



REPORT

Achieving Sustainable Health Financing in Ethiopia: Prospects and Advocacy Opportunities for Domestic Resource Mobilization

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Abbreviations and Acronyms

ART	antiretroviral therapy
BOFED	Bureau of Finance and Economic Development
CBHI	community-based health insurance
DALYs	disability adjusted life-years
EHIA	Ethiopia Health Insurance Agency
ETB	Ethiopian birr
FHAPCO	Federal HIV/AIDS Prevention and Control Office
FMHACA	Food, Medicine and Health Care Administration and Authority
FMOH	Federal Ministry of Health
FY	fiscal year
GDP	gross domestic product
GHE	government health expenditure
GMP	Good Manufacturing Practice
GOE	Government of Ethiopia
GTP II	Growth and Transformation Plan II 2015/16–2019/20
HSTP	Health Sector Transformation Plan 2015/16–2019/20
IMF	International Monetary Fund
MDR-TB	multidrug resistant tuberculosis
MOFEC	Ministry of Finance and Economic Cooperation
NHA	National Health Accounts
PEPFAR	U.S. President’s Emergency Plan for AIDS Relief
PFSA	Pharmaceutical Fund Supply Agency
PMI	U.S. President’s Malaria Initiative
RHB	Regional Health Bureau
SHI	social health insurance
TB	tuberculosis
THE	total health expenditure
USAID	U.S. Agency for International Development
USD	U.S. dollars
WHO	World Health Organization
WOFED	Woreda Office of Finance and Economic Development
WorHO	woreda health office
ZHB	zonal health bureau

Executive Summary

Ethiopia has established ambitious goals for health spending and domestic resource mobilization for health as part of its *Health Sector Transformation Plan 2015/16-2019/20 (HSTP)*. In three years between 2011–2014, Ethiopia succeeded in tripling domestic government expenditure on health, primarily through increased allocations at the regional and local levels and a renewed focus on primary healthcare. Ethiopia's continued strong economic position—with annual real gross domestic product (GDP) growth rates having averaged nearly 10% for the last decade and projected to remain above 8% for the foreseeable future—implies increasing fiscal space for health.

However, Ethiopia's health sector needs are significant, and at current levels of budgetary prioritization, government resources alone will leave a financing gap of as much as US\$2.5 billion annually—or more than 50% of the resource need—by 2020. Even at its peak of \$900 million in 2013/14, donor financing is not adequate to fill this gap, and in recent years the country has seen declines in external support for key programs such as HIV, malaria, and family planning. Inadequate financing of key programs may lead to a resurgence these in epidemics, as has been seen in other countries, and reversal of positive trends in fertility and maternal and infant mortality. In addition, neglecting disease and health areas places a greater long-term cost on the health sector and depresses economic productivity and growth. As such, robust investment in health must be a key pillar of Ethiopia's multi-sectoral development plans.

To achieve the needed level of investment and results, the Government of Ethiopia must focus both on increasing the amount of resources allocated to health and on more efficiently and effectively using these investments to get “more health for the money.”

Efficiency gains are a key piece of how the Government of Ethiopia will be able to create additional fiscal space for health. The health sector has demonstrated significant efficiencies already, achieving significant reductions in infant mortality and higher-than-predicted life expectancy given its

level of health expenditure, in large part prioritizing primary healthcare. However, low and variable utilization of existing health infrastructure and human resources, and inadequate targeting of prevention programs for key disease areas such as HIV, suggests that more could be achieved with marginal additional investment.

The HSTP also aims to increase the health budget as a share of total government expenditure from 6% to 10% by 2020, and the pending national Healthcare Financing Strategy establishes a further target of 15%—in line with the internationally-accepted Abuja target. However, a lack of regular data generation and reporting on health budgeting and expenditure—at both the federal and sub-national levels—makes it difficult to track progress toward these goals. In addition, greater engagement between health institutions (i.e., Federal Ministry of Health, regional health bureaus, zonal health bureaus, and woreda health offices) and finance institutions (i.e., Ministry of Finance and Economic Cooperation, Regional Bureau of Finance and Economic Development, and Woreda Office of Finance and Economic Development) at all levels is needed to ensure both that finance institutions understand the importance of health investment, resource need, and impacts and that health institutions are responsive to the reporting requirements and able to demonstrate that resources are being used efficiently and effectively.

Overall, improving the “negotiation capacity” of health institutions—as identified by the Healthcare Financing Strategy—will be critical to ensure adequate resources for the health sector. Donors can support the Federal Ministry of Health and its counterparts by preparing adequate evidence and adopting harmonized messaging that resonates with the development priorities of the Ministry of Finance and Economic Cooperation and other senior government leaders, as well as positioning key vertically financed programs such as HIV, tuberculosis, malaria, and family planning and reproductive health, to be integrated into emerging domestic healthcare financing schemes, including community-based and social health insurance.

Introduction

In recent years, the financing landscape has shifted, with external health financing plateauing and even declining in some countries and program areas. Development partners have placed increasing emphasis on self-reliance as a cornerstone of future success and sustainability of country programs (USAID, 2018). Accordingly, as developing countries continue to set ambitious targets not only for disease-specific programs but also for the achievement of universal health coverage, the financial burden of achieving these targets has shifted increasingly to the countries themselves.

Ethiopia's experience is a prime example of this changing landscape. Since 2008, total official development assistance for health has been largely flat (OECD, n.d.), while external funding for some programs, most notably HIV, has declined sharply (HP+, 2018). During this period, Ethiopia has significantly increased domestic financing for health. In particular, the government has made significant investment in strengthening health systems and increasing access to primary healthcare through the Health Extension Program. However, Ethiopia remains heavily reliant on the support of its development partners to finance key health inputs, especially essential medicines and quality improvement, through trainings and supportive supervision. To ensure the sustainability of access to needed preventive and curative health services, the Government of Ethiopia must make a concerted effort to increase public domestic financing for the health sector.

Although Ethiopia remains a low-income country, it is faced with a promising opportunity to leverage its significant and sustained economic growth—

nearly 8% real annual growth in gross domestic product (GDP) per capita since 2004 (World Bank, n.d.)—to mobilize new domestic resources for health. Doing so will require a well-harmonized effort by the Ethiopian Federal Ministry of Health (FMOH), regional health bureaus (RHBs), and development partners—including the Global Fund to Fight HIV, Tuberculosis, and Malaria (Global Fund)—to effectively make the case for greater investment in health. At the same time, Ethiopia will need to maximize the impact of its current level of health spending by prioritizing the most effective programs, interventions, and populations and achieving economies of scale in service delivery. To that end, the purpose of this document is to contribute to ongoing efforts to position health, particularly priority health programs, as a national priority and provide the necessary evidence to effectively advocate for increased resource allocations to the health sector. This brief aims to answer three questions central to this effort:

- 1) How are health services currently financed in Ethiopia, and what are the areas of particular vulnerability and need?
- 2) How much can and should Ethiopia spend on health, particularly on priority programs such as HIV, tuberculosis (TB), and malaria, given the country's macro-fiscal context?
- 3) Where should efforts to increase the value of resource for health focus, both in terms of cost savings (e.g., improved efficiency) and increased allocation?

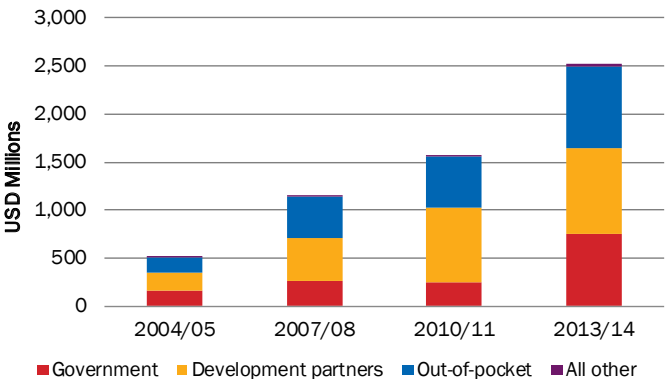
Health Financing in Ethiopia: The Current Context

SOURCES OF HEALTH FINANCING

Historically, resources for health in Ethiopia have come primarily from three sources: tax revenues collected by the Government of Ethiopia (GOE) and executed either at the federal, regional, zonal, or woreda (district) level; external funds provided by bilateral and multilateral development partners, either transferred to the government in the form of grants or loans or executed by nongovernmental organizations (NGOs); and private expenditure by individuals or households spent on health services in both public and private (for-profit or non-profit) facilities. Additional resources for health are provided by other private sources, including both domestic and international foundations, NGOs, and private insurance providers; however, these represent a very small share of total health expenditure (THE) (FMOH, 2014a, 2017a).

THE in Ethiopia increased nearly fivefold (in current USD) from 2004/05 to 2013/14 (Figure 1). Until 2010/11, this growth was driven primarily by development partner expenditure, which increased by US\$589 million over 2004/05–2010/11, compared to an increase of US\$457 million in domestic expenditure. However, over 2010/11–2013/14, domestic expenditure on health increased by US\$845 million compared to just US\$120 million in increased external financing. This growth in domestic spending between 2010/11 and 2013/14 was primarily driven by an increase of US\$507 million in domestically generated government health expenditure (GHE).

Figure 1. Health Financing by Source



Sources: FMOH, 2006, 2010, 2014a, 2017a

Although out-of-pocket expenditure also increased significantly, by US\$314 million, it remained largely unchanged as a percentage of THE. Out-of-pocket spending is driven by use of private facilities and by user fees in the public sector, which are charged for all services except those designated as “exempted” from user fees, including HIV, TB, malaria, family planning, and reproductive, maternal, and neonatal health. In addition, some users who seek services in the public sector are exempted from user fees based on either their eligibility for fee waivers or their participation in community-based health insurance. The 2013/14 National Health Accounts (NHA) found that 61% of all outpatients and 93% of inpatients fully or partially paid for services out-of-pocket (FMOH, 2014b). The higher prevalence of out-of-pocket payments for inpatient services reflects the fact that user fee exemptions are applied primarily to primary healthcare services.

