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MINISTRY OF HEALTH - ETHIOPIA
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HEALTHIER CITIZENS FOR PROSPEROUS NATION!

ETHIOPIA NATIONAL HEALTH ACCOUNTS REPORT 2019/20

PARTNERSHIP AND COOPERATION DIRECTORATE

APRIL 2022

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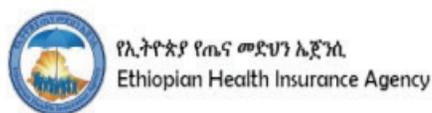
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ETHIOPIA HEALTH ACCOUNTS

2019/2020 (2012 EFY)



FOREWORD

Information on health expenditure is an essential input to informing strategic policymaking, planning, and resource allocation. It is also critical for monitoring the health systems' performance and progress on policy goals, such as universal health coverage, equity, efficiency, and sustainability. The Ministry of Health generates and uses evidence on the magnitude and flow of health sector resources using the health accounts (HA) methodology. The HA estimate informs how total health expenditure flows from financing sources to end users. This is the eighth national health accounts analysis report of Ethiopia. The report presents the results of the analysis on health expenditure data from the 2012 Ethiopian Fiscal Year (2019/20GC), including information on expenditure by source, provider, activity, input, disease, and age. The findings of this HA study provide critical information that the MOH and partners can use to jointly assess the sector's performance. 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.

We are grateful for the technical and financial support provided by development and implementing partners, who closely collaborated with the Ministry starting from the planning up to the finalization of the study. Furthermore, the production of this round of the NHA would not have been possible without the support of different Government and non-government organizations who have generously shared their data on health expenditure.

The Ministry of Health is planning to continue the production of the NHA on a regular basis and this process will provide useful information on trends in health expenditure to inform policy, planning, and resource allocation, which in the end will help to achieve UHC in Ethiopia.



H.E. Dr. Lia Tadesse, Minister,
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ACRONYMS AND GLOSSARY

Acronyms

CBHI	Community-based health insurance
CHE	Current health expenditure
CHAI	Clinton Health Access Initiative
CSA	Central statistical agency
EHIS	Ethiopian Health Insurance Service
ETB	Ethiopian Birr
GBD	Global burden of disease
GDP	Gross domestic product
GHEDB	Global health expenditure database
GoE	Government of Ethiopia
HA	Health accounts
HAAT	Health Accounts Analysis Tool
HAPT	Health Accounts Production Tool
HAD	Health Development Army
HEP	Health extension program
HSTP	Health Sector Transformation Plan
ICD	International classification of diseases
MOF	Ministry of Finance
MOH	Ministry of Health
NEC	Not elsewhere classified
NBE	National Bank of Ethiopia
NGO	Nongovernmental organization
NPISH	Non-profit institutions serving households
OECD	Organization for Economic Co-operation and Development
OOP	Out of pocket
PPP	Purchasing power parities
SHA	System of health accounts
SHI	Social health insurance
STD	Sexually transmitted disease
THE	Total health expenditure
USAID	United States Agency for International Development
VHI	Voluntary health insurance
WB	World Bank
WHO	World Health Organization

EXECUTIVE SUMMARY

Country context

Ethiopia is Africa's second-most populous country and ranks 12th globally, with a projected population of 122.3 million in 2030. Over 55% of Ethiopians are under the age of 20, and less than 25% live in urban areas. Ethiopia has finalized its Growth and Transformation Plan (GTP II) for the period 2015/16–2019/20 and has a five-year health strategic plan for the period 2020/21–24/25 called the “second health sector transformation plan (HSTP II).” This plan aims to improve the health of the population through the realization of progress towards universal health coverage (UHC), creating Woreda transformation and protecting people from emergencies. The HSTP-II strategy builds on the success of the previous health care financing strategy.

National health account in Ethiopia

The national health accounts (NHA) are used to help policymakers understand who pays for health care, who manages health resources, and how resources are spent on interventions or diseases. The NHA tracks healthcare-related expenditures using key financing indicators, such as total and per capita health spending, allowing for cross-country comparisons.

Ethiopia's eighth NHA provides a breakdown of spending by standard disease classifications, financing sources, financing schemes, level and type of provider, and health function. Ethiopia has successfully finalized seven rounds of NHAs to date. This report summarizes the results of the eighth NHA estimations, which were conducted using data from Ethiopia's fiscal year 2012 (July 8, 2019 to July 7, 2020). Data was collected and analyzed between July and October of 2021. Ethiopia's sixth, seventh, and eighth NHAs used the 2011 Framework for Systems of Health Accounts (SHA) (OECD Eurostat and WHO, 2011).

Methods

The SHA model classifies health expenditure according to the tri-axial accounting structure for health care consumption, service delivery, and health financing. Such a tri-axial presentation of health financial information provides policymakers and other stakeholders with a more robust understanding of the health care financing scheme and the flow of health resources.

Health expenditure data was collected from the Ministry of Finance (MoF), 32 universities, 25 bilateral and multilateral donors, a sample of 270 NGOs (112 international and 164 local), 289 employers (28 parastatals and 261 private), 17 insurance companies, and five line-ministries. Moreover, we have used the general household survey data primarily collected in 2019/20 by the MERQ Consultancy in collaboration with the Ethiopian Health Insurance Agency (EHIA) (with a sample size of 5,954 households) for the purpose of evaluating the impact of the CBHI scheme and estimating ability and willingness to pay for CBHI (MERQ and EHIA, 2020). The survey coincided with the NHA study period in both time and methodology.

This round's NHA data was collected using tablets and a CSPRO interface for remote data entry. Stata/SE 17.0 for Windows was primarily used for data structure before moving the final data to the Health Accounts Production Tool (HAPT) for mapping and analysis. The selected approach allowed the study to be completed in less than a year.

Key findings

Total health expenditure (THE): THE increased from ETB 72 billion (USD 3.1 billion) in 2016/17 to ETB 127 billion (USD 3.62 billion)¹ in 2019/20. In the respective fiscal years, this accounts for approximately 4.7 % and 6.3 % of GDP. The share of recurring health care spending increased, while the share spent on

¹ End period mid-market exchange rates from the National Bank of Ethiopia 2019/20 annual report were used.

training and research spending decreased. In contrast, the share of capital spending fell from 8.6 % in 2016/17 to 6.2 % in 2019/20.

Per capita health expenditure: Ethiopia's per capita health expenditure has grown steadily over the past two decades, from USD 4.502 in 1995/96 to USD 33.2 in 2016/17 and to USD 36.30 (including COVID-19 spending) in 2019/20. The amount is still low compared to the USD 43 average for low-income African countries, and it is far less than the \$86 per capita spending the WHO recommended for delivery of essential health services by 2015.

Financing sources: The government's share of THE was 32% in 2016/17 and 32.3% in 2019/20. In contrast, the contribution of the rest of the world (donors) has slightly decreased from 35.2% to 33.9% of THE, even though the amount increased from USD 1.09 billion in 2016/17 to USD 1.23 billion in 2019/20. Similar to previous health accounts, the share of private employers and other sources remained insignificant, as it accounted for only around 2.5% of THE. Community-based health insurance (CBHI) was initiated in Ethiopia as a key mechanism to provide financial protection and mobilize resources. Although the CBHI scaled up to 827 woredas at the end of 2019/20, the share of THE contributed to out-of-pocket expenditure remained at about 30%, and the role of CBHI as a financing source for health remains limited to about 1% of total health expenditure (or 2% of total expenditure managed by the government).

Management of health resources: Ethiopia's government continues to play a key role in managing funding for health. The share of THE managed by the government decreased from 52% to 47% between 2016/17 and 2019/20. The share managed by donors and NGOs increased slightly from 15% to 20%, while the resources managed by insurance companies and private employers remained limited.

Health providers: In 2019/20, spending at the primary health care unit (primary hospitals, health centers, and health posts) accounted for 44% of THE. Tertiary and secondary hospitals' expenditure was 10.5% of THE. Spending on health care system administration and financing has continued to increase—from 4% of THE in 2013/14 to 18% in 2016/17 and to 20% in 2019/2020.

Health care function: Spending on curative services remains at about half of total spending (~56%). Spending on preventive services decreased from 30% in 2016/17 to 19% in 2019/20.

Disease and health conditions: Communicable diseases account for about 46% of THE, while non-communicable diseases (NCD) account for 25% of THE, with households and the government bearing the main financial burden.

COVID-19: About 190 million USD was spent on COVID-19 during 2020 (5% of THE for 2019/20). The government financed about 50% of this, while donors financed 40%.

Conclusion

Ethiopia's National Health Account (NHA) for fiscal year 2019/20 shows that the health-financing system is dependent on external sources and that government spending on health, despite its slight growth, is still low. This implies that the Ethiopian health system is currently highly unsustainable and underfunded. The study also showed little misalignment in the allocation of resources based on national priorities and low capital investment to support and sustain healthcare delivery systems.

Policy implications and recommendations

Ethiopia's Ministry of Health needs to strengthen resource mobilization efforts and the pooling mechanism, giving priority to primary healthcare and preventive health services. Some of the key recommendations made in this study are: increasing government spending on health over time; enacting efforts to expand financial protection mechanisms and for NCD and preventive care; more investment in primary health care (PHC) for UHC; an emergency health financing mechanism should be in place, and the government should introduce new and alternative financing options.

² These amounts are in the billions unless otherwise specified.

1. INTRODUCTION

NHAs collect, map, and summarize data on a country's national or regional health expenditure. NHAs enable policymakers to make critical decisions about who pays for health care, who manages health resources, and how health resources are spent on interventions or diseases. Based on an internationally standardized methodology, NHAs track healthcare-related expenditures using key financing indicators, such as total and per capita health spending, allowing for cross-country comparisons.

1.1 BACKGROUND

Ethiopia, with an estimated 99.7 million mid-year population in 2019/20, is Africa's second-most populous country and ranks 12th globally, with a projected population of 122.3 million in 2030 (CSA, 2013). Over 55% of Ethiopians are under the age of 20, and less than 25% live in urban areas (CSA, 2013). Ethiopian economic growth remained robust even as the world faced difficult macroeconomic instability and various economic and social challenges as a result of the outbreak of the COVID-19 pandemic. In the fiscal year 2019/20, real GDP increased by 6.1%, much more than the 3.5% average growth forecast for Sub-Saharan Africa (World Economic Outlook Update, June 2020).

