TECHNICAL BRIEF

Ethiopia's Health Financing Outlook: What Six Rounds of Health Accounts Tell Us

The USAID-funded HSFR/HFG project provides technical assistance to the Government of Ethiopia to implement and scale-up health care financing reforms across the country. The goal is to increase access to and utilization of health services through improved quality of health care and reduced financial barriers.

Project objectives are to:

- *Improve the quality of health services*
- *Improve access to health services*
- *Improve governance of health insurance and health services*
- *Improve program learning*

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Ethiopia has made important strides toward improving the health status of its population as well as in advancing health sector strategies and health care financing (HCF) reforms. The 20-year national Health Sector Development Program (HSDP), implemented in four five-year plans, began in 1997 and was completed in 2015.[1] As a policy implementation document, it guided the development of subnational plans and set the overarching framework under which the health sector operated, including principles of government leadership, responsiveness to community health needs, and comprehensive coverage of priority health sector issues. 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.[2] To support HCF reform under these comprehensive plans, Ethiopia has also implemented an HCF strategy. The strategy articulated several HCF reforms to increase funding for health, enhance efficiency in the use of available resources, improve the quality and coverage of health services, ensure equity, and promote sustainability.[3] A revised strategy, for 2017–2025,[4] builds upon the successes and challenges of its predecessor in accelerating Ethiopia's progress toward attaining universal health coverage through primary health care. The revised strategy is being used to develop planning and other documents though it has not yet been formally endorsed by the Council of Ministers. It is intended to lead to sustainable HCF that will enable the provision of proven essential health services to all segments of the population, without them incurring financial hardship in accessing services.

[1] *Federal Democratic Republic of Ethiopia Ministry of Health. October 2010. Health Sector Development Program IV 2010/11-2014/15 Final Draft. Addis Ababa.*

[2] *Federal Democratic Republic of Ethiopia Ministry of Health. October 2015. Health Sector Transformation Plan (HSTP) 2015/16-2019/20 (2008-2012 EFY) Addis Ababa.*

[3] *Federal Democratic Republic of Ethiopia Ministry of Health. 1998. Ethiopia Health Care Financing Strategy. Addis Ababa.*

[4] *Federal Democratic Republic of Ethiopia Ministry of Health. 2017. Health Care Financing Strategy 2017-2025. Addis Ababa.*

Health accounts is a globally recognized health expenditure tracking framework used to measure the amount of health expenditures and resource flows in the health systems. Ethiopia has adopted the health accounts methodology and has conducted six health accounts exercises (Box 1). Findings and evidence generated from these exercises have been key resources that have helped policymakers gauge health sector performance and monitor progress of the HSDP, particularly financing indicators; develop spending priorities and set targets when developing plans and strategies such as the HSTP; and make decisions that determine health investments. For example, health accounts data showed high out-of-pocket health spending by households, which was instrumental in developing the health insurance reforms in place today. Findings also showed a low level of resources available in the health sector, and policymakers used this as evidence to support implementation of the retained revenue and utilization component of the HCF reforms.

ETHIOPIA'S GENERAL SPENDING OUTLOOK

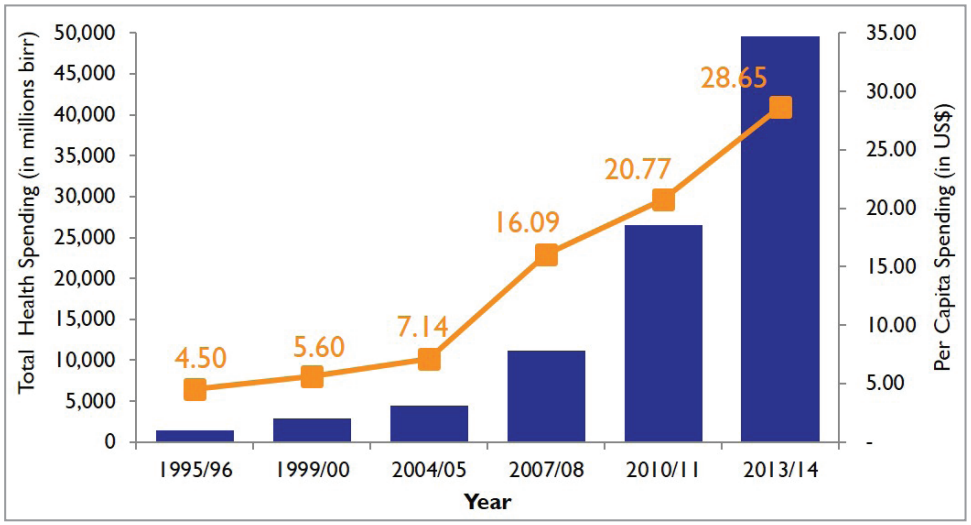
In the past two decades, Ethiopia's health expenditure has grown tremendously in both absolute and per capita terms (Figure 1). The country's total health expenditure rose to nearly 50 billion birr (over US$2.5 billion) in 2013/14 from 1.45 billion birr (US$230 million) in 1995/96. Per capita health expenditure reached (US$28.65) in 2013/14 from a mere (US$4.5) in 1995/96, an average annual growth rate of 49 percent. Though this growth is encouraging, the amount is still very low compared with peer countries and the World Health Organization (WHO) recommendation of US$60 per capita spending for delivery of essential health services by 2015.[5] Also, health spending constituted between 3.5 and 5.6 percent of the gross domestic product in the various years. This is less than the average 7 percent that a recent WHO report estimated for low-income countries.[6]

