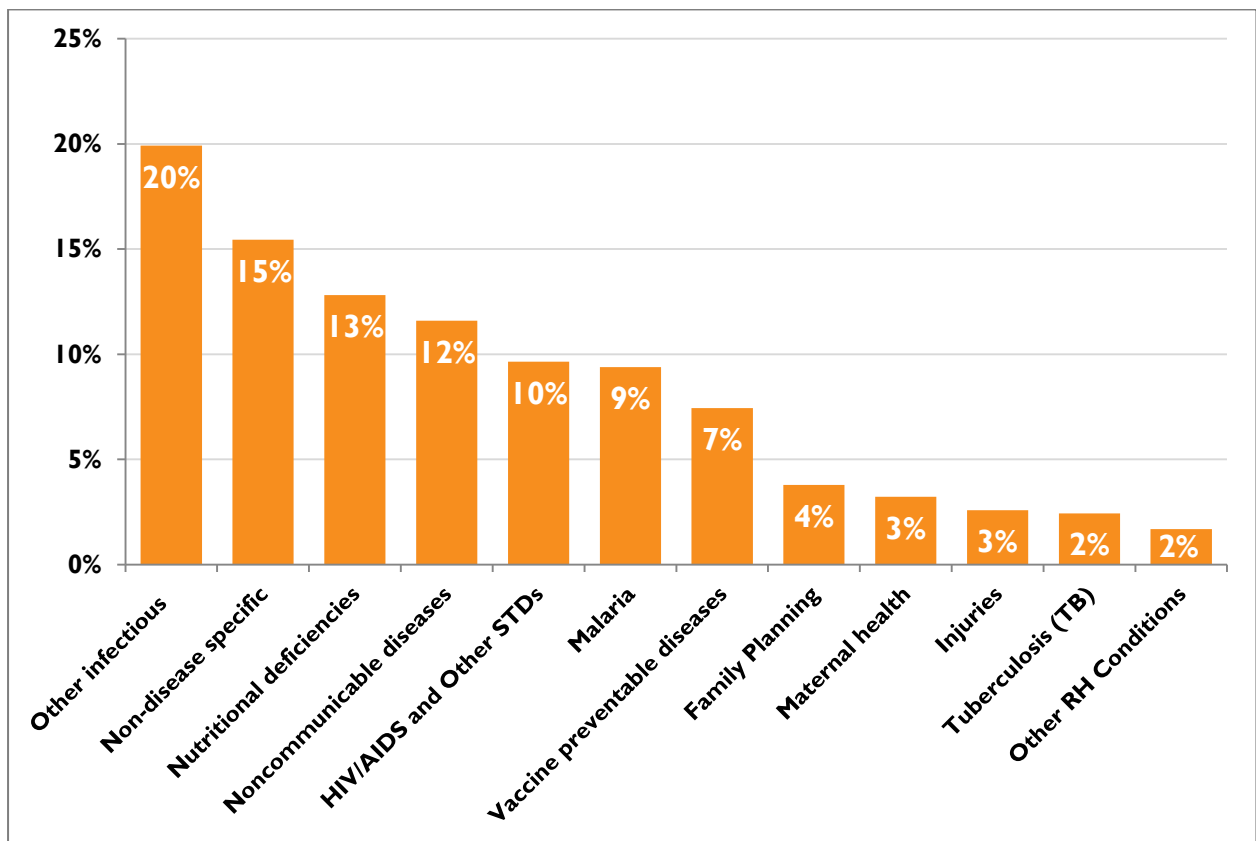


Table 4: Spending on Major Disease and Health Condition (Birr millions)

Types of Diseases and Conditions	Types of health care services and medical goods							Total by Diseases and Conditions	Shared by Diseases and conditions
	Curative and Rehabilitative Care	Ancillary Services (non-specified by function)	Medical Goods and Supplies	Preventive Care	Governance and Health System Administration	Other Health Care Services	Capital, Training and Research		
Infectious and parasitic diseases	9,989.04	95.51	656.14	8,538.14	1,291.01	174.03	3,466.75	24,210.63	49%
HIV/AIDS and Other Sexually Transmitted Diseases (STDs)	572.96	38.26	577.49	2,503.75	454.27	150.97	482.46	4,780.18	10%
Tuberculosis (TB)	794.24	25.68	-	239.75	19.11	1.42	126.58	1,206.78	2%
Malaria	1,800.69	22.81	43.97	1,868.40	201.37	0.01	720.00	4,657.25	9%
Vaccine preventable diseases	83.26	0.01	-	3,463.66	20.76	1.06	123.50	3,692.24	7%
All other infectious and parasitic diseases	6,737.89	8.75	34.68	462.58	595.50	20.57	2,014.21	9,874.17	20%
Reproductive health	766.11	26.12	210.05	2,423.26	235.27	184.23	474.04	4,319.07	9%
Maternal and perinatal conditions	482.75	5.01	19.04	591.76	85.25	138.91	279.13	1,601.86	3%
Family Planning	158.71	20.25	28.31	1,526.65	30.76	1.02	113.61	1,879.31	4%
Other Reproductive Health Conditions	124.65	0.85	162.70	304.85	119.26	44.30	81.29	837.90	2%