Ethiopia has recently finalized its Growth and Transformation Plan (GTP II) for the period 2015/16–2019/20. During the GTP II implementation, the country's economy grew at an average annual rate of 8.2%.³ To enhance this progress, the government of Ethiopia has recently introduced the Homegrown Economic Reform program, with the foundational objectives of sustaining economic growth and maintaining a stable macroeconomic environment.⁴

Ethiopia implemented the first Health Sector Transformation Plan (HSTP-I) from 2015/16 to 2019/20, achieving significant gains in population health and improving access to and utilization of health services. Health outcome indicators improved, with significant reductions in morbidity and mortality associated with major communicable diseases, such as HIV, tuberculosis, and malaria. Maternal and child health also improved, saving millions of women and children's lives. For example, Ethiopia was able to increase births attended by skilled health workers from 5% in 2005 to 50% in 2019, reduce the under-five mortality rate from 123 to 77 per 100,000 live births during the same period (Mini DHS, 2019), and reduce maternal mortality from 676 in 2011 to 401 deaths per 100,000 live births in 2017 (HSTPII). Despite significant progress, mortality and morbidity from communicable diseases, maternal and child health conditions, and other causes of death remain high. There is a significant disparity in service utilization and health outcomes across geographical areas and socioeconomic groups. Emerging pandemics and epidemics, such as COVID-19, also pose a threat to the health system.

Ethiopia is currently implementing its five-year health strategic plan for the period 2020/21–24/25, called the "second health sector transformation plan (HSTP II)." The HSTP II aims at improving the health of our population through the realization of progress towards UHC, creating Woreda transformation, and protecting people from emergencies. To measure progress towards these objectives, the HSTP II has set ambitious but realistic targets that are aligned with the national 10-year development plan and the international Sustainable Development Goals (SDGs), especially Goal 3. Over the past two decades, Ethiopia's 1998 Health Care Financing Strategy was instrumental in building strong resource mobilization and allocation systems that support the implementation of the five-year health sector strategy plan. The strategy made a significant contribution by mobilizing financial resources for improving access to health services and health outcomes. The revised health care financing strategy builds on the previous strategy's success and aims to accelerate progress toward UHC through primary health care. The new strategy is focused on implementing new financing mechanisms in order to boost domestic resource mobilization and ensure sustainable health financing.

³ Annual Report of the National Bank of Ethiopia for 2019/20.

⁴ Ten Years Perspective Development Plan (2021–2030).

1.2 NATIONAL HEALTH ACCOUNTS IN ETHIOPIA

Health care is delivered by a complex and ever-changing mix of public, private for-profit, and not-for-profit providers. In this environment, policymakers require reliable information on the sources and uses of health funds, preferably comparable over time and across countries, in order to improve the performance of health systems. NHAs were created specifically to address this. The NHA is a methodical, comprehensive, and consistent examination of resource flows within the health system over a specified time period. It is intended to capture the full range of information contained in these resource flows and to reflect the main functions of health care financing: resource mobilization and allocation, pooling and insurance, purchasing of care, and the distribution of benefits.

Ethiopia has successfully completed seven rounds of the NHA to date. This report summarizes the results of the eighth NHA estimations, which were conducted using data from the Ethiopian fiscal year 2012 (July 8, 2019 to July 7, 2020). Data was collected and analyzed between July and October of 2021. Ethiopia's sixth, seventh, and eighth NHAs used the 2011 Framework for Systems of Health Accounts (SHA) (OECD Eurostat and WHO, 2011). The eighth-round NHA data enables disaggregation of health expenditures by standard disease classifications, financing sources, financing schemes, financing agents, provider level and type, and health function (inpatient and outpatient care), and it could be used to monitor HSTP progress and to inform the development or reform of financing policies.

1.3 OBJECTIVES AND POLICY QUESTIONS

The NHA informs policymakers on determining whether sufficient resources are being spent on health, whether resources are being used in the most equitable, effective, and sustainable way, and whether resources are allocated in a way that will enable the health system to achieve more value for its money and improve the coverage and quality of health services.

Some of the more specific objectives of the NHA survey include:

- Quantifying total resources spent on health and the contribution of each stakeholder in financing health care
- Generating evidence on the association between health sector priorities and health spending by level and types of health services
- Understanding how health resources are disaggregated by financing agent, disease category, and health programs
- Creating internationally comparable health expenditure data
- Documenting the magnitude and share of health expenditures in a broader macroeconomic context, including its share of gross national product (GDP) and government spending
- Synthesizing health expenditure data and documenting policy implications for further development of health financing in Ethiopia.

In line with the above objectives, the current (eighth) NHA attempts to provide information to answer different health-financing-related policy questions, such as "What is the magnitude of total and per capital health spending in the country? What are the sources of financing for health, and how are resources managed and distributed at each level of the health system? What is the burden of out-of-pocket expenses on households, and how significant is the contribution of private sector in financing for health?"

2. METHODS

The NHA supports policy and resource allocation in low- and middle-income countries by collecting and analyzing health expenditure data using an internationally recognized and standardized methodology to facilitate comparisons across countries and over time. The development of NHAs usually follows the methods which were developed by the WHO, USAID, WB, and other development partners (OECD Eurostat and WHO, 2011). The collection and analysis of health expenditure data through the NHA is supported by standardized data collection and analysis tools and technical support from the WHO and other partners with the aim of institutionalizing the NHA as a routine part of a country's management information system. Ethiopia has been undertaking, in total, eight rounds of NHAs to inform the development, implementation, and monitoring of health financing policies, covering the following fiscal years: 1995/96, 1999/00, 2004/05, 2007/08, 2010/11, 2013/14, 2016/17 and 2019/20. The last three NHA studies used the updated system of health accounts (SHA 2011) framework.

2.1 DEFINITION AND CLASSIFICATION OF HEALTH EXPENDITURE

The production of an NHA is based on a conceptual framework called the System of Health Accounts (SHA) 2011, an internationally recognized, standardized framework for analyzing health expenditure. According to the SHA 2011, which uses a functional classification of health care activities, an NHA should include expenditure on "all activities with the primary purpose of improving, maintaining and preventing the deterioration of the health status of persons and mitigating the consequences of ill-health through the application of qualified health knowledge (medical, paramedical and nursing knowledge, including technology, and traditional, complementary and alternative medicine)." For example, expenditure on activities with the primary purpose of improving water and sanitation, although beneficial for health, should not be included. However, if the primary purpose of the water and sanitation activity is health-related—for example, improving the water supply to health centers—such expenditure should be included. Following the same logic, social care for HIV orphans should not be included, while health care for HIV orphans should be included. The SHA 2011 provides a standardized classification of expenditure. The current analysis followed this classification with some minor modifications to ensure compatibility with the Ethiopian health system.

In this study, health expenditures were defined as expenditures for all activities whose primary purpose was to restore, improve, and maintain health during the study period of 2019/20. This means that the study considered all health expenditures regardless of the type of institution or entity providing or paying for the healthy activity. Health expenditure was defined as spending on the following types of healthcare activities:

- Health promotion and prevention
- Diagnosis, treatment, cure, and rehabilitation of illness
- Caring for people affected by chronic illness
- Caring for people with health-related impairments and disabilities
- Palliative care
- Providing community health programs
- Governance and administration of the health system.

The main criteria for determining whether an activity should be included or not were the following:

- The primary purpose of the activity must be to improve, maintain, or prevent the deterioration of the health status of individuals, groups within the population, or the population as a whole, as well as to mitigate the consequences of ill health.
- The consumption is for the final use of health care goods and services of residents.
- There is a transaction involving health care services and goods.

2.2 SYSTEM OF HEALTH ACCOUNTS (SHA)

The SHA 2011 framework is an internationally comparable standard for reporting expenditure on health. It classifies health expenditures according to the tri-axial accounting framework of consumption, service provision, and financing for the purposes of providing policymakers with timely and accurate information (Figure 1).

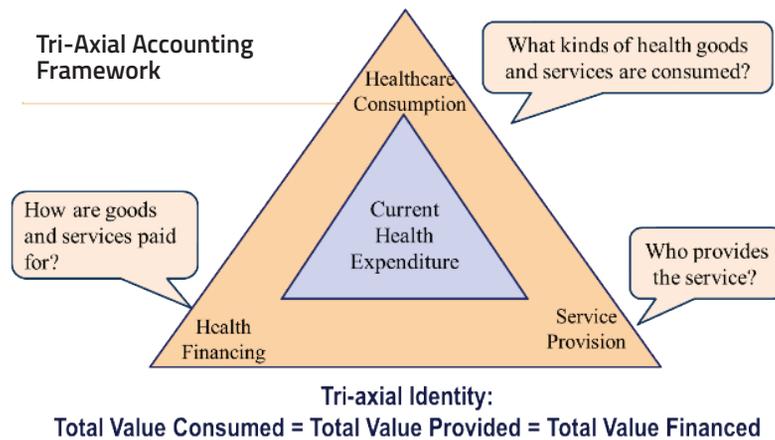


Figure 1: SHA framework

More specifically, the SHA model provides the structure for estimating the health expenditure that is amenable to international, sub-national, and sub-accounts comparisons. The framework defines the boundaries of health care activities to include “all spending activities whose primary purpose is to improve, maintain and prevent the deterioration of the health status of individuals, groups of a population or the entire population of the nation or state”(WHO, 2011).

The SHA 2011 improves on the International Classifications for Health Accounts by providing clearer distinctions of classifications at the levels of source, health provider, and healthcare function (OECD et al., 2011). This approach also provides clear distinctions among capital items. Table 1 shows the major classifications and their definitions that formed the core of the analysis based on the SHA 2011 framework.

Table 1: System of Health Accounts Classifications and Definitions

Classifications	Definitions	Examples
Revenues of Financing Schemes (FS)	Revenue denoted as FS reflects the nature of funds provided by the various institutional units acting as the sources of funds.	Direct foreign financial transfers, internal transfers and grants, transfers distributed by the government from foreign origin, voluntary prepayments from individuals/households, and voluntary prepayments from employers
Revenue of Financing Schemes, Reporting Items (FS.RI)	The institutional units that provide revenue for the various schemes are denoted as FS.RI.	Government, not-for-profit institutions serving households (NPISH), rest of the world, corporations, and households
Financing Schemes (HF)	Financing schemes denoted as HF are components of a country's health-financing system that raise revenue, manage funds, and purchase services, reflecting the financing arrangements on "how" healthcare goods and services are financed or paid for.	Government schemes, voluntary healthcare payments, household out-of-pocket payments, and rest-of-the-world financing schemes (non-resident)
Financing Agents (FA)	FAs are the entities or institutions that receive funds through financing schemes and manage the funds that pay for health services.	The MOH, the EHIS, district councils, and local and international NGOs
Health Providers (HP)	HPs are entities that receive money from a financing agent in order to provide services or perform health functions for consumers of health care goods and services.	All types of hospitals, health centers, and providers of preventative care
Health Care Functions (HC)	HCs refers to the goods or services that consumers purchase from health care providers.	Inpatient and outpatient curative care, prevention, public health programs, and health administration
Health-Care-Related (HCR)	HCR refers to activities that may overlap with other fields of study, such as education, overall "social" expenditure, and research and development, and sometimes may be closely linked to healthcare in terms of operations, institutions, and personnel.	Nutrition, water and sanitation, and environmental health
Capital Formation (HK)	HK refers to the types of assets health providers have acquired during the accounting period and are used repeatedly or continuously for more than one year in the production of health services.	Medical equipment and transport equipment
Disease (DIS)	This is the condition/intervention area by which health expenditure is analyzed.	Infectious and parasitic diseases, reproductive health, nutritional deficiencies, noncommunicable diseases, and injuries
Factors of Provision (FP)	The valued inputs used in the process of provision of health care.	Salaries, health and non-health goods, and consumption of capital

These classifications allow the NHA to accommodate expenditures in more pluralistic health systems, including those found in low-income countries such as Ethiopia, where providers may receive payments from multiple financing sources and where payments may be made to numerous providers.