Table 1: Key Health Spending Indicators

Indicator	2013/2014
Per capita THE (2014 USD)	\$26
Per capita GHE (2014 USD)	\$8
GHE as % of TGE	6.9%
THE as % of GDP (excluding external funding)	4.7% (3.0%)

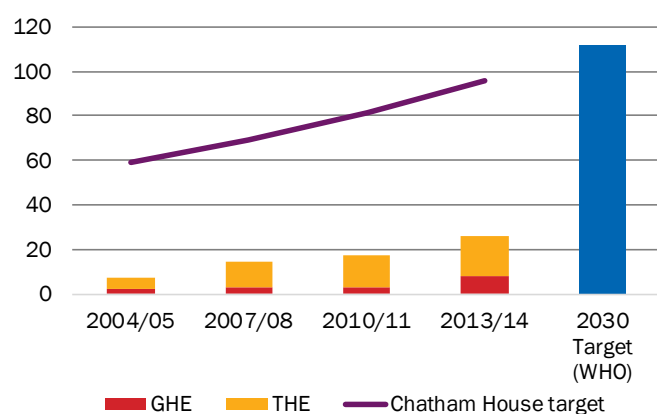
Source: FMOH, 2006, 2010, 2014a, 2017a; IMF, 2018

Despite this growth, health expenditure in Ethiopia remains well below international norms and recommendations for health expenditure. Although THE per capita increased nearly fourfold from US\$7 in 2004/05 to US\$26 in 2013/14 (FMOH, 2017a; Table 1), it remained well below the \$86 (in 2012 terms) recommended by Chatham House to provide “a minimum level of key health services in low-income countries” (McIntyre and Meheus, 2014). Furthermore, the World Health Organization (WHO) estimates that among low-income

countries, the average level of per capita THE required to achieve the Sustainable Development Goals by 2030 is \$112 (Stenberg et al., 2017). To achieve this target, THE in Ethiopia will have to increase by fourfold between 2014 and 2030—an average annual increase of nearly 10%. Figure 2 shows the historical health expenditure in Ethiopia, against the Chatham House target (adjusted for inflation) and the 2030 WHO target.

Government health expenditure was only US\$8 per capita in 2013/14 (Figure 2). While GHE, as a share of total domestically generated government expenditure, increased sharply between 2010/11 and 2013/14 (from 5.1% to 6.9%) (Table 1), it is still at less than half of the Abuja target of 15% (FMOH, 2017a; World Bank, n.d.).

Figure 2: Per Capita Health Expenditure, Historical and Targets

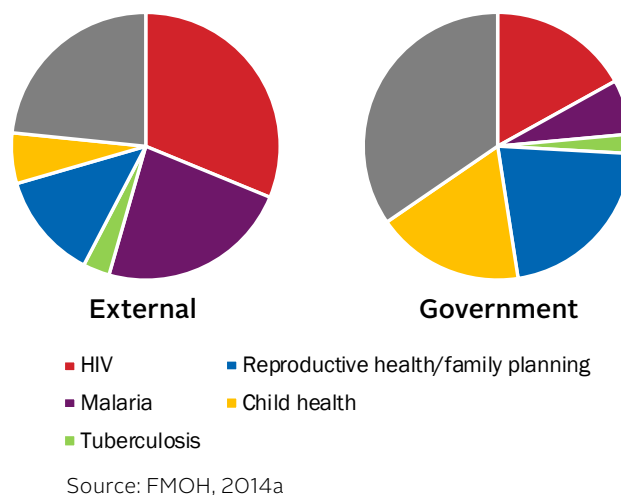


Sources: FMOH, 2006, 2010, 2014a, 2017a; McIntyre and Meheus, 2014; Stenberg et al., 2017

FINANCING OF PRIORITY DISEASE AREAS

According to the latest NHA subaccounts, conducted for 2010/11,¹ spending on three priority disease areas—HIV, TB, and malaria—accounted for 36% of THE. These three disease areas accounted for 58% of external financing for health, compared to just 26% of domestically generated government financing (Figure 3).

Figure 3: Health Expenditure by Disease/Health Area, External vs. Government Sources



All of these disease areas, as well as reproductive health and family planning, have experienced a plateau, and even decline, in funding from development partners since 2010/11. The following sections explore in more detail the financing of and recent financing trends in HIV, TB, and malaria.

Table 2: Key Epidemiological and Financing Indicators for Priority Disease Areas

Disease area	Prevalence and incidence	Burden of disease (DALYs)	Expenditure (% of THE) (2010/11)	External funding as share of disease area expenditure	Estimated resource need for 2020
HIV	610,000 adults and children living with HIV: 0.9% adult prevalence	3%	US\$292 million (19%)	83%	US\$311 million
Tuberculosis	192 cases per 100,000 population incidence	4%	US\$49 million (3%)	51%	US\$91 million
Malaria	2,320,135 annual cases (2015/16)	0.5%	US\$230 million (15%)	79%	US\$142 million

Sources: FMOH, 2014a; Global Fund, 2017a, 2017b; IHME, 2017; PMI, 2015; UNAIDS, 2018; WHO, 2018a, 2018b

¹ Disease/health area sub-accounts were not included in the 2013/14 NHA (FMOH, 2017a).

HIV

By disease area, HIV accounts for the single largest share of health financing (19%), according to the 2010/2011 NHA (FMOH, 2014a). Due in large part to this sizable investment, HIV declined as a share of the burden of disease—measured by disability adjusted life-years (DALYs)—in Ethiopia from nearly 11% in 2000 to just 3% in 2017, and prevalence has fallen below 1% (Table 2) (IHME, n.d.; UNAIDS, 2018).

Both the 2010/11 NHA (FMOH, 2014a) and the 2011/12 National AIDS Spending Assessment (FHAPCO, 2013) found that the vast majority (80–90%) of spending on HIV came from external sources, specifically development partners. The majority of external financing for HIV comes from the U.S. President’s Emergency Plan for AIDS Relief (PEPFAR) and the Global Fund. In 2011/12, these funders accounted for a combined 89% of all external funds for HIV and allocated a combined US\$406 million for HIV in 2011 (HP+, 2018). However, funding from these sources has since declined by more than half to US\$197 million in 2017, with US\$130 million from PEPFAR and US\$67 million from the Global Fund. Funding from PEPFAR has further declined in the last year and is expected to remain below US\$100 million annually.

Donor funding primarily supports provision of antiretroviral therapy (ART), which accounted for 60% of total PEPFAR and Global Fund financing for HIV in 2016 (PEPFAR, 2018). The Global Fund procures all antiretroviral drugs (US\$38 million,

2017) and almost all rapid test kits (US\$22 million, 2017) (PEPFAR, 2018), while PEPFAR support is primarily focused on improving quality of clinical care, treatment, and support (US\$64 million); community-based care (US\$18 million); key populations prevention (US\$13 million); and support for orphans and vulnerable children (US\$11 million) (Table 3). Reductions in external financing, particularly by PEPFAR, have resulted in the consolidation of funding around treatment, and substantial funding gaps are expected to open up for prevention, testing, and community-based services (HP+, 2018). Ethiopia is already facing a funding gap of nearly US\$100 million by 2020 to achieve the targets set by its *HIV/AIDS Strategic Plan 2015-2020 in an Investment Case Approach* (FHAPCO, 2014), largely driven by an increasing number of ART patients (HP+, 2018).

Spending by the Government of Ethiopia, which amounted to an estimated US\$54 million in 2011/12 has focused on prevention (US\$25 million) as well as support for national health systems strengthening (US\$16 million) and treatment (US\$13 million) through the financing of health workers and infrastructure improvement and expansion (Table 3). Out-of-pocket expenditure accounted for just 2% of total HIV spending in 2010/11. Overall, data on spending for HIV is more robust than that for TB or malaria, due to the implementation of the National AIDS Spending Assessment and complimentary efforts by other donors, particularly the U.S. Agency for International Development (USAID), to better understand the HIV funding landscape.

Table 3: HIV Financing by Source and Category, Most Recent Available Year (USD, millions)

	PEPFAR (2016)	%	Global Fund (2016)	%	Government (2012)	%	Total
Clinical and community-based care, treatment, testing, and counseling	93.5	49%	86.0	45%	13.1	7%	192.6
HIV prevention (general, key, and priority populations), including voluntary medical male circumcision	13.6	33%	3.0	7%	24.8	60%	41.4
Orphans and vulnerable children	11.4	76%	3.2	21%	0.5	3%	15.0
Laboratory	3.0	56%	2.4	44%	0.0	0%	5.4
Health systems strengthening, coordination, and surveillance	22.4	59%	0.8	2%	15.5	41%	38.0
Other	0.0	0%	0.0	0%	0.6	100%	0.6
Total	143.9		95.4		54.4		293.0

Sources: PEPFAR, 2018 (for PEPFAR and Global Fund); FHAPCO, 2013 (for government)

Note: Global Fund support for health systems is not included within the HIV financing profile.

Tuberculosis

In 2011/12, TB accounted for just 3% of THE, with approximately half coming from external sources. The U.S. Government and the Global Fund, along with the GOE, contribute roughly equal shares (US\$10–11 million each) to the country's TB program (Global Fund, 2017a). However, out-of-pocket expenditure has historically been a major source of spending for TB, accounting for 36% of total TB expenditure in 2010/11 (FMOH, 2014a).