Box 1: Six rounds of health accounts in Ethiopia

The Federal Ministry of Health (FMOH) has led and reported on the findings of six health accounts exercises since 2001:

1st round Ethiopia National Health Accounts 1995/96 (2001)
2nd round Ethiopia's Second National Health Accounts Report 1999/00 (July 2003)
3rd round Ethiopia's Third National Health Accounts 2004/2005 (March 2007)
4th round Ethiopia's Fourth National Health Accounts 2007/2008 (April 2010)
5th round Ethiopia's Fifth National Health Accounts 2010/2011 (April 2014)
6th round Ethiopia Health Accounts 2013/14 (August 2017)

Figure 1. Ethiopia's total and per capita spending



Source: FMOH Health Accounts Reports

[5] *M Jowett, MP Brunal, G Flores, and J Cylus. 2016. Spending Targets for Health: No Magic Number.*

[6] *World Health Organization. 2017. New Perspectives on Global Health Spending for Universal Health Coverage. Conference Copy for Consultation.*

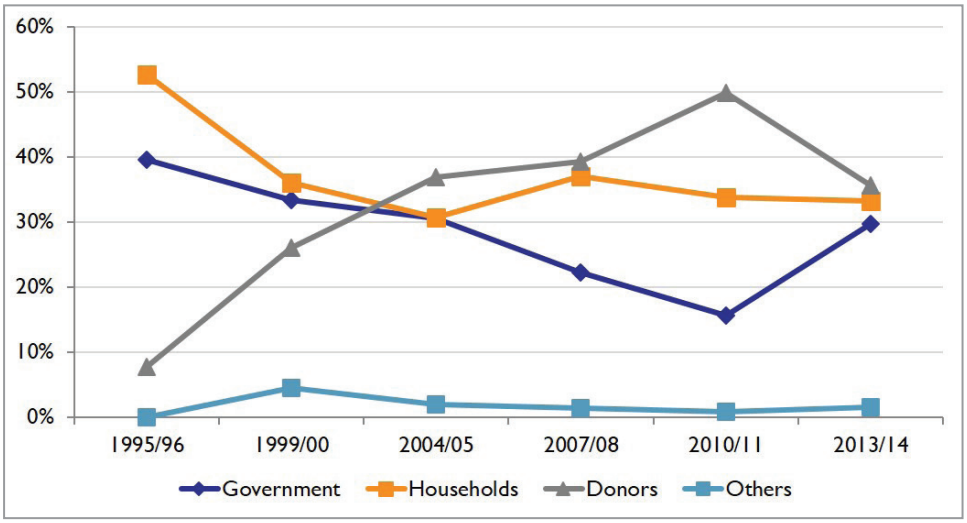
HOW SUSTAINABLE IS ETHIOPIA'S HEALTH FINANCING? WHAT HAS BEEN THE PROGRESS?

According to health accounts data, the share of health spending from government sources has accounted for, on average, around 28 percent of Ethiopia's total health expenditure since 1995/96. As shown in Figure 2, the government's relative contribution has fluctuated, first decreasing substantially from 39 percent in 1995/96 to 16 percent in 2010/11 and then increasing to 30 percent in 2013/14. Nevertheless, the absolute amount of its contribution has increased consistently and significantly, due mainly to accelerated expansion of health facilities throughout the country in recent years.[7] The increase in government financing and its share of overall health spending is encouraging, because such domestic spending pushes the Ethiopian health sector toward financial sustainability. However, Ethiopia's total health expenditure accounted for on average about 8.2 percent of the country's total general government expenditure.[8] This shows that the government still needs to take measures to reach 15 percent of overall government spending on health, as Ethiopia committed to do under the Abuja declaration.

Health accounts data also show that donors accounted for on average 33 percent of country's total health spending. Donors' share of health spending peaked, at almost 50 percent, in 2010/11, from a low of 8 percent during the first health accounts exercise in 1995/96. Although this decrease is encouraging, the most recent (2013/14) health accounts exercise shows a still-high donor share of 36 percent. Given the unpredictability of future donor funding, and the sizable funding gap that Ethiopia could face if donor funding is discontinued, other domestic financing mechanisms/resources are important to consider in order to decrease donor dependency and secure more sustainable sources.