2.3 DATA SOURCES

The eighth NHA study used the primary and secondary data described below. Primary data was collected by undertaking surveys among a wide range of sources:

- All line ministries/agencies with health-related activities and expenditure and 32 universities whose data were not captured in the disaggregated MOF data
- All bilateral and multilateral donors (25) working in Ethiopia's health sector to estimate the magnitude, flow, and purpose of donor spending in the health sector
- Randomly selected 276 NGOs (112 international and 164 local) to understand flows of health resources through this sector
- A stratified sample of 289 employers (28 parastatals and 261 private employers) to understand the extent to which employers provide medical insurance or reimbursement to their employees
- All 18 insurance companies (one public and 17 private) operating in the country during the study period to estimate the amount of health resources managed by these entities

In addition to the primary data described above, data was also collected from the following sources:

- The MOF, which provided audited data for EFY 2012 (2019/20) on government spending on the health sector at all levels of government (federal, regional, and woreda) and by various types of providers.
- General household survey data primarily collected with a sample size of 5,900 households in 2019/20 by the EHIS and MERQ Consultancy for the purpose of evaluating the impact of CBHI intervention (EHIS and MERQ 2020). This survey data was used to estimate and track household health expenditure. As the survey year coincided with the NHA study year, it was not necessary to carry out a separate survey.
- Expenditure data from the MOH, including SDG pool fund financial reports and COVID-19 spending as well as annual resource-mapping data from donor and implementing partners for the 2012 EFY.
- Health service unitization by delivery channel, disease type, and region from DHIS-2 for the 2012 EFY for the purpose of developing distribution keys for unpacking government and other spending by diseases.
- MOH unit-cost database compiled from different sources. 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.
- Reimbursement data from the EHIS, which shows how much money was reimbursed to a health care provider under the CBHI scheme, which is part of the health care service.
- Central Statistical Agency's population projection of 2012 EFY to estimate per capita health spending of the country.
- Annual reports of the National Bank of Ethiopia (2019/20) for the GDP estimates and exchange rates to convert the different foreign currencies into Ethiopian birr and US dollars.

2.4 DATA MANAGEMENT, VALIDATION, AND MAPPING

Once the dataset from various sources were collected, data management and validations activities were conducted using different tools, including CPro, Stata, and MS Excel. CPro was used for data entry and tabulation for the survey data from donors, international NGOs, local NGOs, private employers, and parastatals. The datasets were then exported into Stata for further cleaning, validation, and computations. Stata and MS Excel were used for the management of datasets collected from other sources. The bulk of the data management and validation as well as mapping activities were carried out during a three-week validation workshop with the participation of relevant stakeholders.

The mapping involved assigning expenditures to their respective classifications within the SHA 2011 framework. The expenditures were assigned to institutions providing financing schemes' revenue (FS, RI: the institutions), revenue of financing schemes (FS: nature of the funds), financing schemes (HF), capital (HK), financing agents (FA), health providers (HP), healthcare functions (HC), health-care-related (HCR), factor of provision (FP), age (AGE), gender (GEN), beneficiary (BEN), and diseases (DIS) codes. The SHA categorizes diseases into infectious and parasitic diseases, reproductive, nutritional deficiencies, noncommunicable diseases, injuries, and unspecified diseases/conditions. The infectious and parasitic subcategory comprises HIV and AIDS, malaria, TB, diarrheal diseases, neglected tropical diseases, respiratory infections, COVID-19, and vaccine-preventable diseases. The reproductive health subcategory includes maternal conditions, perinatal conditions, and family planning, while noncommunicable diseases includes diabetes, hypertension, mental illnesses, diseases of the sensory organs, and respiratory, digestive, and oral diseases.

2.5 DATA ANALYSIS

The Health Account Production Tool (HAPT) was used for this round of the NHA study. The HAPT is software developed by the USAID-funded Health Systems 20/20 Project with additional input from the WHO and WB. It was developed to reduce complexity in the documentation and methodology of measuring financial resource flows in the health sector and to enhance the comparability of outcomes across countries. The tool has features for storing previous health account estimations, customizing NHA codes, streamlining data collection and data importing, data mapping, double-counting, application of consistent weights to data, and validation and automatic generation of graphs and tables. All the previous seven NHA studies also used this tool for performing the abovementioned activities. For this round of the NHA study, the HAPT tool was used in conjunction with Stata.

2.6 LIMITATIONS AND CHALLENGES

Compared to the previous rounds of NHA studies, the eighth round used more detailed government data received from the MOF and the general household survey data collected in the same fiscal year. This has improved the quality of the results produced. At the same time, dealing with such complex data required greater efforts by the technical team.

The inclusion of COVID-19 spending in this round of the NHA study has inflated the total and per capita health expenditure of the country. Hence, comparing results with the previous NHA study results is a challenge. For this reason, we have attempted to show the results both with and without the COVID-19 spending. The fact that this round of the NHA only captured COVID-19 expenditure for six months can be considered as another limitation.

3. FINDINGS

This chapter presents the findings of the 2019/20 NHA study. In most cases, the results for this NHA are compared with the previous NHA results of Ethiopia, but, in certain cases, the findings are compared with those of other countries in the Sub-Saharan region. The discussions of the findings focus on specific health financing policy issues falling under the main three health financing functions: resource mobilization, risk pooling, and purchasing.

3.1 HEALTH EXPENDITURE IN 2019/20

3.1.1 Total health expenditure

The steadily increasing trend of THE over the last two decades has also continued between the seventh (2016/17) and eighth (2019/20) round of NHAs. The THE (recurrent and capital) of Ethiopia was estimated at ETB127.47 billion (USD 3.63 billion) in 2019/20. Compared to 2016/17, it has shown an increase by nearly 76% in nominal terms, as the THE in 2016/17 was ETB 72 billion (USD 3.1 billion). However, the inflation-adjusted growth was only 16%, from ETB72 billion to ETB84 billion.⁵ Between 2016/17 and 2019/20, the share of recurrent health spending⁶ increased from 87.8% to 92.4%, while the share of training and research spending decreased slightly (1.5%). Capital spending, on the other hand, has decreased from 8.6% to 6.2%. Table 2 provides the summary of results from the seventh and eighth NHA studies of Ethiopia.

Table 2: Total Health Expenditure by Financing Source and Spending Category, 2016/17 and 2019/20 (in billion)

Health Spending Categories, 2019/20						
Source of Financing	Recurrent (ETB)	Capital (ETB)	Training and Research (ETB)	Total (ETB)	Total (USD)	Share by Source
Donors	40.52	2.69	-	43.21	1.23	33.9%
Government, including parastatals	34.02	5.15	1.86	41.04	1.17	32.2%
Federal levels	8.56	2.91	1.86	13.33	0.38	10.5%
Regional and woreda level	25.46	2.24	-	27.71	0.79	21.7%
Households: Direct OOP	38.92	-	-	38.92	1.11	30.5%
CBHI (voluntary prepayment)	1.13	-	-	1.13	0.03	0.9%
Private employers and others	3.13	0.04	-	3.16	0.09	2.5%
Total	117.7	7.9	1.9	127.47	3.63	100%
Share (as a% of THE)	92.4%	6.2%	1.5%	100%		
Health Spending Categories, 2016/17						
Source of Financing	Recurrent (ETB)	Capital (ETB)	Training and Research (ETB)	Total (ETB)	Total (USD)	Share by Source
Donors	22.55	2.80		25.35	1.09	35.2%
Government, including parastatals	17.19	3.37	2.62	23.19	1.00	32.0%
Federal levels	2.75	1.55	2.62	6.93	0.30	9.6%
Regional and woreda level	14.44	1.82		16.27	0.70	22.5%
Households: Direct OOP	21.83			21.83	0.94	30.2%
CBHI (voluntary prepayment)	0.25			0.25	0.01	0.35%
Private employers and others	1.54	0.00		1.54	0.07	2.1%
Total	63.37	6.18	2.62	72.2	3.1	100%
Share (as a% of THE)	87.8%	8.6%	3.6%	100%		

⁵ The real spending is calculated by deflating the total spending of the current HA year (2019/20) to the previous HA year (2016/17).

⁶ Spending on health care delivery, health care commodities and supplies, and general health care system operations.

3.1.2 Per capita health expenditure

Ethiopia’s per capita health expenditure has grown steadily over the past two decades, from USD 4.50 in 1995/96 to USD 36.40 (including COVID 19 spending) in 2019/20.⁷ Though this growth is encouraging, the amount is still very low compared to the USD 43 average per capita health expenditure among low-income African countries,⁸ and it is far less than the \$86 per capita spending the WHO recommended for delivery of essential health services (Jowett et al. 2016).

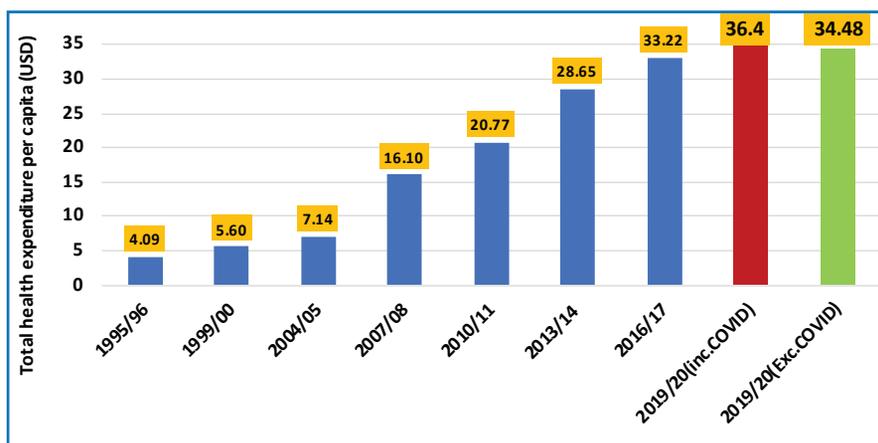


Figure 2: Per Capita Health Expenditure, 1995/96–2019/20

3.2 SOURCE OF HEALTH FINANCING

Ethiopia’s health sector has multiple financing sources which have assisted in the growth of THE, including the government treasury (federal, regional, and woreda/district levels), bilateral and multilateral donors, household out-of-pocket expenditure, CBHI (voluntary prepayment), and private employers and others.