For 2018, GOE resources for TB were allocated primarily to case detection and diagnosis (US\$3.9 million), health systems (US\$2.5 million), and HIV/TB integration (US\$1.5 million) (Table 4). Non-Global Fund external donors primarily financed case detection and diagnosis (US\$5.7 million), detection and diagnosis of multidrug resistant (MDR) TB (US\$4.8 million), treatment of MDR resistant TB (US\$2.3 million), and program management (US\$2.1 million). Resources from the Global Fund were allocated to TB prevention, care, and treatment (US\$6.8 million) and drug-resistant TB (US\$5.5 million).

Ethiopia's TB program faces a significant financing gap of approximately, US\$37 million for 2020—41% of the program's estimated resource need—based on the latest Global Fund gap analysis and funding request (Global Fund, 2017a).

Malaria

Spending on malaria accounts for 15% of THE, of which 79% comes from development partners (FMOH, 2014a). Again, the Global Fund and the U.S. Government, through the President's Malaria Initiative (PMI), have been the largest sources of external financing, each contributing an average of US\$30–45 million annually (PMI, 2015; Global Fund, n.d.). The Global Fund provides the majority of malaria commodities, including insecticide-treated nets, rapid diagnostic tests, and artemisinin-based combination therapy, with PMI filling the gaps; PMI primarily supports indoor residual spraying (US\$11 million) and supply chain and distribution (US\$10 million) (PMI, 2018). Out-of-pocket spend on malaria is relatively low, at just 14% of total expenditure, according to the 2010/2011 NHA (FMOH, 2014a).

Commitments from both PMI and the Global Fund declined in 2018 and the FMOH is exploring alternative sources of external financing from nontraditional donors, particularly China. In mid-2018, the FMOH Department of Disease Prevention and Control submitted a funding request to the Chinese Center for Disease Control and Prevention for malaria programming. At the time of data collection, a response had not been received and the FMOH would not share the terms of the request.

Table 4: Tuberculosis Financing, by Source and Category (USD)

Program Area	Government	External (non-Global Fund)	Global Fund
TB Care and Prevention: Case Detection and Diagnosis	\$3,877,226	\$5,655,336	\$6,790,561
TB Care and Prevention: Treatment	\$855,283	\$1,509,363	
Key Population Programs	\$0	\$47,765	
MDR-TB: Case Detection and Diagnosis	\$442,750	\$4,779,507	\$5,516,791
MDR-TB: Treatment	\$757,595	\$2,298,270	
TB and HIV Coinfection	\$1,523,936	\$502,786	\$2,056,832
Resilient and Sustainable Systems for Health	\$2,548,274	\$0	N/A
Program Management	\$927,043	\$2,065,504	\$613,372

DOMESTIC RESOURCES FOR HEALTH

Management of Public Domestic Resources for Health

Given the decentralized nature of Ethiopia's health system, it is difficult to track government contributions to the health sector (Box 1). The 2010/2011 NHA, which is used in this report due to a lack of disaggregation in the 2013/2014 NHA, shows that funds from block grants managed and executed by RHBs account for the largest share (about 44%) of domestically generated funds for health (FMOH, 2014a, 2017a). By comparison, the FMOH received only about 15%—a similar share to what was managed and spent by parastatal companies. Woredas managed just 5% of government health resources, a similar share to the Federal Ministry of Education, while 8% of estimated government expenditure on health was attributed to “health-related” spending.

In FY 2010/11, domestically generated resources accounted for 94% of funds managed by RHBs, 100% managed by woredas, and 90% managed by the Federal Ministry of Education. In contrast, just 9% of funds managed by FMOH were from domestic sources in 2010/11. However, recent expenditure data shows that this share has increased significantly—to 42% in 2016/17 (FMOH and FHAPCO, 2018).

Overall, increases in domestic resource spending for health have come primarily at the subnational level, although financed by federal transfers rather than locally generated revenues. The significant increase in government health expenditure between FY 2010/11 and FY 2013/14, which corresponded with the implementation and scale-up of the Health Extension Program, appears to have flowed primarily to RHBs. Between 2010/11, the value of funding managed by RHBs increased more than fourfold, from US\$114 million to US\$481 million. In contrast, the amount of funding managed by FMOH remained almost unchanged at US\$405 million in 2013/14 compared to US\$402 million in 2010/11. However, there has been a significant increase in domestic funds managed at the federal level. From 2012/13 to 2016/17 domestic health expenditure at the federal level (including FMOH, Federal HIV/AIDS Prevention and Control Office [FHAPCO], federal hospitals, and

BOX 1.

KEY DATA GAP

Lack of available health expenditure data and inadequacy of National Health Accounts

The FMOH conducts a resource mapping exercise that includes funding levels (primarily from external sources) and program allocations but does not publish a formal budget document or track regional health spending.* Instead, the NHAs serve as the primary data source for financing flows and allocations. NHAs have historically been conducted at three-year intervals and provide a limited level of disaggregation, particularly in the most recent NHA (2013/14; FMOH, 2017a). A new NHA is currently underway, which will cover FY 2016/17.

Given Ethiopia's rapid economic growth—with GDP roughly tripling since the 2010/11 NHA—the financing landscape has likely changed significantly. This lack of reliable and regular health spending data makes it difficult to analyze health financing trends and ensure compliance with health financing targets and accountability in how public funding for health is used.

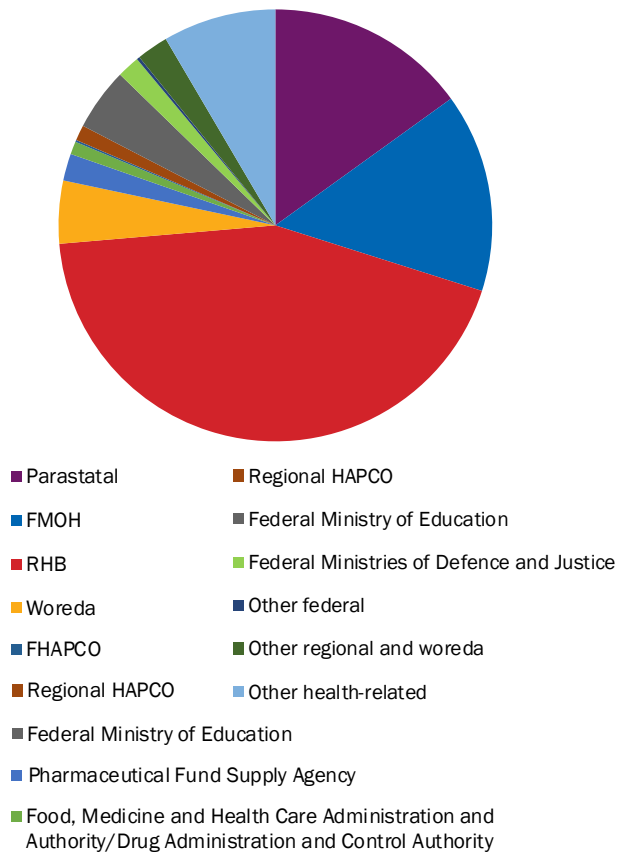
* The resource tracking exercise was not made available for the purposes of this assessment.

other agencies) increased three-fold from US\$48 million to US\$142 million (FMOH and FHAPCO, 2018).

How Government Spends Domestically Generated Resources for Health

Given the pooling of funds from different sources, it is difficult to determine precisely how domestically generated funds for health are spent. However, examining RHBs and woredas—which account for roughly half of domestically generated funds spent for health (Figure 4) and for which 94% of the total funding is domestically generated—Palladium found that 16% is spent at the primary healthcare level, 40% is spent at zonal and regional hospitals, and 44% is spent on administration.

Figure 4. Domestically Generated Health Spending by Agent, FY 2010/11



Source: FMOH, 2014a

Data on management of health resources by agent was not available in the 2013/14 NHA.

Salary payments are one of the primary ways that the government contributes financially to the health sector. FMOH, RHBs, and woreda health offices pay salaries for their own staff as well as clinical and support staff at their respective facility levels. They also fund the construction, maintenance, and operation of their respective facilities. The significant increase in domestic funding for health at the RHB level between 2010/11 and 2013/14 likely primarily supported increased numbers of health workers and health facilities. Under the Health Extension Program, 38,000 government-salaried health extension workers have been added and 15,000 health posts have been constructed (UNICEF, 2016; Workie and Ramana, 2013).

Government financing for consumables (e.g., medicines and supplies) is largely negligible (Box 2). Consumables are instead financed either by development partners (e.g., for services designated as exempted from user fees, including HIV, TB, malaria, family planning, and maternal, child, and reproductive health) or by clients through user fees. Consumables that are paid for with user fees are procured through the Pharmaceutical Fund Supply Agency's (PFSA) revolving drug fund (Carasso et al., 2009). Through the revolving drug fund, consumables are procured by PFSA and sold to public health facilities at a mark-up. The revenues are, in turn, used for the next round of procurement and to cover part of PFSA's operating costs. The government also provides direct funding for PFSA's operation as part of the federal budget.

At the federal level, increases in the allocation of domestic resources have primarily gone to referral hospitals and other federally managed curative and rehabilitative care and infrastructure projects. In total, these accounted for 89% of the increase in domestic resource allocations at the federal level between 2012/13 and 2016/17. Additional allocations for disease programs, including HIV, TB, and malaria promotion and prevention, accounted for just 7% of the increase in funding.

BOX 2.

KEY VULNERABILITY

Commodity financing

Although an estimated two-thirds of health funding managed by the Government of Ethiopia is domestically generated, allocations of domestic funds for drugs and supplies are extremely low. Instead, there is a heavy reliance on inequitable user fees and development partners to finance procurements. In particular, for priority health programs such as HIV, TB, malaria, and family planning, procurements are almost exclusively externally financed.