The final major source of health funding has been household out-of-pocket spending, which accounted for about 37 percent of total health expenditure over the period 1995/96 to 2013/14. Implications of the large share of health expenditure this spending comprises are discussed more in the next section.

Figure 2. Trends in health financing by source



Source: FMOH Health Accounts Reports

[7] *Includes the opening of 1,839 health facilities (health posts, health centers, and hospitals) and concomitant increases in staffing and operational budgets.*

[8] *UNICEF Ethiopia. 2017. National Health and Nutrition Sector Budget Brief: 2006-2016. Addis Ababa.*

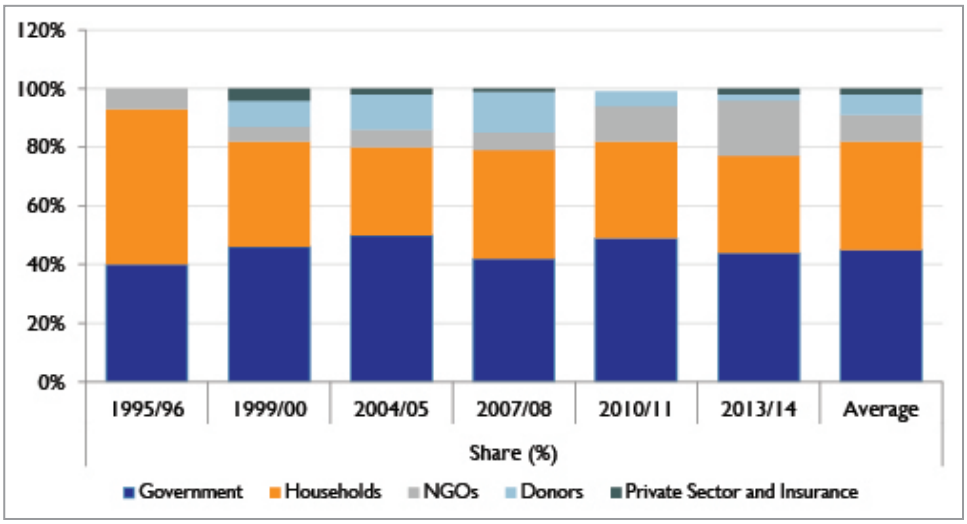
TO WHAT EXTENT ARE RESOURCES POOLED?

Out-of-pocket spending on health is a critical determinant of households' financial burden. High out-of-pocket expenditures result in household financial hardship and cause millions to forgo needed health care. In low-income and lower middle-income countries, household out-of-pocket spending has been about 40 percent of health expenditure in recent years.[9] As noted above, in Ethiopia, household out-of-pocket spending remains a major domestic source of financing for the health sector, accounting for on average 37 percent of total health expenditure over the health account years. Although its share declined from 53 percent in 1995/96 to 33 percent in 2013/14, this recent figure is still much higher than the 15–20 percent that the WHO considers a threshold beyond which financial catastrophe among the country's population due to health care expenses becomes significantly more likely. To reduce this risk, the Ethiopian government has been working on expanding the country's risk-pooling mechanisms, including insurance.

Based on lessons learned from piloting community-based health insurance (CBHI) in 13 woredas (districts), Ethiopia has expanded CBHI from the 13 pilot woredas to more than 500 today, and is gearing up for further expansion to establish CBHI schemes in 80 percent of woredas and enroll at least 80 percent of households by 2020.[10] The commitment from the government to support CBHI will help reduce the role and proportion of out-of-pocket spending in overall financing of the health sector. It also means that the government remains the critical body in pooling and managing resources coming to the health sector (Figure 3).

Government has traditionally played the largest role in managing health resources in Ethiopia. Health accounts data show that government's managerial role has stayed stable over the last two decades, accounting for 45 percent of the health resources on average. The role of donors in managing resources has varied. Households, through their out-of-pocket expenditures, have consistently managed a large portion of health sector resources, on average about the same as government. As insurance coverage expands, the household percentage is expected to decline and the private sector and insurance segment increase. CBHI is only reflected in the 2013/14 health accounts findings, the fiscal year in which CBHI scale-up began.

Figure 3. Who manages the resources coming to the health sector?



[9] *World Health Organization. New Perspectives on Global Health Spending for Universal Health Coverage.*

[10] *Federal Democratic Republic of Ethiopia Ministry of Health. October 2015. Health Sector Transformation Plan (HSTP) 2015/16-2019/20 (2008-2012 EFY) Addis Ababa.*

WHICH PROVIDERS CONSUMED HEALTH FUNDS? HAS THERE BEEN ANY CHANGE?