The trends of the share of each of the above health financing sources (government, donor, household, and other private sources) from the total health spending in the eight NHA studies are shown in the figure and table below (Figure 3 and Table 3).

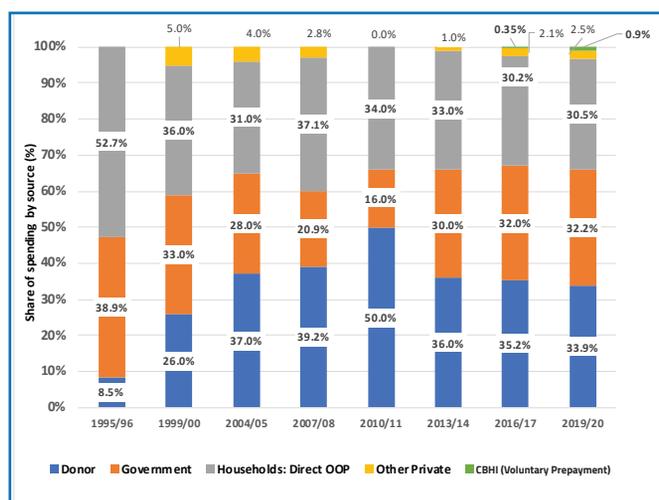


Figure 3: Total Health Expenditure by Source of Financing (%), 1995/96–2019/20

7. The Central-Statistical-Agency-projected total population of 99.7 million was used for the per capita estimation.

8. World Health Organization global health expenditure database: <http://apps.who.int/nha/database>, accessed on December 10, 2021.

Domestic resources: Domestic sources' overall contribution to the THE (government, household out-of-pocket expenditure, CBHI (voluntary prepayment), and other private) has increased slightly from 65% in 2016/17 to 66% in 2019/20.

Government: Government spending increased by 18% in real terms, from ETB 23.1 billion (USD 1 billion) in 2016/17 to ETB 41.04 billion (USD 1.17 billion) in 2019/20. As a result, the government's share of total health spending increased slightly, from 32% in 2016/17 to 32.3% in 2019/20. In general, health has been prioritized through a pro-poor policy, with an average pro-poor spending of around 65% of total general government expenditure going to the five pro-poor sectors of agriculture, education, health, infrastructure, and water from 2010/11 to 2019/20 EFY.⁹ Nonetheless, public funding for the health sector accounted for approximately 8.5% of total general government spending in 2019/20. While this expenditure is higher than the 8.1% share in 2016/17 and the average of 6.2% for other low-income countries (WHO, Global Health Expenditure Data Base, 2021), it is significantly lower than the 15% target set by the Abuja Declaration. Similarly, government health expenditure as a % of GDP has increased from 1.3% in 2016/17 to 1.93% in 2019/20. This is slightly higher than the low-income country's average of 1.3% in 2020.

Donors (rest of the world): Donor spending remains a critical source of financing for health services. Donor spending increased from USD 1.09 billion in 2016/17 to USD 1.23 billion USD in 2019/20. The share of donors in THE has decreased slightly from 35% to 34%, which is higher than the 30% average for low-income countries.

Household OOP: As expected, considering the relatively low government expenditure, OOP payments continue to play a significant role in Ethiopia in 2019/20 (30.54% of total financing, which is 2% of the GDP). This means that OOP's share of THE is higher than the global average (21%) and the 15% and 20% threshold suggested by the WHO to minimize financial catastrophe and impoverishment due to accessing health care services (WHO, Health System Financing, 2010). However, it is less than the low-income country average (43%). Increasing OOP payments over the years 1995/96 to 2019/20 contributed to THE and total per capita health expenditure growing faster than GDP and GDP per capita.

CBHI (voluntary prepayment): Ethiopia has a health insurance program, the CBHI program, that provides financial protection for citizens in the small-farming and rural economy and the informal sector in urban settings. The CBHI contribution to the THE has increased from 0.35% in 2016/17 to 0.9% in 2019/20. Although the contribution of voluntary prepayment or CBHI is very low, it has a positive impact on health service utilization and financial risk protection and promotes solidarity across groups (Alula M. Teklu et al., 2021).

Private employer and others: The health expenditure from private employers and other sectors in Ethiopia played an insignificant role, contributing to only 2.5% of the THE in 2019/20, slightly higher than the 2.1% in 2016/17.

TABLE 3: THE KEY INDICATORS OF HEALTH FINANCING

Indicators of the Level of Health Care Expenditure		1995/96	1999/00	2004/05	2007/08	2010/11	2013/14	2016/17	2019/20 (Inc. COVID)	2019/20 (Exc. COVID)
1	Total expenditure on health (in billion USD)	0.23	0.36	0.52	1.20	1.60	2.50	3.10	3.63	3.44
1	Total expenditure on health (in billion ETB)	1.45	2.93	4.50	11.10	26.50	49.57	72.05	127.47	120.8
2	Total expenditure on health as % of GDP	3.8%	5.0%	5.0%	4.5%	5.2%	4.7%	4.2%	6.3%	6.0%
3	Health care spending by the government as a % of GDP	1.5%	1.7%	1.4%	0.9%	0.8%	1.4%	1.4%	2.0%	1.9%
4	General government expenditure on health as % of total government expenditure	5.2%	5.6%	4.8%	4.8%	3.5%	7.6%	8.1%	8.5%	7.8%
5	Out-of-pocket expenditure on health as a % of GDP	2.0%	1.8%	1.6%	1.7%	1.8%	1.6%	1.3%	1.93%	1.93%
6a	Total health expenditure per capita (USD)	4.1	5.6	7.1	16.1	20.8	28.7	33.2	36.4	34.5
6b	Total health expenditure per capita (PPP \$)	13.6	23.2	29.7	47.7	75.6	81.3	106.7	105.3	99.8
6c	Health care spending by the government per capita (USD)	1.6	1.8	2.0	3.4	3.3	8.6	10.6	11.7	10.8
6d	Health care spending by the government per capita (PPP \$)	5.3	7.7	8.3	10.0	12.1	24.4	34.2	34.0	31.2

3.3 MANAGEMENT OF HEALTH RESOURCES

Financing agents are the intermediary institutions receiving and managing funds from financing sources to pay for or purchase health goods and services. Figure 4 shows the transition in management of resources over the 2013/14, 2016/17, and 2019/20 NHA studies.

Overall management of resources: In Ethiopia, the government¹⁰ continues to play a key role in receiving and managing funding for health. The share of THE managed by the government decreased slightly from 52% to 47% between 2016/17 and 2019/20.

The share managed by donors and NGOs increased slightly from 15% to 20.3% between 2016/17 and 2019/20, while funding managed by insurance companies and private employers remained limited. On the other hand, funding managed by households OOP has decreased from 33.7% in 2013/14 to 30.2% in 2016/17 and 30.5% in 2019/20.

¹⁰ Note that government-managed resources include CBHI scheme, treasury/loans, and some of the donor resources.

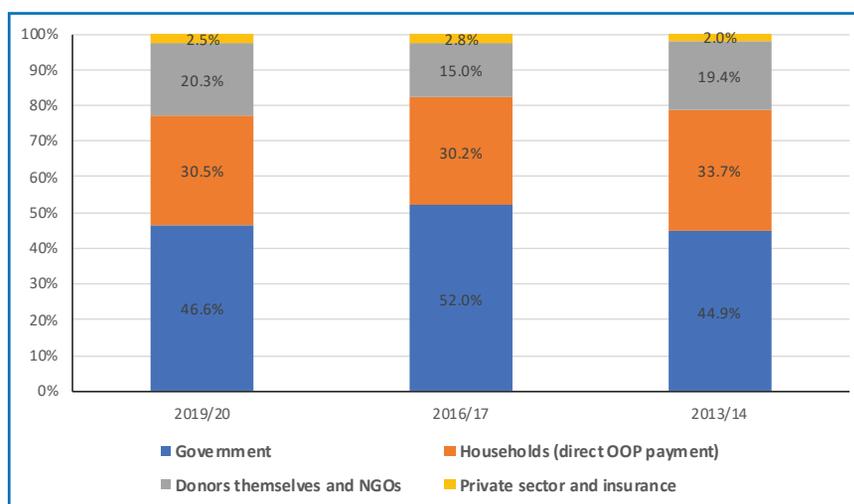


Figure 4: Total Health Expenditure by Financing Agent, 2013/14–2019/20.

Out of the government-managed resources, the share managed by regional health bureaus increased from 48% to 65% between the 2016/17 and 2019/20 fiscal years, while the share managed by the MOH decreased from 44% to 35% of THE (Figure 5).

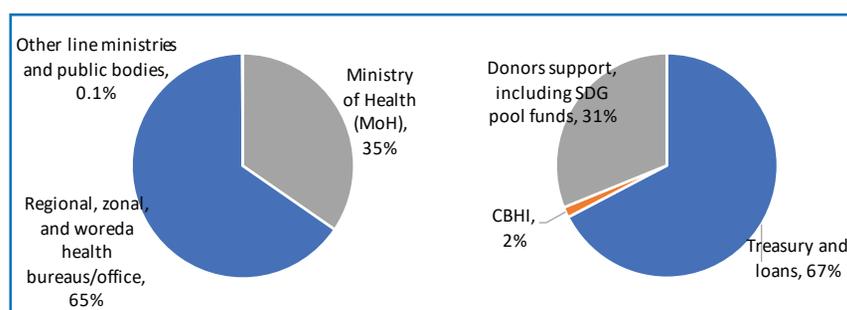


Figure 5: Total Government-Managed Resources by Type of Institution and Financing Source, 2019/20

3.4 POOLING OF HEALTH RESOURCES

In 2011, CBHI was initiated in Ethiopia as a key mechanism to mobilize resources and provide financial protection against out-of-pocket health expenditure in the informal sector. At the end of 2020, the CBHI scaled up to 827 woredas, with about 49% of all eligible households enrolled.

While the coverage of CBHI has continuously increased, the role of CBHI as a financing source for health remains limited to about 0.9% of THE (or 2% of total expenditure managed by the government). As described above, out-of-pocket levels remain high, covering about one-third of the THE, with limited change compared to 2016/17. While private employers, including insurance companies, contributed about 2.5% of THE, these resources are not pooled with other resources in the health system.

3.5 HEALTH EXPENDITURE BY PROVIDERS OF HEALTH SERVICES IN ETHIOPIA

In 2019/20, spending at the primary health care unit (primary hospitals, health centers, and health posts) accounted for 44% of THE, of which health centers and health posts accounted for about one-third (30%) of the THE. General and tertiary public hospital spending constituted about 10.7% of THE, while the share of the private clinics and hospitals spending was 15.1%. On the other hand, expenditure on providers of governance and health administration has continued to increase—from 4% of THE in 2013/14 to 18% in 2016/17 and to 20% in 2019/2020.