Insurance as a Mechanism for Domestic Resource Mobilization

Over the past decade, Ethiopia has focused on the implementation of publicly managed insurance schemes as a primary mechanism for mobilizing resources and increasing financial protection for health and, ultimately, achieving universal health coverage. A social health insurance (SHI) scheme was proposed in 2010 and formally approved by parliament and the president in 2012. The scheme aims to cover all formal (both public and private) sector workers and is to be funded by a 3% payroll tax split between employee and employer and a 1% tax on pensions. Upon implementation, it is estimated that SHI will cover 11% of the population (EHIA, Unpublished). However, as of late 2018, the scheme has yet to be implemented. Key informants cited a variety of reasons for the delay in implementation, including resistance from the FMOH, lack of agreement over contribution rates, and the scheme's financial sustainability. A financial sustainability analysis of the scheme, updated in 2015, indicates that, while the scheme would generate an estimated 45 billion Ethiopian birr (ETB) (approximately US\$1.7 billion) between 2019 and 2025, expenditures would exceed revenues in every year from 2019 onward, resulting in a cumulative deficit of ETB 15 billion (approximately US\$550 million) (EHIA, Unpublished).

Community-based health insurance (CBHI) was piloted in 2011 and has since been scaled up to more than 374 of the country's approximately 1,000 woredas (districts). As of April 2018, there were approximately 3.5 million enrolled households and 11.9 million beneficiaries—approximately 11% of the population. The Ethiopia Health Insurance Agency (EHIA) recommends an annual contribution rate of ETB 240 (US\$6.67) per household, although regions are responsible for ratifying or modifying this rate. Premiums are collected in cash by kebele (subdistrict) leaders who are allowed to keep 3% of the contributions collected. Each woreda (district) is supposed to identify 10% of its population as indigent whose premiums are fully subsidized by the woreda and regional governments. In fiscal year 2017, approximately US\$23 million was collected in

premiums (excluding subsidies by woreda and regional governments) while just US\$10 million was paid out in facility reimbursements. This discrepancy may be due to a variety of reasons, including low service utilization, a waiting period on the use of benefits, and problems with timely identification card disbursement.

Table 5. Key Insurance Indicators

Indicator	CBHI	SHI*
Population Coverage	11% (2018)	11% (2018 est.)
Contribution (type and rate)	ETB 240 (annual)	Payroll: 3% Pensions: 1%
Revenue (contributions)	ETB 521 million (2017)	ETB 5,103 million (2018 est.)
Total Reimbursements	ETB 236 million (2017)	ETB 5,031 million (2018 est.)
Medical Loss Ratio	45% (2017)	99% (2018)
Benefits Package (type)	Based on user fee schedule	Negative list (exclusions)

*SHI figures are estimated, pending implementation of the scheme.

Source: EHIA, Unpublished

Benefits under SHI are based on a negative list of services (i.e., a list of explicit exclusions), with specific exclusions for preventive physicals, accidents, and occupational injuries, dental and eye care, elective procedures, and certain surgical procedures (Federal Negarit Gazette, 2012). In addition, SHI will not reimburse for any service provided free-of-charge in public facilities (i.e., exempted from user fees) including HIV, TB, and malaria services. While CBHI lacks a defined benefits package, reimbursement is based on the public facility user fee schedule and generally covers all non-exempted services available at primary healthcare facilities.² Therefore, none of the resources mobilized through CBHI or SHI go to HIV, TB, malaria, or other exempted health services (Box 3).

2 The user fee schedule is established by each Regional Health Bureau.

BOX 3.**SUSTAINABILITY OPPORTUNITY****Integration of HIV, TB, malaria and other exempted services into insurance**

Earmarked payroll taxes (for SHI) and voluntary contributions (for CBHI) have been the central focus of domestic resource mobilization efforts for health. By achieving target implementation—meaning the launch of SHI to all formal sector employees and scale-up of CBHI to 80% of households in 80% of woredas—an additional \$280 million annually could be mobilized for health in 2020. This would represent an increase in government expenditure on health by an estimated 23%, above a scenario without insurance.

Integration of HIV, TB, malaria, and other exempted health services into these schemes is critical to ensure that these programs, which face the heaviest dependency on external financing, can benefit from this potential increase in domestic resources.

BOX 4.**ADVOCACY OPPORTUNITY**

Engagement and collaboration with EHIA will be critical to ensure that:

- Insurance schemes are financially sustainable and politically viable, which will require increasing access to preferred providers (including private providers) and sustained quality improvement
- Priority exempted health services are integrated into the benefits package to ensure execution of collected revenues and a sustainable financing stream for key commodities

The EHIA was established in 2010 to serve as the governing and implementing body for SHI. It has also served as the de facto governing body for CBHI, although it does not have a formal mandate. A proclamation formalizing CBHI, including its financing, membership, benefits package, and oversight by EHIA has been drafted but not yet submitted for parliamentary approval (Box 4).

Private Sector Contribution to Health**Private Providers**

In 2013/14, private health facilities in Ethiopia accounted for an estimated 20% of outpatient visits and 21% of inpatient admissions—percentages generally unchanged from 2010/11 (FMOH, 2014b)—although trends in private sector utilization over the past five years are not known and may have changed significantly. The 2016 Demographic and Health Survey and recent studies indicate that private sector facilities and their utilization is heavily concentrated in urban areas (PSI and FPwatch, 2016). FMOH has conducted a private sector assessment, including the number of private facilities; however, at the time of data collection, it was not available to be shared. In a facility survey conducted in 2015, PSI found that 88% of health providers sampled in Addis Ababa were private commercial or not-for-profit nongovernmental.

Private providers are not currently well-engaged by the GOE. There was some disagreement within FMOH about the current role of private facilities in priority health programs—such as for HIV, TB, and malaria—and what services they were providing; however, the consensus was that private providers play a larger role in testing and identification than in treatment. It was noted that private providers could charge for testing, but not for drugs, which providers could obtain for free from the government. The lack of profit incentive may explain limited engagement, although key informants have suggested that private providers often sell family planning commodities at a loss as a way to attract clients for other, more profitable

services. It was also suggested that there is a lack of guidance for private providers, particularly for malaria treatment.

FMOH has established a public-private partnerships unit within its Partnership and Cooperation Directorate (formerly the Resource Mobilization Directorate). This unit is still nascent and currently working to draft guidelines for the development and implementation of health sector public-private partnerships. Current engagement by the FMOH with the private sector has focused on the contracting out of diagnostic services, such as testing and imaging, and support functions for tertiary-level facilities.

Private Insurance

Aside from direct service provision, the private sector has contributed to the health sector in other key ways. In 2013/14, 16 private health insurance providers were operating in Ethiopia (FMOH, 2017a). However, their total coverage was less than 1% of the total population as of 2016 (CSA and ICF, 2016). Although no known study has comprehensively analyzed the benefits packages of private health insurance providers, anecdotal evidence suggests that they do not generally cover services or commodities provided free-of-charge in public facilities (e.g., HIV, TB, and malaria treatment and contraceptive methods). However, where drugs and commodities associated with these services are provided free-of-charge in private facilities, consultation fees may be covered.

Pharmaceutical Industry

Ethiopia has made significant efforts in recent years to attract and strengthen investment in pharmaceuticals. Ethiopia has developed the *National Strategy and Plan of Action for Pharmaceutical Manufacturing Development in Ethiopia (2015–2025)* with the goal of becoming a regional hub for pharmaceutical manufacturing (FMOH and FMOI, 2015). WHO has been providing key technical support for quality improvement and certification, has supported the Food, Medicine and Health Care Administration and Authority (FMHACA) in the development and implementation of a roadmap for achieving Good Manufacturing Practice (GMP) certification for all

domestic pharmaceutical manufacturers, and has provided GMP trainings to manufacturers and GMP audit trainings to FMHACA. Although no domestic pharmaceutical plants were GMP compliant as of the last audit in 2016, there is an expectation that two firms are close to achieving compliance. As of November 2018, an audit for all pharmaceutical companies in the country was ongoing and was being led for the first time by FMHACA.

Currently, 11 pharmaceutical manufacturers operate in Ethiopia; all serve the domestic market. The GOE, through PFSA, purchases the majority of domestically manufactured pharmaceuticals, however, the exact share is unknown. The domestic private sector purchases the remainder and also procures from the international market.

All PFSA procurements must be approved by FMHACA. GMP certification is required for open contract agreements, but FMHACA grants exemptions on a by-procurement basis. Increased donor engagement, particularly by the Global Fund, was highlighted as a critical opportunity to accelerate strengthening of the domestic pharmaceutical industry. WHO key informants expressed the opinion that, in the long-run, procurement of essential medicines and supplies from the domestic production market may be an effective way to achieve greater value for money, due to both lower supply chain costs and reduced wastage (i.e., longer drug shelf lives) (Box 5). Greater domestic procurement may

BOX 5.

SUSTAINABILITY OPPORTUNITY

Strengthening domestic pharmaceutical production

The potential benefits of domestic pharmaceutical production are complex and merit further analysis. Ethiopia is unlikely to receive lower unit prices domestically than it can in the international market, but supply chain challenges (particularly given Ethiopia's landlocked status) and foreign currency shortages suggest potential long-term benefits to domestic production and procurement.

also lessen delays in the procurement process, and subsequent stockouts, due to reduced shipping times. A study by WHO found that locally produced medicines had an availability rate of 48%, compared to 19% for imported medicines, which may highlight greater ease and responsiveness of local procurements.