Types of Diseases and Conditions	Types of health care services and medical goods							Total by Diseases and Conditions	Shared by Diseases and conditions
	Curative and Rehabilitative Care	Ancillary Services (non-specified by function)	Medical Goods and Supplies	Preventive Care	Governance and Health System Administration	Other Health Care Services	Capital, Training and Research		
Nutritional deficiencies	4,873.83	0.02	209.21	1,207.41	19.33	4.02	40.97	6,354.79	13%
Noncommunicable diseases	4,064.76	1.63	42.94	13.78	357.55	3.57	1,265.14	5,749.37	12%
Injuries	806.58	0.17	18.75	0.34	116.89	-	338.38	1,281.11	3%
Non-disease specific	3,912.04	16.35	389.21	1,461.01	386.43	295.27	1,198.39	7,658.71	15%
Total	24,412.37	139.80	1,526.29	13,643.93	2,406.48	661.13	6,783.67	49,573.67	100%
Share by type of services	49%	0%	3%	28%	5%	1%	14%	100%	

Figure 14: Spending on Major Diseases and Health Conditions



2.11 On What Types of Services Was Spending by Diseases Made?

Out of the total spending on infectious and parasitic diseases, 49 percent was on curative and rehabilitative care services. Sixty percent of reproductive health spending was on preventive care as was 57 percent of HIV/AIDS and STD spending and half of malaria spending. In contrast, almost all spending on non-communicable diseases and injuries (96 percent and 95 percent, respectively) and about three-quarters of spending on nutritional deficiencies and tuberculosis (77 percent and 71 percent, respectively) was on curative care services.

Table 5: Breakdown of Spending on Major Diseases and Health Conditions by Type of Health Care Services and Commodities (%)

Types of Diseases and Conditions	Types of health care services and medical goods							Total by Diseases and Conditions
	Curative and Rehabilitative Care	Ancillary Services (non-specified by function)	Medical Goods and Supplies	Preventive Care	Governance and Health System Administration	Other Health Care Services	Capital, Training and Research	
Infectious and parasitic diseases	41%	0%	3%	35%	5%	1%	14%	100%
HIV/AIDS and Other Sexually Transmitted Diseases (STDs)	12%	1%	12%	52%	10%	3%	10%	100%
Tuberculosis (TB)	66%	2%	0%	20%	2%	0%	10%	100%
Malaria	39%	0%	1%	40%	4%	0%	15%	100%
Vaccine preventable diseases	2%	0%	0%	94%	1%	0%	3%	100%
All other infectious and parasitic diseases	68%	0%	0%	5%	6%	0%	20%	100%
Reproductive health	18%	1%	5%	56%	5%	4%	11%	100%
Maternal and perinatal conditions	30%	0%	1%	37%	5%	9%	17%	100%
Family Planning	8%	1%	2%	81%	2%	0%	6%	100%
Other Reproductive Health Conditions	15%	0%	19%	36%	14%	5%	10%	100%
Nutritional deficiencies	77%	0%	3%	19%	0%	0%	1%	100%
Noncommunicable diseases	71%	0%	1%	0%	6%	0%	22%	100%
Injuries	63%	0%	1%	0%	9%	0%	26%	100%
Non-disease specific	51%	0%	5%	19%	5%	4%	16%	100%
Total	49%	0%	3%	28%	5%	1%	14%	100%

3. CONCLUSIONS AND POLICY RECOMMENDATIONS OF THE SIXTH HEALTH ACCOUNTS

Through successful implementation of consecutive health sector development plans (HSDP I-IV), Ethiopia has significantly expanded and improved access to health care services. With its multi-faceted health sector reforms and successful planning, budgeting, and implementation capacity, as well as demand creation through the HEP and HDA, Ethiopia has successfully expanded access to basic health care services that are predominantly provided by government. However, the country still faces challenges to improve health outcomes to the desired level, partly because of a low level of investment in health care.

3.1 Conclusions

Overall health spending trends: The various rounds of Ethiopia's HA show that health spending has increased steadily both in absolute amounts and on a per capita basis. In 2013/14, THE increased to Birr 49.6 billion (\$2.5 billion) from Birr 26.5 billion (\$1.6 billion) in 2010/11. That said, 2013/14 spending on health accounted for 4.73 percent of the country's GDP, a lesser share from 5.2 percent in 2010/11 and much less than the \$8.83 billion annual investment needed under HSDP-IV under the base scenario.

Per capita health spending: Ethiopia's per capita spending on health increased from \$20.77 in 2010/11 to \$28.65 in 2013/14. However, this is still far below the globally recommended \$60 per capita estimated to make essential health care services available in low-income countries, and it does not meet the country's HSDP-IV target of increasing per capita spending on health by \$11.96 per year (from the baseline of \$20.77 in 2010/11) – under the target, per capita spending would have reached \$32.73 in 2013/14.