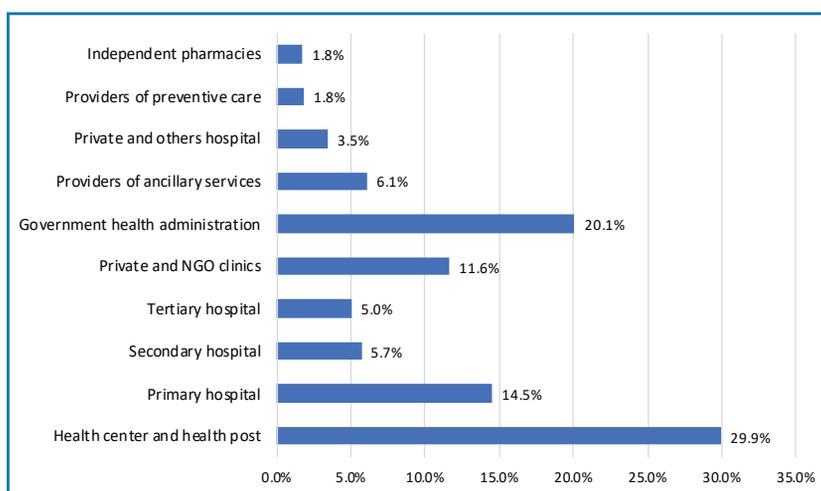


Figure 6: Total Health Expenditure by Provider 2019/20

3.6 GOVERNMENT EXPENDITURE BY PROVIDERS OF HEALTH SERVICES

In 2019/20, 38% of total recurrent government health spending went to public hospitals (tertiary hospitals accounted for 16%, primary hospitals for 12%, and general hospitals for 10%), while 33% went to public health centers and health posts. A little over one-fourth (26%) of the recurrent government resources go to health system governance. Providers of ancillary services (including independent pharmacies), providers of preventative care, and other providers not elsewhere classified accounted for 2.8% of the total government's recurrent health spending. Furthermore, primary health care providers, which include district hospitals, health centers, and health posts, received about 45% of the government's total recurrent health expenditure in 2019/20. This is markedly lower than its share in 2016/17 (61%), which was in line with the government's health policy, which focuses on providing preventive and promotive services at the primary health care level (Figure 7).

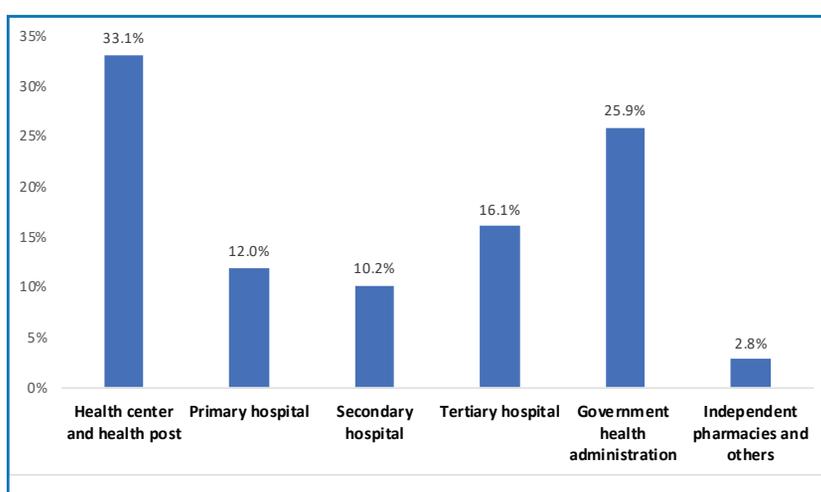


Figure 7: Recurrent Government Health Spending by Provider

The total government capital formation/investment during the study period is presented in Figure 8. Accordingly, the largest share of the government's capital spending on the health sector was on hospitals (58%), followed by health system administration and financing (health system governance) (31%), and providers of ambulatory health care, which includes health centers and hospitals (9%). The remaining balance (2%) went to other providers, including providers of ancillary services, the rest of the economy, unspecified providers, etc. Out of the country's overall THE¹¹ capital formation, training and research accounted for 6.2% and 1.5% respectively.

¹¹ The overall country's THE includes recurrent health expenditure, capital formation, and health-related expenditures.

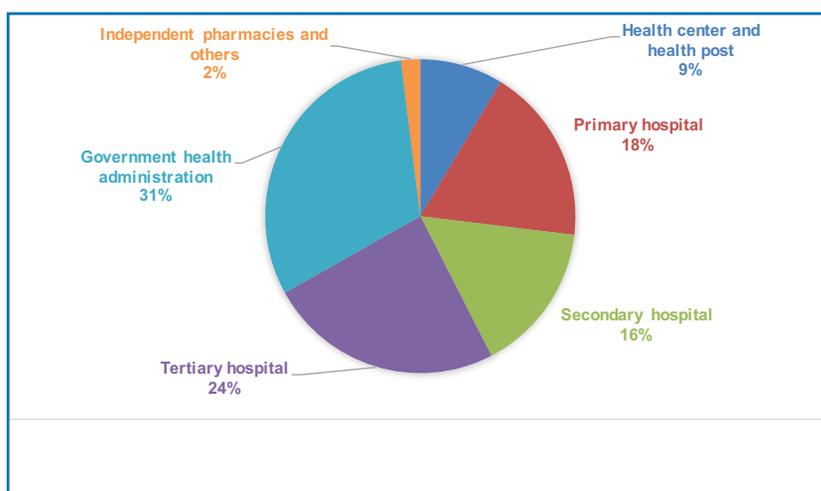


Figure 8: Total Government Capital Formation by Provider (%)

The sum of government recurrent and capital spending by health providers is shown in Table 4. The breakdown shows that the most significant share went to public hospitals (42%), followed by providers of ambulatory health care (29%)—these are basically public health centers and health posts in the Ethiopian context. On the other hand, providers of health care system administration and financing (health system governance) accounted for 27% of the spending. Independent pharmacies, which include ancillary service providers and other unidentified providers, accounted for 2.6% of total government health spending.

Table 4: Total Government Health Spending by Provider (Recurrent Expenditure and Capital Formation)

Provider	Share (%)
Health center and health post	28.96
Primary hospital	13.03
General hospital	11.11
Tertiary hospital	17.49
Government health administration	26.78
Independent pharmacies and others	2.64
Total	100.0

3.7 HEALTH EXPENDITURE BY TYPE OF HEALTH SERVICE IN ETHIOPIA

Curative care continues to account for more than half of THE (56%). The share of preventive care of THE decreased significantly from 30% in 2016/17 to 19% in 2019/2020, while the share of spending on governance and health system and financing administration almost doubled from a little over 10% in 2016/17 to 20% in 2019/2020.

Of curative care expenditure, about 83% was spent on outpatient care, and the remaining 17% was spent on inpatient care.

The share of total spending on curative care included hospitals (43%), public health centers and health posts (28.5%), private clinics (20.5%), and other unspecified providers (NEC) (5.5%). About 35% of curative care spending was made at the primary-health-care level (i.e., district hospitals, health centers, and health posts). The largest share of curative care spending on hospitals went to public hospitals (88%), while private hospitals accounted for 11% of hospital spending. The remaining balance of about 1% was allotted to specialized (other than mental) and unspecified hospitals.

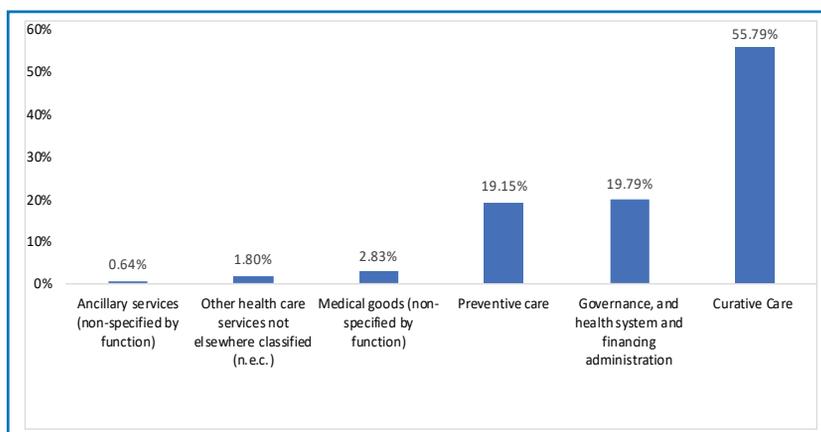


Figure 9: Total Health Expenditure by Health Care Function

3.8 GOVERNMENT HEALTH EXPENDITURE BY TYPE OF HEALTH SERVICE

The 2019/20 health account findings show that about half of government recurrent spending (56.1%) was directed to curative health care services.¹² The second-largest share went to health system governance (24.2%), followed by preventive care (17.3%). Other health care services (not elsewhere classified) and medical goods (non-specified by function) accounted for 2.0% and 0.3% of the government's recurrent health spending respectively (Figure 10). Notably, preventive care decreased from 26% in 2016/17 to 17.3% in 2019/20, while government spending on health system governance increased from 20% in 2016/17 to 24.2% in 2019/20.

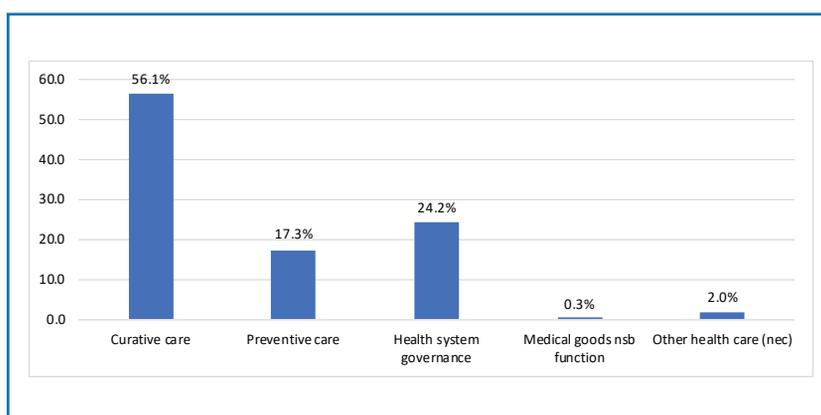


Figure 10: Total Government Recurrent Health Spending by Function

The total capital expenditure in 2019/20 was about ETB 7.9 billion, of which the government accounted for 72% of the total capital investment¹³ in the health sector. As shown in Figure 11, capital investment items in the current health accounts exercise are disaggregated only into machinery and equipment, which accounted for 26% of government capital spending, and unspecified gross-fixed capital formation (HK.nec) accounted for 74%. Furthermore, spending on health-related training and research in the 2019/20 fiscal year accounted for about 4.6% of the total government expenditure on the health sector.