However, the same study found that PFSA's "procurement prices for locally produced and imported medicines were 1.20- and 0.84-times international reference prices, respectively" and the government was willing to pay up to 25% more for locally produced medicines. In the public sector, patients paid 22% more for locally produced products than imported alternatives (Ewen et al., 2016, p. 8). However, in the private sector, retail prices for imported products were 193% more than domestic alternatives. This is likely a consequence of Ethiopia's foreign currency shortages.

Although domestic manufacturing of pharmaceuticals has traditionally focused on relatively basic products like antibiotics and anti-inflammatory drugs, two manufacturers—India-based Cadila and U.S.-based Access Bio—are currently producing malaria tests kits and are doing at least partial assembly at their Ethiopian plants. Cadila is also expected to be close to receiving WHO Prequalification for TB drugs.

At the same time, FMOH and the Federal Ministry of Industry, with support from the Ethiopia Investment Commission, are actively looking to attract international manufacturers with the technical expertise to scale production and increase product portfolios. Two Chinese firms have recently entered the domestic market, bringing broader expertise and portfolios. For all firms, appropriate precautions and oversight must be in place to assure quality standards. All new manufacturers entering the market will have to have GMP certification, even while legacy firms continue to work toward it.

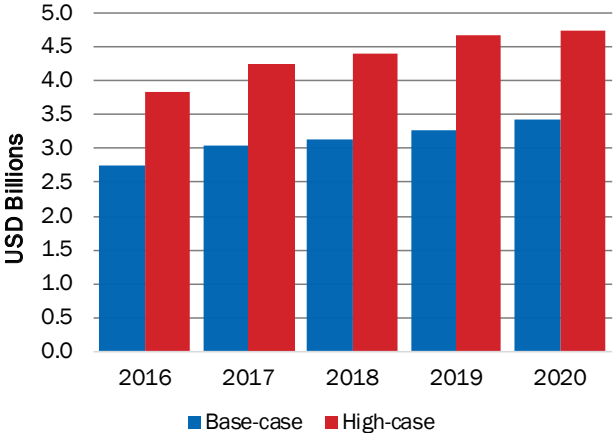
KEY TAKEAWAYS: HEALTH FINANCING OPPORTUNITIES

- Despite a heavy reliance on external financing for health over the past two decades, NHAs demonstrate that between 2010/11 and 2013/14 most new money for health in Ethiopia came from domestic sources, with 53% of the increase coming from government (domestic revenues) and 33% coming from households (FMOH 2014a, 2017a).
- Subnational (regional and woreda) governments account for roughly half of government expenditure on health and have grown with the Health Extension Program's increased focus on infrastructure and human resources at the primary healthcare level. However, increased domestic financing for commodities for priority health services, such as HIV, TB, malaria, and family planning, will likely require new resources to be mobilized at the federal level.
- Despite a current total coverage rate of only approximately 11%, CBHI and SHI are still seen as a primary conduit for mobilizing new resources and achieving financial protection for health and are a central focus of the government's healthcare and health financing strategies and current efforts.
- Increased private sector engagement and oversight can increase efficiencies, improve quality, and broaden access to priority health services, particularly in urban areas where private facilities are much more prevalent and more trusted than their public counterparts.

Finding the Money: Improving Allocations and Efficiency for Health Spending

In 2015, the Ethiopia Federal Ministry of Health adopted its most recent health sector strategy, the five-year *Health Sector Transformation Plan 2015/16–2019/20* (HSTP) (FMOH, 2015). The HSTP lays out the first phase of implementation of the country’s 20-year health sector roadmap, *Envisioning Ethiopia’s Path towards Universal Health Coverage through Strengthening Primary Health Care*, and costs the implementation of all government health programs and services. Costs were estimated under both a base-case scenario to achieve the expected progress needed to achieve the country’s 20-year targets and a high-case scenario with increased investment in human resources for health and infrastructure. The total annual cost of these activities is estimated to increase from US\$2.8 billion in 2015/16 to US\$3.4 billion in 2019/20 under a base-case scenario and to US\$4.7 billion by 2019/20 under the high-case scenario (Figure 5).

Figure 5. Resource Requirement for Health, by Scenario



Source: FMOH, 2015

Despite gains in domestic health spending, the piloting and proposal of health insurance mechanisms to improve both pooling and resource mobilization for health, and increased engagement of the private sector, Ethiopia continues to face significant challenges to meet its health financing goals. The HSTP estimates a resource gap for the health sector of 10–44% over the period of 2015/16–2019/20.

To meet its health financing needs, the FMOH, in coordination with the Ministry of Finance and Economic Cooperation (MOFEC) and other ministries and agencies at the federal, regional, and local level, must continue to emphasize the need for greater budget allocations and prioritization of health at all levels of government. In addition, efforts must be made to ensure that existing and future resources are used in the most cost-effective manner. By prioritizing those interventions that are the most efficacious and targeting populations that have the highest need, Ethiopia can increase the value and impact of its current domestic resource allocations to health. To ensure that funding for health is adequate and can meet the country’s needs it will be critical to demonstrate:

- 1) The health and economic impacts of health expenditure, and why health should be prioritized among competing financing needs;
- 2) Clear and realistic targets for health spending, grounded in the country’s universal health coverage targets and current macroeconomic context; and
- 3) Efficient and effective use of funding for health, including the achievement of pre-determined targets.

HEALTH AS A DEVELOPMENT PRIORITY

Rationale for Health Spending

Available evidence demonstrates that public investment in health, particularly in high-impact programs and interventions, can yield significant returns not only in terms of health status but also in productivity and economic gains. The World Bank noted that Ethiopia's investments in health had a positive impact on economic development (World Bank, 2016a). Multi-country studies of return on investment for priority health areas have quantified the economic benefits of such investment. A study of the cost and benefits of providing ART for 3.5 million people living with HIV in low- and middle-income countries found that doing so would result in 18.5 million life years saved and a subsequent economic return of US\$12–34 billion through increased labor productivity and averted downstream healthcare and social protection costs (Table 6) (Resch et al., 2011). Against an estimated cost of US\$14.2 billion, this represents an average expected benefit of US\$1.62 for every US\$1 spent on HIV treatment. Similar estimates for investments in malaria (Purdy et al., 2013) and TB (Stop TB Partnership, 2015) suggest that their returns could be even higher. Family planning is also especially well-documented as a best buy for public investment, with every dollar spent on family planning estimated to save US\$2.20 in pregnancy-related costs and between US\$2–6 toward the achievement of the Millennium Development Goals.³

This body of evidence indicates that investing in health not only saves lives but also saves money—by averting future costs—but also yields economic returns through enhanced productivity. Despite this, health is not currently viewed as an economically productive sector by MOFEC. There is a need for increased use of evidence and advocacy directed at MOFEC to demonstrate the value of investing in health (Box 6).

Table 6. Estimated Returns on Investment to Key Health Areas

Health Area	Return on Investment (for every dollar spent)
HIV (ART)	\$1.62
Malaria	\$2.78
TB	\$27+
Family Planning	\$2.20+

Estimates presented here consider selected and different potential returns and should not be compared or used for purposes of prioritization across health areas.

BOX 6.

KEY DATA GAP

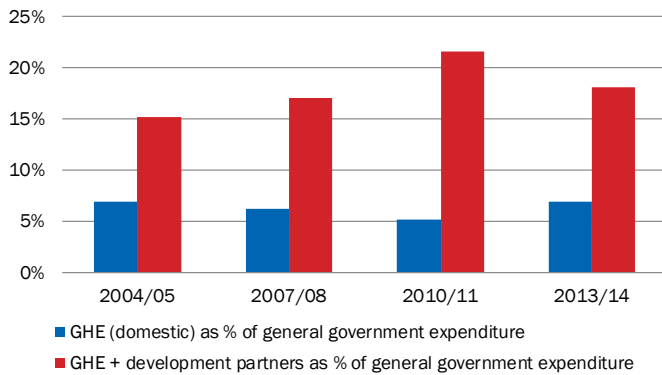
Estimates of cost-effectiveness and return-on-investment of health expenditure in an Ethiopian context are needed to add credibility to the case for additional health spending and reposition the health sector among Ethiopia's development priorities.

Prioritization of the Health Sector

Key informants have indicated that health has stagnated as a financing priority and that the top national priorities are education and infrastructure. MOFEC generally considers health as a well-funded sector and views any need for additional funding as evidence that current funds are not being well-used. While GHE accounted for just 6.9% of total government expenditure in FY 2013/14 (Figure 6). If government and development partner health expenditure is considered together, it accounts for an estimated US\$1.65 billion. That is to say that in the absence of donor funding, 17% of total government expenditure of US\$9,478 would need to be allocated to health to maintain current spending levels.

³ A new model for estimating the impact of family planning investment on the Sustainable Development Goals was recently developed by Health Policy Plus.

Figure 6. Health Expenditure Relative to Total Government Expenditure



Recent efforts by the FMOH to secure a greater share of the domestic budget for health have focused on the potential implementation of earmarked taxes, particularly on alcohol, tobacco, and sugary beverages (so-called “sin taxes”). The Partnership and Cooperation Directorate of FMOH is currently developing a proposal for these taxes, however, it is not clear if this proposal will focus on the creation of new taxes, an increase of current tax rates, or earmarking of existing revenues. MOFEC has been resistant to previous proposals by the FMOH to implement earmarks, due to their rigidity and the limitations they place on MOFEC’s ability to respond to new priorities. It is unclear how MOFEC will respond to this round of proposals, as the FMOH has not thus far engaged them in the process (Box 7).