Overall health accounts findings reveal that on average approximately 42 percent of total health spending in Ethiopia is consumed by primary and preventive care service providers. Hospitals consumed on average around 22 percent. The higher relative spending at the lower level of care 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. However, the data in Table 1 indicate that the balance between the two shares has fluctuated. This warrants further investigation into the reasons and determining factors driving these variations and addressing where required.

Table 1: Total health expenditure by provider

Providers of health services	Share (percent)*						
	1995/96	1999/00	2004/05	2007/08	2010/11	2013/14	Average
Health centers and clinics	18%	14%	30%	31%	26%	36%	26%
Hospitals	18%	27%	18%	20%	23%	28%	22%
Providers of preventive care	5%	16%	8%	27%	27%	12%	16%
Others (unspecified providers)	6%	14%	7%	7%	12%	11%	9%
Health administrators	7%	6%	8%	9%	8%	4%	7%
Training and research institutions	3%	3%	5%	3%	4%	3%	4%
Pharmacies	33%	20%	24%	2%	0%	3%	14%
Rest of the economy/world	10%	0%	0%	1%	0%	3%	2%

Source: Calculations based on data from FMOH Health Accounts Reports
**Figures below one percent are not considered.*

WHAT WAS HEALTH SPENDING USED FOR?

Although the provider allocation seems to be in line with HSDP/HSTP plans, review of the health spending by function indicates that overall spending is largely on curative services (Table 2). On average, curative care consumed around half of total health spending, while preventive services consumed one-fourth. Capital investments consumed close to 10 percent on average. Although there is no optimal balance between curative and preventive care, the fact that curative care spending is more than double that of preventive care requires further study. Curative care is generally more expensive than preventive care, but this may not be the only reason for the current balance. Questions to consider are whether this difference is in line with a well-considered curative care strategy, or if patients are obtaining curative care services for conditions that could be addressed in preventive care settings in which case more/better investment in preventive care services and access to them might be needed.

Table 2. Total health expenditure by type

Health care expenditure	Share (percent)*						
	1995/96	1999/00	2004/05	2007/08	2010/11	2013/14	Average
Curative care (out- and inpatient)	18%	14%	30%	31%	26%	36%	26%
Preventive care	18%	27%	18%	20%	23%	28%	22%
Capital investment	-	-	15%	6%	7%	10%	9%
Governance and administration	6%	8%	7%	8%	8%	5%	7%
Training and research	3%	3%	-	2%	4%	3%	3%
Medical goods (non-specified by function)	-	-	-	3%	0%	3%	2%
Ancillary and other services	5%	-	9%	14%	2%	2%	6%

WHAT DOES IT TAKE TO REGULARLY TRACK HEALTH SPENDING INFORMATION?

To maximize the utility of health accounts data, it's important to conduct health accounts exercises regularly. The Ethiopian government has made significant progress toward institutionalizing health accounts within its structure, including establishing the Health Economics and Finance Analysis (HEFA) unit within the FMOH. HEFA fully owned and led the 2013/14 health accounts exercise. However, the unit could benefit from having more HCF policy expertise. This could be achieved by strengthening existing member capacity or adding personnel who have the skills needed. The collaboration that has started between the FMOH and the Ethiopian Central Statistical Agency to capture health spending by households through regular household surveys conducted by the Agency would also be beneficial to further institutionalize the regular production of health accounts.

It is also important to take steps to streamline the data collection process. Ways to minimize the need to collect primary data directly from the different health sector stakeholders, and thereby reduce the cost of conducting health accounts exercises, could be explored. For example, nongovernmental organizations are required to regularly provide their program description and annual performance to their respective ministries, including the FMOH. The FMOH could require that these reports include financial information in a format that can readily feed into health accounts, and enforce regular reporting by linking it to the NGO license renewal process. Similarly, the FMOH could work with the Ministry of Finance and the National Bank to create a mechanism by which the FMOH could obtain regular information on health spending by development partners and insurance companies.

Images on pages 5 and 7 by Gonzalo Guajardo for Communication for Development Ltd.
Image in page 6 by Ayenew Haileselassie, HSFR/HFG

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The HFG project is a six-year (2012-2018), $209 million global health project. The project builds on the achievements of the Health Systems 20/20 project. To learn more, please visit www.hfgproject.org.
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Cooperative Agreement Number:
AID-OAA-A-12-00080
Agreement Officer Representative Team:
Scott Stewart (GH/OHS) sstewart@usaid.gov
Jodi Charles (GH/OHS) jcharles@usaid.gov

Abt Associates
www.abtassociates.com
6130 Executive Boulevard
Rockville, MD 20852