¹² In terms of curative care, OP and IP services accounted for 57% and 42% respectively.

¹³ Including health-related expenditures (spending on training & research).

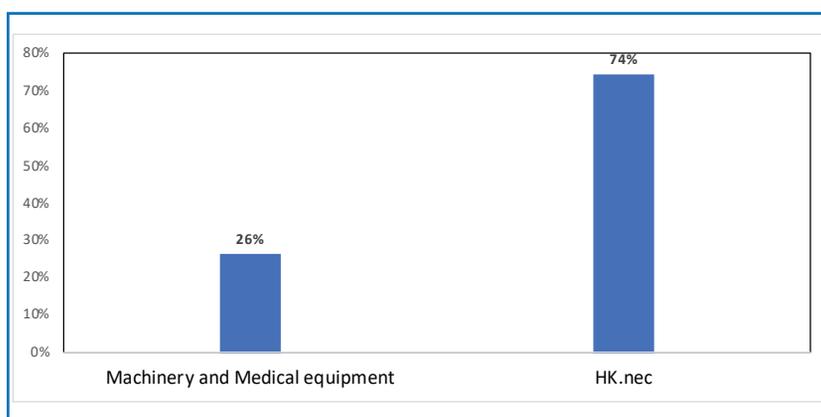


Figure 11: Programmatic Use of Government Capital Formation on Health

In 2019/20, the government of Ethiopia spent over ETB 41 billion of treasury resources on health care, out of which about 83% was spent on recurrent health expenditure, while the remaining balance (17%) went to capital formation/investment.¹⁴ Moreover, a significant proportion of the resources managed by the government (including resources from the SDG pool fund and other financing sources that flow through the government) were spent on curative care (43.8%), followed by health system governance (34%), and preventive care (20.8%) (Figure 12). These results are surprising given the government’s health policy, which emphasizes providing preventive and promotive health care services at the primary-health-care level.

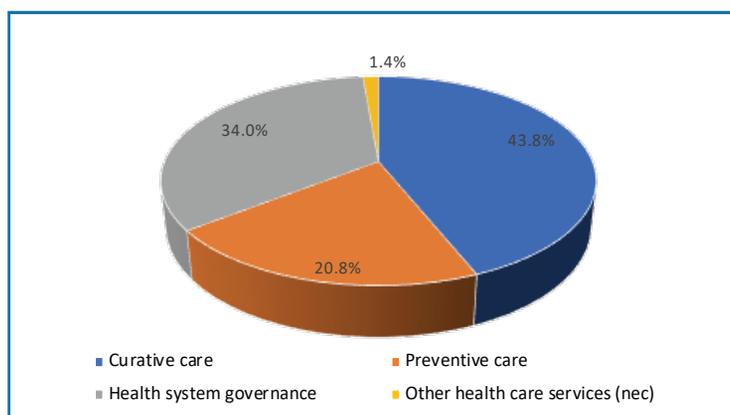


Figure 12: Programmatic Use of Resources Managed by the Government

3.9 NGO-MANAGED HEALTH RESOURCES

Resources managed by NGOs: Philanthropic financing can be acquired directly from people or through philanthropic fundraising organizations. Philanthropic revenue can be invested straight into patient care or in an endowment fund to generate revenue to cover current expenses. NGOs¹⁵ managed around Birr 25.7 billion, which is 20.3% of THE in 2019/20. Of this amount, 44% was spent on preventive health care (compared to 29% in 2016/17), followed by 22% on health governance, finance, and administration, 12% on curative care, and 7% on medical goods. NGOs spent 8% on capital expenditure from their total expenditure, which marks a 3%age-point increase compared to 2016/17. The share of NGO spending on medical goods increased from 0.4% to 7% between 2016/17 and 2019/20. Similarly, spending on ancillary services increased from 1% to 3%. On the other hand, the share of curative care decreased

¹⁴ This includes ETB 1.9 billion of health-related expenditures (training & research) by the government.

¹⁵ Includes donors and international and local NGOs

considerably from 22% to 12%. Rehabilitative and long-term care spending from NGO-managed resources were below 1% in 2019/20.

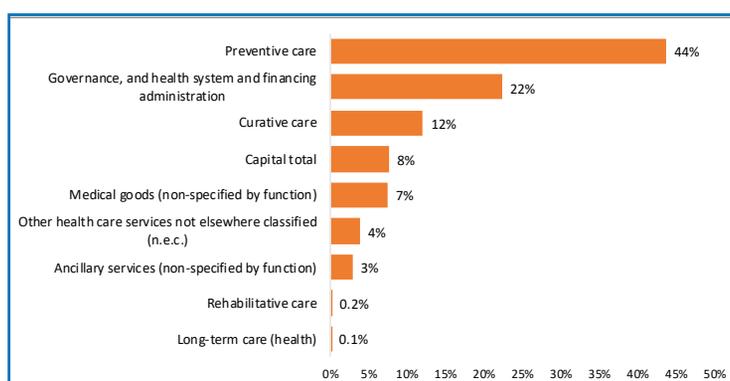


Figure 13: Programmatic Use of Resources Managed by NGOs

The priority for government-managed resources was on curative care (51%), whereas the priority for NGO-managed resource spending was on preventive care (44%). On the other hand, capital spending out of government-managed resources was approximately 17%, while it was only 12% for NGOs.

3.10 PRIVATE SECTOR EXPENDITURE

Private health financing includes private insurance expenditure, OOP spending by households excluding CBHI scheme, and expenditure by non-profit organizations, private companies, and employers. In Ethiopia, total private health expenditure was Birr 42.09 billion, which was 33% of THE in 2019/20. The lion's share was contributed by households in the form of OOP spending (92.6%) and by private employers (6.4%). Only 0.3% was contributed by other private corporations. Although the overall contribution of the private sector to THE remained small, the private employers' contribution increased from 6.2% to 6.4%. Health spending in the private sector increased from ETB 23.6 billion in 2016/17 to Birr 42.09 billion in 2019/20.

As a % of total private health expenditure, OOP spending was 92.6%. Although the OOP share of total private spending decreased slightly in 2019/20, this is due to the slight increase in the contribution of private corporations, as the nominal value of OOP spending increased considerably from Birr 22.1 billion in 2016/17 to 38.92 billion.

The CBHI contribution expenditure¹⁶ of households was about Birr 1.13 billion, which is more than four times the 2016/17 CBHI contribution of Birr 250 million. Contributions to CBHI have risen significantly in recent years, rising from 1.14% of total household health expenditure (including OOP and CBHI) in 2016/17 to 2.8% in 2019/20. Efforts have been made to advance CBHI, with the establishment of CBHI schemes in different woredas. OOP is expected to fall as CBHI matures in the coming years (see section 3.11 for more information).

¹⁶ Reimbursement to health care providers (facilities) from premiums collected.

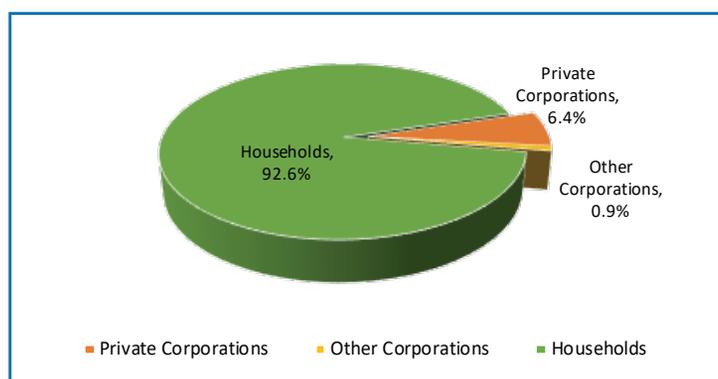


Figure 14: Distribution of Private Sector Health Financing

3.11 CBHI CONTRIBUTION

CBHI is a form of micro health insurance, which is an overarching term for health insurance targeted to low-income people. The schemes are usually voluntary and characterized by community members pooling funds to offset the cost of healthcare. Despite much hope in these systems, evidence suggests the impact of CBHI on financial protection and access to needed health care is moderate for those enrolled (WHO, 2020).

3.11.1 CBHI contribution from the overall health spending

The 2016/17 and 2019/20 Ethiopia's NHA studies show that the share of CBHI spending of THE, despite the increase through time, is very low. Only 0.9% in 2019/20 of the total spending is made through CBHI, while the figure in 2016/17 was 0.3%--so, despite the overall limited amount, the share has increased by 200% over the three years. The small share of CBHI in THE is in line with the findings from other countries. Based on the WHO's global health expenditure database, the share of voluntary health insurance as % of current health expenditure for selected countries is shown in Table 5. With the exception of Zimbabwe, the contribution of CBHI in all the selected countries is lower than 10%.

Table 5: CHE, VHI, and OOPs in Selected Sub-Saharan African Countries (2019)¹⁷

Country	Current Health Expenditure (CHE) per Capita in USD	Voluntary Health Insurance (VHI) as of Current Health Expenditure (CHE)	Out-of-Pocket (OOP) as % of Current Health Expenditure (CHE)
Burkina Faso	42.34	2%	34.7%
Burundi	20.57	1%	24.7%
Cameroon	54	7%	72.5%
Malawi	30.4	6%	16.9%
Mali	34.28	0%	31.4%
Nigeria	71.47	1%	70.5%
Rwanda	51.4	2%	11.7%
Zimbabwe	103.03	27%	24.4%

¹⁷ WHO global health expenditure database: <http://apps.who.int/nha/database>, accessed on December 10, 2021.

3.11.2 CBHI contribution excluding exempted health services

There is a three-tiered health financing model for health facilities focusing on 100% subsidization of key reproductive, maternal, child, and newborn health (RMNCH) and other high priority health services (e.g., malaria and tuberculosis treatment); partial cost recovery wherein salaries and non-drug operational costs are typically subsidized; and full-cost recovery wherein the services—and resources required to provide them—are fully charged to the patient receiving that service. In order to show the contribution of CBHI in a better way, the expenditures of the subsidized or exempted services can be excluded from the denominator in computing the share of CBHI. Based on the 2019/20 NHA results, about 43% of the total health spending is supposed to be for exempted services. Accordingly, the share of CBHI spending from the total expenditure for non-exempted services would be 1.7%—an increase of 89% as compared to the 0.9% when the spending of exempted health services is included.