Sources of financing health: In 2010/11, about half of THE (49.9 percent) was covered by donors and international NGOs. This has fallen to 36 percent, an encouraging trend toward reliance on domestic sources of health financing. However, the 36 percent of health financing coming from foreign sources is still very high. Additionally, over half of the domestic financing is household out-of-pocket spending at time of sickness. This need for payment at the time of care can prevent some households from accessing health care and can be catastrophic for some households that decide to seek health care. From 2010/11 to 2013/14, government spending on health increased dramatically, by 257 percent, a positive development, and the share of government spending on health increased from 16 percent to 30 percent. Health spending accounted for 6.65 percent of general government expenditure in 2013/14; while this is still far below the Abuja commitment to spend 15 percent of total government spending on health, it is an increment and an encouraging trend compared with the 5.6 percent share in 2010/11.

Management of health resources: Though it provides less than one-third (30 percent) of THE, government remains the major manager of health resources. In 2013/14, about 44 percent of THE was managed by government, a slight drop from nearly 49 percent in 2010/11. Households remain managers of their entire spending as spending decisions are made by themselves at time of sickness. This also shows that risk pooling remains low, with funds managed through insurance accounting for only slightly over 1 percent of THE.

Spending by type and level of providers of health care services: The bulk of health spending was at primary health care services providers. Thirty-six percent of THE was at public health centers, private clinics, and public health posts in 2013/14; more than half of this spending occurred in government primary health care units (health centers and health posts). On the other hand, 28 percent of the health spending was at the hospital level, over 80 percent of which was in public hospitals. With regard to spending of health funds from the Treasury, 34 percent went to health centers and health posts, and 32 percent went to hospitals.

Health spending on health functions: In 2013/14, nearly half (49 percent) of THE was made on curative services, 28 percent on preventive care. Capital investment accounted for 10 percent. The rest was spent on health governance and administration (5 percent). Training and research, and medical goods each accounted for 3 percent of spending and ancillary services accounted for 2 percent.

Health spending by type of diseases and health conditions: In line with the country's disease burden, the significant share (49 percent) of health spending was made on prevention, control, and curative care of infectious and parasitic diseases. Within this category, HIV/AIDS was the major expenditure, accounting for 10 percent of THE. This was followed by malaria and tuberculosis, which accounted for 9 percent and 2 percent, respectively. Spending on nutritional deficiencies prevention, control, and curative care accounted for 13 percent of THE. Another major spending category that this round of HA was able to estimate was spending on non-communicable diseases, which accounted for 12 percent of THE. This reflects the increasing global need to address non-communicable diseases. If one adds spending on injuries to the non-communicable disease category, total spending on the category would increase to 15 percent. The remaining 15 percent was spent on diseases and health conditions that could not be specified.

3.2 Policy Implications and Recommendations

Increase the magnitude and per capita spending on health with emphasis on domestic financing: Though health spending is steadily growing both in overall and per capita terms, it is still far below what is needed and the globally recommended amount and regional commitment. Thus, Ethiopia needs to continue increasing spending significantly so that it will be able to adequately provide essential health service to all citizens. More importantly, the country needs to continue increasing its domestic financing to make health financing more sustainable.

Expand financial protection to reduce financial burden on households and increase health service utilization by citizens: One of the predominant features of financing health in Ethiopia is high reliance on household out-of-pocket spending. The country needs to expedite its effort to expand financial protection through the various health insurance programs, mainly through the CBHI program, which will provide financial protection for citizens in the small farming rural economy and informal sector in urban settings. Out-of-pocket spending should be reduced to a level at which it does not keep people from seeking health care or prove catastrophic when they do seek care.

Provide purposive financial protection for the poor and needy segments of the population: Given Ethiopia's level of socio-economic development, large segments of the population cannot afford to pay for health care. The country needs to expand coverage of health insurance to provide financial protection for all citizens. This includes a targeted subsidy of insurance premiums for the poor so they can access health care without incurring a financial burden. Until all woredas establish CBHI schemes and poor households are enrolled to these schemes through the targeted subsidy, government needs to provide them financial protection through the fee waiver system. Another important program that benefits the poor and marginalized groups is strengthening the exemption system so that services that have public health nature can be provided freely to all.

Institutionalization of HA and regular generation of evidence for policy decision

making: The government has already made important progress toward institutionalization of HA. The FMOH has established the HEFA Case Team. The team fully owned and led the recent HA exercise, but it needs to be strengthened so that it will be able to generate HA data more regularly and routinely. In addition, the team needs to conduct research on health care financing, efficiency, and effectiveness, and other topics to further evidence-based health financing policy decision making. The HEFA Case Team needs continuous training and technical support to ensure full institutionalization of HA. There is also strong need to incorporate training on the HA methodology into pre-service public health and health economics/financing programs.

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