TARGETS FOR DOMESTIC HEALTH SPENDING

Current Targets

The HSTP establishes targets for government mobilization of resources for health based on the country’s national development plan, the *Growth and Transformation Plan II 2015/16–2019/20* (GTP II) (National Planning Commission, 2016). GTP II establishes targets for macroeconomic and fiscal performance. Based on these targets, the HSTP estimates that in the most recent FY 2017/18, the government resource allocation to

BOX 7.

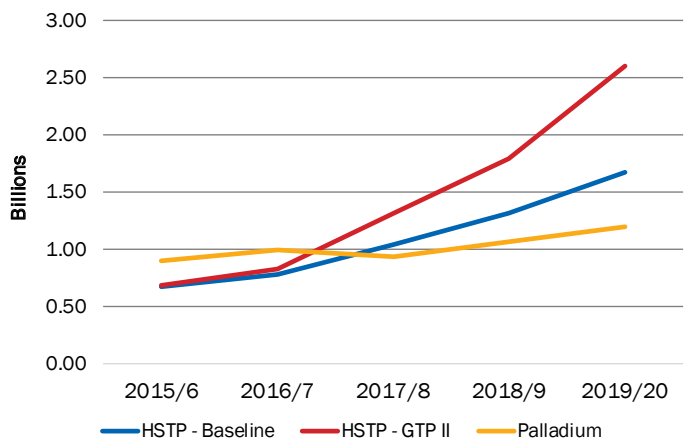
KEY VULNERABILITY

Lack of FMOH engagement with MOFEC

The FMOH does not regularly engage with MOFEC during the conceptualization and development of health financing and resource mobilization strategies. This has led to delays and challenges in the approval process due to misalignment between FMOH and MOFEC priorities. FMOH staff noted that they do not have an established line of communication with or point of contact within MOFEC. To ensure that future strategy proposals are feasible and successful, FMOH must foster close and regular collaboration and engagement with MOFEC.

health (excluding subsidies paid to CBHI and SHI) would be approximately US\$1.3 billion, nearly double its baseline estimate of US\$694 million in 2015/16 and well above a baseline scenario based on historical trends (Figure 7). Based on the GTP II targets, the resource allocation to health is further expected to nearly double again to ETB 2.60 billion by 2019/20.

Figure 7. Comparative Scenarios of Government Health Spending



The GTP II/HSTP government health spending targets are largely predicated on an increase in the share of the general government budget allocated to health from 6% to 10% by FY 2019/20. The 2013/14 NHA indicates that, at 6.9%, prioritization of health within the budget already outperformed baseline expectations (FMOH, 2017a). However, there is a lack of available data on more recent trends on budget allocation to health (Box 8). If no specific efforts are made to increase prioritization of health and health remains constant at 6.9% of government expenditure, Palladium projects, based on current macroeconomic and fiscal trends (IMF, 2018) that government spending will remain well below targets established by the HSTP (Figure 7). Given the ambitious nature of the budget targets set in the GTP II and HSTP, it may be necessary to develop alternative solutions for mobilizing new funds, creating new fiscal space for health, including both innovative financing mechanisms and efficiency gains.

Ethiopia has a draft national healthcare financing strategy, which was most recently updated in 2017. The strategy has been reviewed by the MOFEC and submitted to the Council of Ministers, chaired by the Prime Minister, but is still awaiting approval. The draft strategy recommends that the government incrementally increase its spending on health to, at a minimum, 15% of total health expenditure—in line with the Abuja targets—to “make the health financing situation in Ethiopia more sustainable” (FMOH, 2017b, p. 5). While the strategy does not specifically identify how this target should be attained, it calls for increased budget allocation for health and the exploration of the use of innovative financing mechanisms based on international best practices and experiences. The strategy does not identify disease-specific opportunities for resource mobilization, such as the current HIV mainstreaming guidelines, which recommend that all line ministries and their subnational counterparts allocate up to 2% of their budget for HIV prevention activities.

BOX 8.**KEY DATA GAP**

Data on government allocations to the health sector is not regularly published at either at the federal or regional level. A lack of budget transparency makes it difficult to track progress toward health financing and resource mobilization targets, and ensure accountability for implementation of relevant strategies, such as the Health Care Financing Strategy.

Understanding Fiscal Space and Macroeconomic Context for Health Budgeting

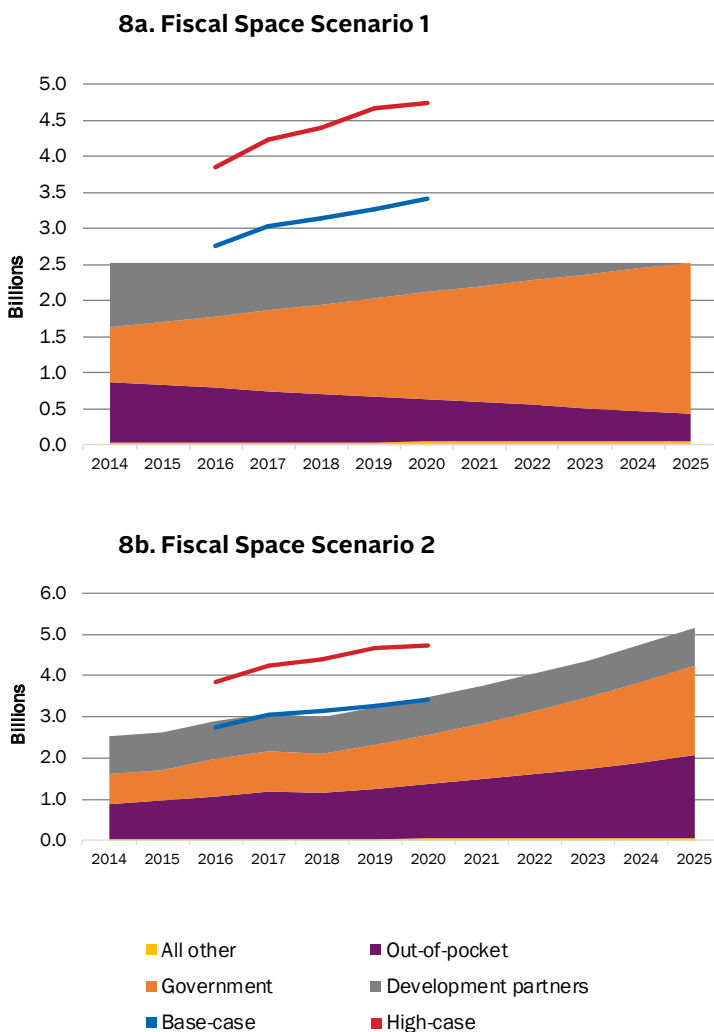
Economic Growth and Revenue Generation

Increased domestic public expenditure on health in Ethiopia has been driven, in large part, by the country’s robust macroeconomic performance. Between FY 2010/11 and FY 2016/17 Ethiopia’s economy—measured by real GDP growth—nearly doubled in size and domestic government revenues increased from US\$4.2 billion to US\$11.4 billion (IMF, 2018). International Monetary Fund (IMF) estimates project that economic growth will remain strong, at above 8% real annual growth through FY 2021/22, and general government revenues as a percentage of GDP will increase from 14.7% in FY 2017/18 to 16.3% in FY 2021/22.

These trends will create substantial new fiscal space for health even without significant increases in budget prioritization, as called for in the HSTP. Palladium estimates that, by maintaining 6.9% of general government budget for health, Ethiopia will increase its domestically generated government health expenditure to US\$2.2 billion by 2025. The increase is sufficient to (1) replace all current external financing for health and (2) achieve the HSTP goal of reducing out-of-pocket expenditure to 15% of THE by 2025, assuming current levels of THE are maintained (see *Fiscal Space Scenario 1*, Figure 8a). However, this scenario will leave Ethiopia well below its target of US\$3.4–\$4.7 billion in THE by 2020.

On the other hand, with the same increase in government expenditure for health, if current levels of donor financing are maintained and out-of-pocket increases proportionally to growth in GDP per capita, THE will meet the HSTP base-case requirement and surpass US\$5 billion by 2025 (see *Fiscal Space Scenario 2*, Figure 8b). These comparative scenarios highlight the implications of potential reductions in donor financing and the likely need both to create additional space through reducing current costs and for increased budget advocacy to achieve the HSTP target of 10% of general government expenditure for health. In addition, the value of increased fiscal space created through economic growth is subject to the country’s broader monetary challenges.

Figure 8. Source of Health Financing with Increased Government Fiscal Space, Compared to HSTP Resource Requirement (2014–2025)



Monetary Policy and Foreign Exchange

Past growth in domestic health spending has been undercut by depreciation of the Ethiopian birr against major global currencies, particularly the U.S. dollar. Between FY 2010/11 and FY 2016/17, the birr depreciated by 26% against the U.S. dollar, before being officially devalued by 15% in 2017 (Amboko, 2018). The National Bank maintains a managed floating exchange rate, which consistently overvalues the birr. Based on the current exchange rate in the parallel informal market, the official exchange still overvalues the birr by approximately 25%. Palladium’s estimates, based on historical trends, project the continued depreciation of the birr by 19% between FY 2017/18 and FY 2021/22. While this may not have a significant effect on salary, operational, or infrastructure costs, which are the primary components of the health sector currently funded by the GOE, it would significantly impact the government’s ability to procure commodities or supplies on the international market and denominated in dollars. Based on historical trends, Palladium calculates that an increase in the nominal budget of more than 5% would be required simply to maintain purchasing power.

The National Bank’s efforts to maintain the value of the birr—by buying birr and selling foreign currency reserves—have also contributed to a foreign currency shortage in the country. Low growth in exports, as compared to imports, has further depleted foreign currency reserves. Low reserves, which are currently sufficient to cover less than two months of imports, were identified as a key area of macroeconomic vulnerability (IMF, 2018). The IMF has noted the need for a more flexible exchange rate policy and reduced foreign currency controls to increase export competitiveness and make it easier to access foreign currency. Difficulty in obtaining foreign currency has been identified by partners in family planning as a key challenge to achieving sustainability and prevents them from shifting away from external financing to domestic financing sources (Box 9).