3.11.3 OOP expenditure between CBHI and non-CBHI households

In order to understand the impact of CBHI membership on the burden of households, the total and per capital OOP expenditure for CBHI members and non-CBHI members were computed using the household survey data. As indicated in the table below, the results show that the per capita OOP health expenditure of CBHI members and non-CBHI members were 278 ETB and 439 ETB respectively. In other words, with the 2019/20 CBHI coverage rate of 34%, the per capita OOP spending for members has dropped by 58% compared to non-members. If the EHIS increases the coverage to 100% with the current CBHI service provision modalities, the total OOP reduction would be up to 10.7 billion ETB.

Table 6: OOP Spending for CBHI Members and Non-CBHI Members

Variables	CBHI Member	Non-CBHI Member	Total
The Current Coverage-2019/20 (34%)			
Total OOP (billion ETB)	9.44	29.48	38.92
Share of the total	24%	76%	100%
OOP per capita (ETB)	278	439	387
Share of OOP to total household expenditure	2.1%	3.3%	2.8%
Assume 100% CBHI Coverage			
Total OOP (billion ETB)	27.983	-	27.983
Reduction of OOP due to CBHI	-	-	10.723

3.12 EXPENDITURE BY DISEASES AND HEALTH CONDITIONS

The prevention and treatment of infectious and parasitic diseases took a little less than half (46%) of Ethiopia's total health resources (Figure 15), which is less than the figure reported in 2016/17 (53%). Neglected tropical diseases and vaccine-preventable diseases each shared about 18% of the total expenditures on infectious diseases. HIV/AIDS and other STDs took 13.2% health spending on infectious and parasitic diseases, while malaria took 11.6%. Other non-specified infectious and parasitic diseases took about 15%, and expenditure on COVID-19 (see section 3.13) was 11% of total spending on infectious diseases (Table 7).

Reproductive health took 12.5% of THE, of which 44% went to maternal conditions and 29% to family-planning programs. Perinatal care shared 13% of total spending on reproductive health, while 11% of

reproductive health expenditures was spent on unspecified reproductive activities. Nutritional deficiencies took 3.8% of THE, a marked decrease from the previous report (11%).

Non-communicable diseases shared 24.7% of THE in Ethiopia, a significant increase from the figure reported in NHA 7 (11%). Nearly half (47%) of health expenditures on non-communicable diseases was spent on cardiovascular diseases, followed by digestive (13.3%) and respiratory diseases (8.2%). Other non-specified non-communicable diseases shared 24%, while the rest of the non-specified non-communicable diseases each took 6% or less of the expenditures on non-communicable diseases (see Table 7). Injuries took just 1.6% of THE in the country.

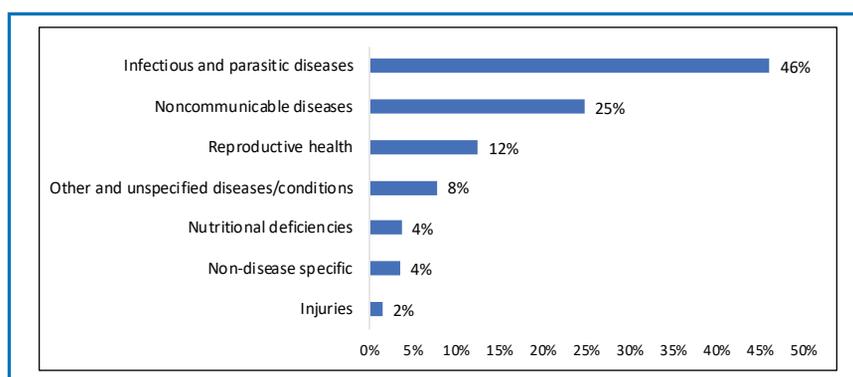


Figure 15: Health Expenditures by Diseases and Health Conditions

Table 7: Spending on Major Diseases and Health Conditions

Descriptive	Share	Major Classification	%age
HIV/AIDS and other STDs	13.2%	Infectious and parasitic diseases	46.1%
Tuberculosis (TB)	7.7%		
Malaria	11.6%		
Respiratory infections	3.1%		
Diarrheal diseases	2.3%		
Neglected tropical diseases	18.3%		
Vaccine-preventable diseases	17.6%		
Leprosy	0.0%		
COVID-19	11.3%		
Other and unspecified infectious and parasitic diseases	14.9%		
Maternal conditions	43.7%	Reproductive health	12.5%
Perinatal conditions	13.6%		
Contraceptive management (family planning)	29.4%		
Unspecified reproductive health conditions	13.2%		
Nutritional deficiencies	3.8%	Nutritional deficiencies	3.8%
Neoplasms	5.6%	Noncommunicable diseases	24.7%
Endocrine and metabolic disorders	5.5%		
Cardiovascular diseases	47.0%		
Mental and behavioral disorders and neurological conditions	5.2%		
Respiratory diseases	8.2%		
Digestive diseases	13.3%		
Diseases of the genito-urinary system	5.1%		
Sense-organ disorders	4.8%		
Oral diseases	2.0%		
Other and unspecified noncommunicable diseases	24.7%		
Injuries	1.6%	Injuries	1.6%
Non-disease specific	3.6%	Non-disease specific	4%
Other and unspecified diseases/conditions	7.9%	Other and unspecified diseases	8%
Total			100%

3.13 COVID-19 HEALTH FINANCING

Ethiopia is currently experiencing a range of hazards as a result of climatic conditions, conflict, and, most recently, the COVID-19 pandemic. Addressing these hazards and their impacts has inevitably diverted resources from planned development investments, including health system strengthening, to emergency response. Although Ethiopia has made significant progress on various health indicators in the past several years, the COVID-19 pandemic disrupted the health system and has posed a challenge to maintaining the achievements so far. However, over the past two years, the government of Ethiopia has strengthened its preparedness efforts and has set up a national preparedness and response coordination mechanism.

As the first case of COVID-19 was reported in Ethiopia in March 2020, this round of the NHA is the first systematic tracking of COVID-19 pandemic expenditure. With the NHA VIII study period covering 2012 E.C. (2019/20), the results include about six months of COVID-19 expenditure.

3.13.1 Sources of finance for the COVID-19 emergency response

The COVID-19 pandemic control and prevention program in the Ethiopian national health system is financed through domestic funds from the state budget, private sector investments, and external funds received from bilateral and multilateral donors. In addition to this, the MOH, by repurposing existing resources, has also made resources available for the COVID-19 response.

The total (recurrent and capital) COVID-19 expenditure in Ethiopia was estimated at Birr 6.6 billion (US\$ 189.4 million), which accounted for 5.2% of THE. Of the infectious and parasitic diseases total expenditure, COVID-19 expenditure share was 11.3%.

The source of COVID-19 expenditure was primarily government with 50%, followed by development partners with 42%, and the remaining 8% was from private corporations and others that included but was not limited to manufacturers, importers, service providers, and new entrepreneurs. The resource types were financial, in-kind (material, equipment, and infrastructure), and HR and technology. The share of COVID-19 recurrent spending in 2019/20 was 70%, and 95% of the capital expenditure was financed by the government of Ethiopia.

The per capita THE, including COVID-19 expenses, was USD 36.4 in 2019/20, but excluding COVID-19, it stood at USD 34.48, with about a USD 1.18 increase from the 2016/17 per capita expenditure. Thus, a large part of the health expenditure increase in 2019/20 was due to the COVID-19 pandemic. Though additional resources were expected to finance the COVID-19 recovery and management, the majority of resources were availed by re-purposing existing resources.

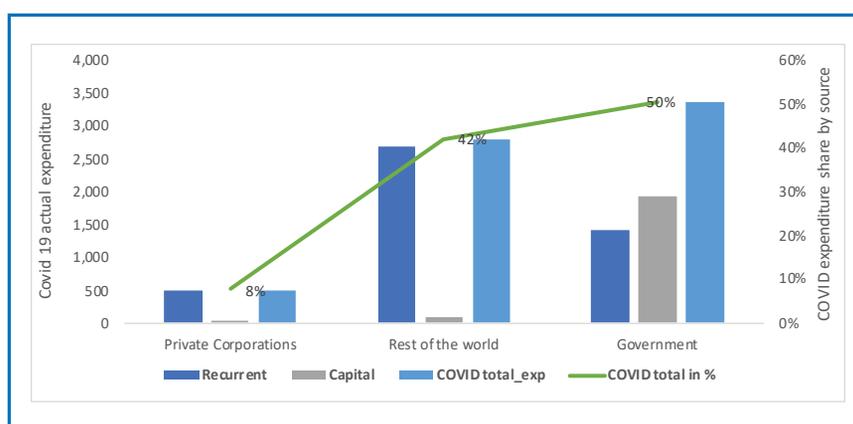


Figure 16: Financing Source of COVID-19 Prevention and Management

3.13.2 Providers of COVID-19 emergency response services

About 56% of the total COVID-19 emergency response expenditure was spent at hospitals. Providers of ambulatory care took the next largest share (24.8%) of the 2019/20 total COVID-19 response expenditure. Expenditure on providers of health care system administration and financing took 15.7% and providers of preventive care 2.4% of the total COVID-19 expenditure in 2019/20.

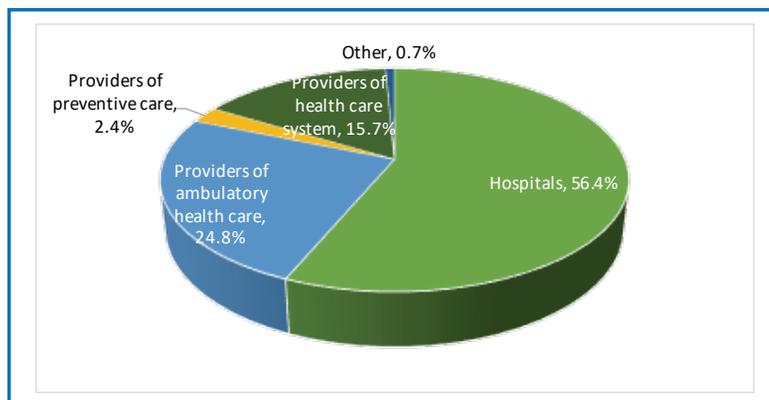


Figure 17: COVID-19 Expenditure by Provider Type

3.13.3 COVID-19 resources by type of health service

Nearly three-fourths of the COVID-19 emergency response expenditure was on preventive care. This is followed by curative care services, which accounted for 15.4% of COVID-19 emergency response recurrent health spending in 2019/20.

Governance and health system administration accounted for a little over 10%, and the remaining less than 1% went to other health functions, including long-term care, medical goods not specified by function, and other health care provisions (Figure 18).

