USAID
FROM THE AMERICAN PEOPLE

# AFRICAN STRATEGIES FOR HEALTH

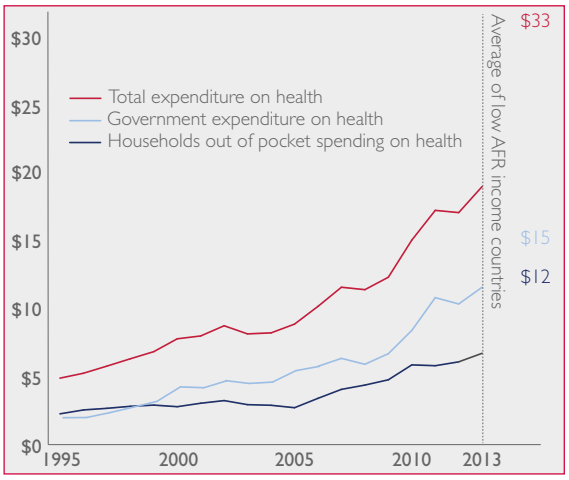
# HEALTH FINANCING PROFILE: ETHIOPIA

Key country indicators

| Development indicators* | |
|---|---|
| Total population | 94,101,000 |
| Total fertility rate (births per woman) | 4.5 |
| Gross national income per capita (PPP) | 1,350 |
| **Health care expenditure indicators**** | |
| **Expenditure ratio** | |
| Total expenditure on health as % of GDP | 5.1%<br>↑ avg. low-income countries (5%)<br>↓ global avg. (9.2%) |
| **Level of expenditures** | |
| General government expenditure on health as % of total government expenditure*** | 5.4%<br>↓ targets set by Abuja Declaration (15%) |
| **Selected per capita indicators** | |
| Per capita total expenditure on health (PPP int.$) | 69 |
| Per capita government expenditure on health at average exchange rate (US$) | 4 |
| Per capita government expenditure on health (PPP int.$) | 42 |
| **Sources of funds** | |
| General government expenditure on health as % of total expenditure on health | 61% |
| Private expenditure on health as % of total expenditure on health | 39% |
| External resources for health as % of total expenditure on health | 32.3% |
| Out-of-pocket expenditures as % of private expenditure on health | 90.6% |

*Note: WHO aggregates are calculated using absolute amounts in national currency units converted to Purchasing Power Parity (PPP) equivalents*

Per capita expenditure in US$ (constant 2013 US$)**




*World Health Organization (WHO) Global Health Observatory, 2013
**WHO Global Health Expenditure Database, 2013
***Ethiopia's Fifth National Health Accounts, 2010/11

## Contextual Factors

In Ethiopia, the public sector remains a major recipient of health sector resources. The 2014 National Health Accounts (NHA) report (2010/2011) indicates private providers (for-profit and non-profit) are concentrated in urban areas (where less than 20% of the population lives) and receive only 16% of the total national expenditure on health.[1]

Health care financing reforms in Ethiopia began in 1998, when the Federal Ministry of Health (FMoH) developed a Health Care Financing Strategy to improve and diversify resource mobilization for health, ensure equitable and efficient resource allocation and use, and secure financial protection for its citizens. The 2010/11 NHA shows Ethiopia's health care financing reforms have yielded tremendous achievements. A 300% increase in total health expenditure has been measured, as well as an increase in per capita health expenditure from $7.10 in 2004-5 to $20.77 in 2010-11.[1] Key components of the reforms, guided by the Health Care Financing Strategy, include:

- ***Revenue retention and utilization (RRU):*** Service fees are retained by health facilities to institute quality improvements and eliminate drug shortages.
- ***Facility governance:*** Facility governing boards and bodies oversee annual planning, budget allocation, and review of expenditure reports.
- ***Systematizing fee waivers:*** Families who cannot afford to pay for services are registered to receive services free of charge.
- ***Standardizing the package of exempted services:*** A basic package of critical public health services is standardized for the entire population. Application of user fees is also made transparent and standardized.
- ***Private wings and outsourcing of non-clinical services:*** Some public hospitals outsource certain services and have established private wings for patients who are willing to pay for a higher standard of services at a premium over the public user fees rates.

Despite these efforts, an estimated annual increase in public health expenditure between 9-13.5% is needed in order to address resource constraints and provide effective clinical care at all levels of the health system.[1] The Government of Ethiopia (GoE) has introduced and financed two types of health insurance: community-based health insurance (CBHI) for the agricultural and informal sectors, and social health insurance (SHI) for those employed in the formal sector. The Health Sector Transformation Plan (2015/16-2019/20) highlights a need for increased government budget allocation to the health sector, continued strengthening of health care financing reforms, scaling up CBHI and SHI, and the introduction of innovative domestic financing mechanisms, to deliver towards the goals of Universal Health Coverage (UHC).

## Health Financing Functions

- ***Revenue contribution and collection:*** The health sector is financed through three sources: government budget (including on-budget donor support), off-budget donor assistance, and private out-of-pocket expenditures. Public expenditure is allocated through two financing arrangements: the MDG performance fund (MDGPF) channeled through the FMoH, and block grants provided to regional states by the Ministry of Finance and Economic Development. Block grants mainly cover recurrent costs such as salaries and operational costs, and the MDGPF supports the procurement of equipment and commodities, construction of health facilities, capacity building of health extension workers, and the establishment of CBHI.[1] Patient user fees and those recovered from waivered services at the district level pay for service providers at facilities.