BOX 9.
KEY VULNERABILITY
Foreign exchange controls and volatility

Ethiopia's monetary policy is a double-edged sword for health financing. On one hand, tight management of the exchange rate and foreign exchange controls reinforces the country's dependence of external financing for commodity procurements and stifles the ability of the private sector to access international markets. On the other, allowing the exchange rate to float freely would further reduce government purchasing power for commodities. The ability of government to use domestic revenues to meet its full procurement needs, particularly for medicines and supplies not currently produced domestically (including those for HIV, TB, and malaria) will be contingent upon national monetary policy.

GETTING MORE FOR THE MONEY: EFFICIENCY IN HEALTH SPENDING

Achieving sufficient and sustainable domestic financing for health in Ethiopia will require not only the mobilization of new resources but also greater efficiencies in the use of existing resources. The World Bank notes that Ethiopia has already achieved substantial efficiencies in the use of funding for health, when measured by the relationship between spending levels and health outcomes (World Bank, 2016b). In particular, Ethiopia achieved a significant reduction in under-five mortality—by 80 under-five deaths per 1,000 live births—with an increase in THE per capita of just US\$5. In addition, Ethiopia has a higher-than-predicted life expectancy, given its level of health expenditure per capita. According to the World Bank, these efficiencies have been achieved through Ethiopia's focus

on preventive and primary healthcare, which is considered more cost-effective than investments in secondary and tertiary services, and through targeting poor and disadvantaged groups. Nonetheless, according to in-country experts, additional efficiency improvements are needed and must focus on targeting funds to high-burden and at-risk populations, increasing absorptive capacity and ensuring execution of allocated funds, ensuring appropriate use and oversight of funds, and improving quality and effectiveness of interventions.

Palladium has developed a set of key efficiency indicators that can summarize performance in three areas: budget execution, resource allocation, and technical implementation (Table 7).

Table 7. Efficiency Indicators

Indicator	Value
Budget Efficiency	
FMOH budget disbursement rate	Not available
FMOH budget execution rate	Not available
Allocative Efficiency	
Is burden of disease considered in MOFEC and Bureau of Finance and Economic Development transfer formulas?	No
Is an epidemiological modeling tool used to make resource allocation decisions?	Yes (Spectrum)
Outpatient visit equivalents per clinical staff per day (health centers/hospitals)	3.7/2.5 (2013/14)
Facility stockout rate for selected drugs	36%
Technical Efficiency	
Absenteeism rate	10% (2012 est.)
Rate of false positive tests (HIV/TB)	4.7% (2004-05)/ 2.4% (2014-16)
Treatment failure rate (HIV/TB)	34% (2013)/ 16% (2017)

Sources: Desalegn et al., 2018; Eshetie et al., 2018; Feysia et al., 2012; Mann et al., 2016a, 2016b; Shanks et al., 2013; Telele et al., 2018a

Budget Efficiency

Efficiency in the use of funds means, first and foremost, that funds allocated for health programs and inputs are used for that purpose. This can be measured by the budget execution rate (i.e., the percentage of allocated funds actually spent). The disbursement rate (i.e., the share of allocated funds released to the executing ministry, bureau, or office) can be a key indicator in understanding bottlenecks in the financial management process and whether allocated funds are available and timely.

The FMOH and MOFEC did not make budget and expenditure data available for the purpose of this analysis. Key informants within the health sector indicated that the absorptive capacity of the FMOH has increased in recent years and budget execution rates are generally high and similar across programs. However, there is anecdotal evidence suggesting that the government has struggled to spend domestically generated and budgeted funds and does so at a lower rate than external funds. For example, when the Government of Ethiopia previously allocated nearly US\$1 million in domestically generated funds for family planning commodity procurement, these funds were not spent.

Allocative Efficiency

Allocative efficiency can refer to the way in which resources are distributed geographically, by program area or intervention, and to different inputs. There is not a singular definition or set of indicators for allocative efficiency, however Table 7 summarizes selected indicators.

Allocations for specific programs within the health budget are based on model estimates conducted using Spectrum and the OneHealth Tool and summarized in the HSTP.⁴ This modeling guides allocation across programs at the national level. However, allocation of resources to the regional and woreda level—which represent the majority

of domestically generated government spending for health—does not consider variations in disease burden across geographic areas. This means that available resources for health may not be aligned with areas of higher rates of infection, particularly for malaria and HIV/TB coinfection. There is some indication of this misalignment in patient volumes (measured by the number of outpatient equivalent visits per clinical staff per day), which range from 1.1 to 7.2 (average 3.7) in sampled public health centers and 1.5 to 5.8 (average 2.5) in sampled public hospitals (Mann et al., 2016a, 2016b). This is compared to volumes of 7 and 6 outpatient equivalents in Kenya, for health centers and hospitals, respectively, and volumes of 4 and 5 in Ghana. This suggests that future investments do not need to focus on increasing the number of health workers but rather should focus on quality improvement, availability of essential medicines, and demand creation in order to increase patient volumes (Box 10).

When essential medicines are available at the national level, local stockouts of essential medicines can be another indicator of inefficient allocation of resources. A study by WHO found that only 64% of sampled essential medicines were available at the time of facility visits (Ewen et al., 2016) and key informants indicated that while stockouts at the national level were rare,

BOX 10.

SUSTAINABILITY OPPORTUNITY

Increased demand and utilization

Public health facilities in Ethiopia have relatively low patient volumes (per clinical staff), suggesting that future government investment should focus on improving availability of essential drugs and supplies and provider training, rather than increasing the number of health workers.

4 The OneHealth Tool and Spectrum make up a suite of software developed by the UN Inter-Agency Working Group on Costing. OneHealth is used to estimate the resource requirement for key disease programs, including HIV, TB, and malaria, and the costs of strengthening health system functions, including human resources for health, infrastructure, health information systems, supply chain, governance, and financing. Spectrum estimates the impact on health outcomes (e.g., morbidity and mortality rates) of achieving program targets based on dynamic changes in demography, epidemiology, and service coverage.

local stockouts were common (Box 11). This was attributed, at least in part, to a lack of capacity for quantification, particularly in facilities from which PEPFAR has withdrawn support. The inefficient distribution of drugs and supplies leads to higher costs (for emergency procurements and supply chain) and higher rates of wastage.

Specific inefficiencies also exist within program areas. The *Mid-Term Review of the National HIV/AIDS Strategic Plan 2015–2020 in an Investment Case Approach* notes that the national strategic plan fails to appropriately target the most at-risk and high-impact groups (e.g., key populations). Its definition of most-at-risk populations does not reflect international guidelines and definitions, and the strategy entirely excludes mention of both men who have sex with men and people who inject drugs. As a result, inadequate resources are allocated to prevention and testing of these groups (Box 12). Resources are instead spent on the general population, where testing yields are very low and impact of additional invested resources is minimal (FMOH and FHAPCO, 2018).

Technical Efficiency

Better use of existing resources also means ensuring that funds spent are used in a way that is technically efficient and maximizes their impact. That is to say that the products or services purchased are effective and appropriately applied or prescribed. Table 7 summarizes selected indicators around the effectiveness of human resources for health, laboratory testing, and drug efficacy.

As the majority of government expenditure for health goes to health worker salaries, absenteeism is a key indicator of effectiveness of this investment. High rates of absenteeism mean that a high share of government resources are not reaching patients and not contributing to improved health outcomes. However, previous assessments indicate that absenteeism in the health sector in Ethiopia is around 10%, far lower than other countries in sub-Saharan Africa (Feysia et al., 2012). However, other factors may contribute to reduced quality of investment in the health workforce (Box 13).

BOX 11.

SUSTAINABILITY OPPORTUNITY

Improved quantification

Local stockouts indicate an opportunity to increase availability of drugs and supplies by improving allocation, rather than overall procurement volumes. This will increase the effectiveness of current health investments.

BOX 12.

SUSTAINABILITY OPPORTUNITY

Improve population targeting for HIV

Resources for testing and prevention of HIV do not appropriately target key populations, where they will have the greatest impact. Resources should be realigned to reflect international definitions and best practices.

BOX 13.

SUSTAINABILITY OPPORTUNITY

Retention of the health workforce

A number of studies (Gesese et al., 2016; van de Klundert et al., 2018) have found that Ethiopia experiences high turnover rates, particularly for rural health workers. Van de Klundert et al., suggests that local human resource management interventions may be effective in increasing the attractiveness of these posts.

In addition, Ethiopia has historically experienced substantial emigration of medical professionals, which represents a significant inefficiency and loss of return on investment of the GOE's investment in training of health professionals. However, a number of efforts are being made to reengage diaspora, particularly in health, and recent changes in the country's political climate may make remaining in or returning to Ethiopia more attractive to medical professionals.

Misdiagnosis of diseases, both false negatives (where positive patient is incorrectly diagnosed as negative) and false positives (where a negative patient is incorrectly diagnosed as positive) can be costly for the health sector in terms of further transmission, retesting, and inappropriate use of expensive drugs. Misdiagnosis and treatment of negative patients represents an unnecessary cost and potential area of savings. In Ethiopia, additional cost savings could be achieved through more accurate diagnostics and a reduction in false positives, particularly for HIV and TB (Table 7).