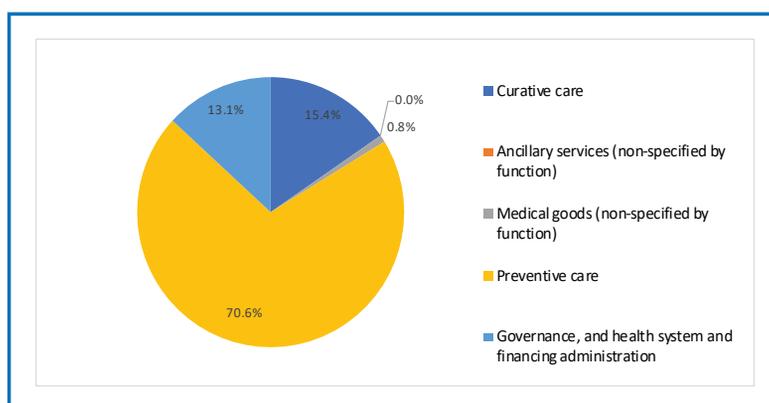


Figure 18: COVID-19 Spending by Care Type in 2019/20

3.13.4 Management of COVID-19 resources

The COVID-19 pandemic has been a novel experience for the whole world. For Ethiopia, with a resilient health system not yet well established, the COVID-19 pandemic has been a critical challenge for the health system and the country as a whole. During such an emergency situation, resource alignment

and mobilization is very important. Accordingly, the MOH, in collaboration with other ministries, established a sectoral and a national COVID-19 task force. The sectoral COVID-19 task force included a resource mobilization and allocation for COVID-19 response sub-group, which mobilizes, allocates, and monitors resources. Fund management is a key function regardless of who finances it, as it determines where, for what purposes, and how expenditures are made.

The government, as shown in Figure 21 below, played a significant role in managing COVID-19 response resources in 2019/20. Around 91% of the COVID-19 resources was managed by the government, and the remaining 8.7% was managed by development partners.

Given the large share of COVID-19 resources managed by government, the following questions should be considered. Could budget execution and fund release be accelerated during the pandemic? How were the COVID-19 funds managed? Can similar fund management modality be adopted for the whole health care financing system?

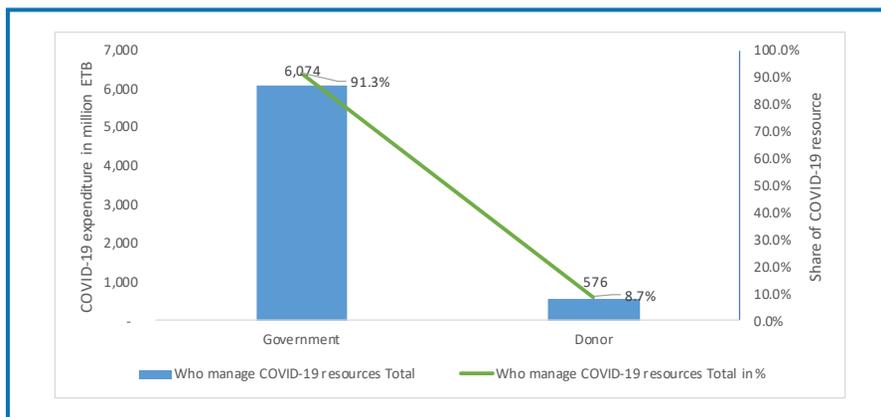


Figure 19: Who Managed COVID-19 Resources?

4. SUMMARY, CONCLUSIONS, AND POLICY RECOMMENDATIONS

The NHA study provides vital information on total health spending, contributions by different stakeholders, the distribution of health spending by various levels of providers, and health functions, as well as by disease conditions. The NHA also measures whether health spending follows priorities outlined in health policies and strategies and highlights what modifications are required to ensure health-financing schemes are targeted at improving service provision and health outcomes.

4.1 SUMMARY OF KEY FINDINGS

- **Total and per capita expenditure:** THE increased to 3.62 billion USD, including COVID-19 expenditure—a 16% increase compared to 2016/17. The per capita expenditure also increased (to 36.3 USD per capita) but remains significantly less than the globally recommended 86 USD needed to ensure access to essential health services.
- **Financing source:** Donors, governments, and households continue to finance roughly one-third of THE each. The 1% spending pre-payment via the CBHI scheme. Financing from the private sector (outside of households) is limited. The government's health spending is 8.5% of total government spending, which is well below the Abuja target of 15%.
- **Financing agent:** Similar to the previous rounds, the government manages about half of all resources for health, of which regional health bureaus manage 65% and the MoH manages 35%. The majority of donor resources (60%) are managed by NGOs and donors themselves, while the remaining 40% is managed by the government.
- **Provider:** Spending at the primary-health-care-unit (PHCU) level (primary hospitals, health centers, and health posts) accounted for 44% of total spending.
- **Health care function:** Spending on curative services remained at about more than half of total spending (~56%). Spending on preventive services decreased from 30% in 2016/17 to 19%.
- **Disease and health conditions:** Communicable diseases accounted for about 56% of THE, while non-communicable diseases (NCD) accounted for 25% of THE, with households and the government bearing the main financial burden.
- **COVID-19:** About 190 million was spent on COVID-19 during 2020 (5% of THE for 2019/20). The government financed about 50% of this, while donors financed 40%.

4.2 CONCLUSIONS

The Ethiopian NHA for fiscal year 2019/20 shows that the health financing system is dependent on external sources and that government spending on health, despite its growth, is still low. Although THE increased compared to the previous NHA rounds, resources were still inadequate to provide the basic package of cost-effective interventions, the essential healthcare package, and meet the Abuja target. This implies that the Ethiopian health system is currently highly unsustainable and underfunded and may have difficulty recovering from the COVID-19 pandemic. Therefore, it is critical that the MOH implement mechanisms for resource mobilization, allocation, and management as outlined in the revised health financing strategy.

Sources of financing continue to be fragmented and not effectively pooled. There was an inefficient allocation of health resources across programs, as the program areas focused on infectious and

parasitic diseases and reproductive health were responsible for two-thirds of health spending. The study also showed misalignment in the allocation of resources based on national priorities (the HSTP II). In addition, the allocation of health resources was not in balance across levels of healthcare and functions, and spending in certain instances did not correlate with the burden of disease. Lastly, the study found low capital investment to support and sustain healthcare delivery systems.

4.3 POLICY IMPLICATIONS AND RECOMMENDATIONS

The MOH needs to strengthen resource mobilization efforts and the pooling mechanism, giving priority to primary health care and preventive health services and capital items. Some of the key recommendations made in this study are:

- **Long term:** Increase government spending on health over time, including adequate funding at all levels. Based on experience from other countries, resources generated from insurance schemes are often insufficient, although they are one of the key pillars to achieving UHC for all populations. Furthermore, Ethiopia is spending less than the WHO's targets and less than many other low-income countries.
- **Short term:** Given the current fiscal constraints and the economic downturn, present a comprehensive case to donors and the government to ensure the level of health spending per capita is sufficient to respond to the pandemic and maintain access to essential services. Organize discussions with donors, the MOF, sub-national-level health and finance bureaus, and other key stakeholders to advocate for the share of donor resources managed by the government to increase or at least be maintained at previous levels.
- **OOP:** The OOP share of THE has stagnated at about one-third, which is insufficient to protect households from catastrophic health expenditure and reduce financial barriers to care, especially among poorer households. Efforts to expand financial protection need to continue, especially those that target the poor, such as subsidies for indigents to enroll in insurance and expansion and improvements to the fee-waiver system.
- **NCD and preventive care:** In line with the increasing burden of disease attributed to NCDs, the share of NCD expenditure of THE increased markedly compared to previous NHA studies, with the government and households bearing the main burden. The government should develop a long-term plan to shift NCD expenditure away from the reliance on OOP and towards more sustainable and equitable financing sources. The share of spending on curative care for NCDs and other diseases and conditions was over 80%, which does not align with the government's preventive care strategy. Additional resources allocated to preventive care could reduce future health care needs and improve the quality of life and productivity for people living with or at risk of developing NCDs.
- **PHC:** Ethiopia has long prioritized primary health care (PHC) as its strategy to realize UHC and accordingly is spending almost half of THE at the PHCU level and about 60% of THE on expenditure attributed to PHC services. Given its key role in the Ethiopian health system, it is important to continuously improve the quality and efficiency of PHC. The ongoing revamping of flagship programs, such as the Health Extension Program (HEP) and Woreda transformations, are an important part of this and should be sufficiently financed and prioritized.
- **Government health administration (GHE):** Spending on GHE has increased markedly since the last round of the NHA. It is advisable to conduct an analysis to better understand the root causes of this development.

- **Emergency health-financing mechanism:** Although the NHA report shows that overall spending on health has continually risen in the last two decades, health systems in Ethiopia have recently been hit by a number of catastrophic events or shocks, like the war crisis or different epidemic outbreaks, like the COVID-19 pandemic. These events have had an impact on the health system that differs from the predictable and long-term health system stresses, like population ageing. Therefore, to build resilient and sustainable health systems that can respond timely and effectively to future shocks or outbreaks and provide basic health services, they need a strategic shift and the development of a clear emergency health-financing mechanism.
- **Introducing new and alternative financing options:** Modern health-financing approaches should be explored to achieve better results in the health sector compared to the traditional approach to financing the health system, such as performance-based financing, multi-sectoral collaboration, and innovative financing options.

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ANNEXES

GLOSSARY OF TERMS

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 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 care. This is expenditure on outpatient and inpatient health services whose principal intent is to achieve the principal intents listed above.

Double-counting: Identification and management of instances when two data sources cover the same health spending. 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 farther from actual consumption of services. This implies privileging spending reported by financing agents over financing sources.

Financing schemes (HF): The main funding mechanisms by which people obtain health services. Financing schemes categorize 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 fundraising (taxes/compulsory pre-payments vs. voluntary payments), and the extent of risk pooling.

Financing agents (FA): 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. These may include the MOH, 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.

General health administration and insurance: Activities of private insurers, 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 (HK): 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. Those goods and services differ significantly from other inputs that are used repeatedly or continuously for more than one year in the production of health services—for example, hospital infrastructure, road ambulances, or MRI machines, etc. are classified as capital formation.

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): Entities and actors who provide medical goods and services as their main activity, such as hospitals, health centers, clinics, or pharmacies.

Health care functions (HC): Health care 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-care-related/memorandum items (HKR): In the SHA 2011, expenditure on “research and development in health” and “education and training of health personnel” are considered investments and, as such, are recorded as additional memorandum items to the capital account.

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.

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

Medical diagnostic labs: These 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 a facility laboratory.

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: 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, Ethiopian Electric Utility, and the Commercial Bank of Ethiopia.

Per capita expenditure: Expenditure per person, which is 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 are considered as part of inpatient and outpatient curative care expenditures.

Pharmacies: Comprise establishments that are primarily engaged in the retail sale of medicinal preparations that 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 intervention (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 NGOs, health promotion and sensitization programs, and campaigns to promote use of specific health care services.

Providers of occupational health: According to the 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). This item refers to providers that 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 MOF 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, gross capital formation, and health-related expenditures (such as educational training and R&D).