The public health sector budgeting and management approach is mainly input-based and not linked to outputs or outcomes. Harmonizing fragmented off-budget donor financing (accounting for nearly half of external assistance), and better planning and coordination between regional governments and the FMoH, can lead to improved resource efficiency.

- ***Pooling:*** When scaled up, the CBHI and SHI insurance schemes will cover the majority of households in the country, in the process increasing risk pooling and reducing out-of-pocket spending. The GoE contributes general subsidies for premium payments to cover expenses for outpatient and inpatient services, surgery, and medicines for the enrolled households. Currently, 6.5 million people benefit from enrollment in the CBHI system, constituting almost 7% of the country's population (health insurance coverage nationwide was <1% two years ago).[2]

In comparison, SHI is designed to be payroll-based and mandatory for public sector employees, before expanding to the public sector as well. The program is scheduled to launch implementation in January 2016.

For both of these risk pooling arrangements, the GoE needs to carefully calibrate benefit package design, provider payment mechanisms, and coordinate cross subsidization within and between the two programs. The FMoH has established the Ethiopia Health Insurance Agency (EHIA) to take on joint management of the SHI and CBHI programs. It is currently working with development partners to evaluate lessons and support evidence-based decisions on payment mechanisms.

- ***Purchasing:*** A significant share of health services (61%) is purchased through expenditure by the government. However, over 35% is bought through out-of-pocket payments made by households.[3] Performance-based contracting is used to improve supply, by transferring money from purchasers (the MoH, regional health bureaus and district health offices) to service providers (health facilities) conditional on achieving predetermined performance targets.

Under the CBHI scheme, providers are paid on a fee-for-service basis. The reimbursements for services rendered to CBHI members, coupled with the retention of revenue collected by health facilities, has increased the resources for health at facilities.

## Meeting the Goals of Universal Health Coverage (UHC)

UHC can only be achieved when access to health services and financial risk protection are equitably addressed. Equitable financial protection means that everyone, irrespective of their level of income, is free from financial hardship caused by using needed health services.

### *Financial protection*

Estimates of the financial burden of out-of-pocket spending for households range between 1.07-4% of household income.[4] To improve financial protection, the GoE has established fee waivers, exemption programs, pilot CBHI schemes, and a legal framework for health insurance in the formal sector.

Services delivered at the facilities do not require copayments for those enrolled under the CBHI pilots. The fee-waivers and exemptions systems allow the poorest individuals to receive services at facilities.

The EHIA introduced new financial protection-related indicators in the 2013/14 Annual Plan. These could help guide planning and budgeting, and include coverage of risk pooling schemes, percentage of the poor whose premium is paid by the government, and percentage of risk pooling scheme members utilizing services.[4]

### *Equity in financing and utilization*

The total number of health care facilities, particularly primary care centers, has increased nearly 10-fold since 2005 and distribution on a per capita basis is largely equitable. Secondary and tertiary level service capacity, however, has not improved significantly. In regions where standardization of the fee waiver system and package of exempted services has been successfully accomplished, inequities in access to care have been reduced. Analysis of utilization of selected fee-exempted services shows that the poorest quintile is behind in using these services for reasons related to social and cultural factors as well as cost and geographic access.[5]

Health service utilization among CBHI members is nearly double the national average, with 0.7 facility visits per person per year.[2] However, the largest improvements in health service coverage between 2005 and 2011 occurred among the wealthiest households. Trends in the numbers of outpatient department visits for curative care between 2000 and 2011 also indicated a wide disparity between utilization in urban and rural areas.[5]

In order to improve UHC goals of equity, financial protection and improved access to care, the GoE will need to speed up implementation of CBHI and SHI by identifying those at greatest need, while also advocating for increased resource allocation from public sector budgets and international partners.

### Endnotes


1. Wang H and Ramana GNV. Universal health coverage for inclusive and sustainable development: Country Summary Report for Ethiopia. World Bank Group. August 2014.
2. Health financing Reforms: Ethiopia Experience. Technical Brief prepared for USAID SOTA conference. November 2015. USAID
3. WHO Health System Financing Profile, Ethiopia. 2013.
4. Alebachew A, Hatt L, Kukla M, Nakhimovsky S (2014) Universal Health Coverage Measurement in a Low-Income Context: An Ethiopian Case Study. Bethesda, MD: Health Finance & Governance Project, Abt Associates Inc.
5. Alebachew A, Hatt L, Kukla M (2014) Monitoring and Evaluating Progress towards Universal Health Coverage in Ethiopia. PLoS Med 11(9): e1001696.



Additional information can be obtained from:
African Strategies for Health 4301 N Fairfax Drive, Arlington, VA 22203 • +1.703.524.6575 • AS4H-Info@as4h.org
www.africanstrategies4health.org



*This publication was made possible by the generous support of the United States Agency for International Development (USAID) under contract number AID-OAA-C-11-00161. The contents are the responsibility of the authors and do not necessarily reflect the views of USAID or the United States Government.*