Treatment failure rates—due either to drug resistance or default (i.e., discontinuation before completion of a full drug regimen)—are also indicative of an inefficient use of resources, as inputs do not achieve their intended or expected outcomes. Although HIV, TB, and malaria treatment have all been highly successful at reducing mortality rates, current rates of treatment failure do demonstrate that there is still room to improve the efficiency of current resources (Box 14). Table 7 shows the most recent reported failure rates for both HIV and TB. While most cases of treatment failure are due to default, recent study found that, in Ethiopia, transmitted

BOX 14.**SUSTAINABILITY OPPORTUNITY****Improving treatment adherence**

High rates of treatment failure suggest that a significant share of drugs are being used ineffectively. Improved community engagement and retention activities led by health extension workers could reduce mortality rates and the need for repeated or second-line treatment, achieving improved health outcomes and reduced mortality rates without significant additional funding for drugs.

drug resistance among ART patients was 3.9% (Telele et al., 2018b). Improved engagement with the private sector may be an important area of focus to ensure the effectiveness of testing and screening and that the recommended guidelines are implemented. High discontinuation and failure rates demonstrate the need to continue to focus on ensuring high-quality services, appropriate counseling, and follow-up for key health services, particularly HIV and TB treatment.

KEY TAKEAWAYS: EVIDENCE FOR ADVOCACY

Current health spending targets, as elaborated in the HSTP, are highly ambitious and likely unachievable in the proposed timeframe. The FMOH will need to consider how to rationalize its allocation of funds, given realistic prospects for resource mobilization, and how to more effectively use its current resources through improved allocative and technical efficiencies.

Ethiopia's current macroeconomic and monetary challenges, particularly the close management of its exchange rate, have important implications for the purchasing power of domestic resources and for the ability of the government to procure commodities from the international market, and must be closely monitored.

Efficient use of domestic resources for health will be critical not only to do more with what is currently available but also to demonstrate that health is a productive investment with a strong rate of return. Better making the economic argument for health spending, including with better data on impacts (including multi-sector impacts) and efficiency of spending, will be necessary for advocating to the MOFEC and other stakeholders to secure greater funding for the sector.

Mobilizing the Money: Understanding the Health Budget Process

Increasing domestic allocations to health at the federal and subnational level will require sustained, effective, and targeted advocacy. A comprehensive understanding of the budget process is critical to be able to identify and use key entry points and identify the appropriate audience and timing of advocacy efforts. The following section illustrates this process and identifies key opportunities for advocacy.

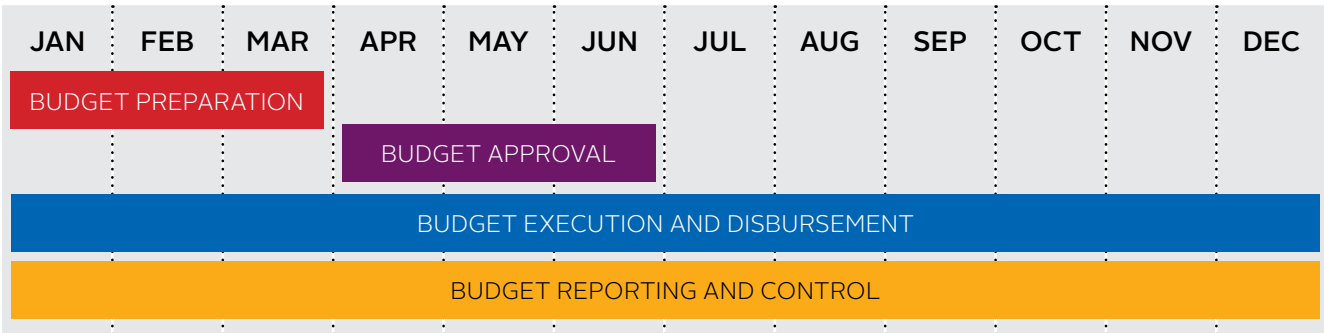
DECENTRALIZATION AND RESOURCE ALLOCATION

Under Ethiopia’s federal system of government, regions are highly autonomous and have significant discretion over their budgets. As a result, public financing for health is highly decentralized, with resources coming from at least three different sources, and is subject to the budget processes of each. Budgetary allocations between sectors are, generally, not done at the national level. Instead, the federal government, which collects the majority of tax revenues, provides block grants to each regional government. At the federal level, MOFEC allocates funds to the FMOH, in

addition to the nonsector-specific block grants made to each region. Each regional government subsequently subdivides these grants to regional sector offices, zonal governments, and woredas (districts) within its jurisdiction. At the regional and woreda level, funding is allocated by the Bureau of Finance and Economic Development (BOFED) and Woreda Office of Finance and Economic Development (WOFED) to their respective RHBs and woreda health offices (WorHOs) (FMOH, 2007).

Woredas are responsible for allocating funds to district hospitals, health centers, and health posts for their operation. RHBs are responsible for the staffing and operation of all regional hospitals. At both the regional and woreda level, block grants may be supplemented by external (e.g., donor) support and by regionally collected tax revenues and local contributions, such as those mobilized by Health Development Armies.⁵ Local resources are not well tracked and make up a small share of the overall resource envelope for both health and in the general budget.⁶

Figure 9. Health Budget Process



5 Health Development Armies are a network of families, including a model family, that encourage and influence each other to lead healthy lives. They also contribute voluntarily, either financial or in-kind, to community health programs and projects, including the construction of health posts.

6 Communities also provide in-kind contributions to health, principally through the construction of health posts. However, the quality of this infrastructure may be lower than those financed by regional and local government.

HEALTH BUDGET PROCESS

The FMOH has made significant efforts to harmonize this complex budget process under the principal of “one plan, one budget, one report” (FMOH, 2007). Within this harmonized vision for the budget process at all levels, the budget process has four main stages: preparation, approval, execution, and reporting and control. The following sections describe each stage of the budget process and are based primarily on the FMOH’s *Health Sector Development Plan Harmonization Manual* (FMOH, 2007), with timelines updated and revised for current practice based on key informant interviews.

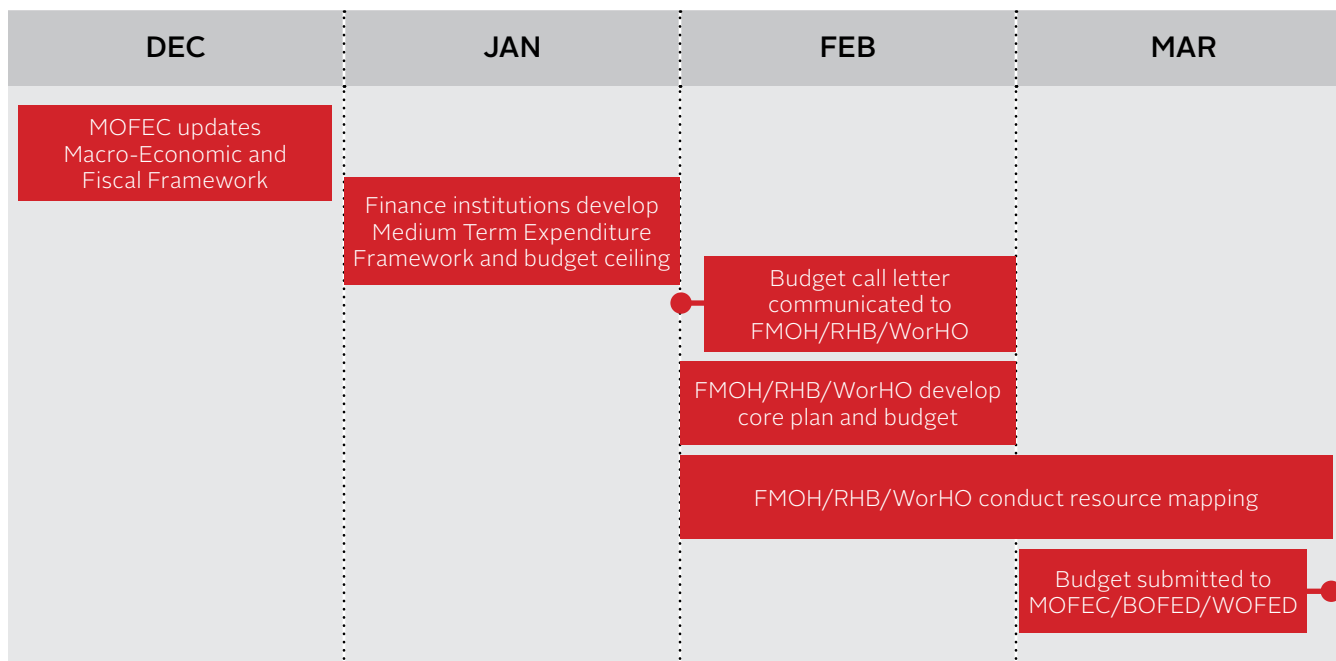
Budget Preparation

The budget preparation process is part of the government’s strategic and annual planning processes conducted in anticipation of the upcoming fiscal year, which spans from July 1 to June 30. At the federal level, MOFEC first prepares or updates the Macro-Economic and Fiscal Framework, which forecasts government revenue and expenditure for the coming three years on a rolling basis. Based on this, MOFEC prepares or updates its three-year Medium Term Expenditure Framework and establishes a

budget ceiling for each line ministry and region. These budget ceilings are communicated to all government offices through a budget call letter in February. Budget ceilings are similarly cascaded to agencies at their respective regional, zonal, or woreda level by the relevant finance institution (e.g., BOFED, WOFED) (FMOH, 2007).

Within FMOH, the resource mobilization team in the Partnership and Cooperation Directorate conducts a resource mapping exercise to determine how much funding will be available from different sources and for which programs during the coming fiscal year. This resource mapping exercise typically occurs in February and includes input from all financing sources, both domestic and external, although key informants have suggested the focus is predominantly on external sources. The budget mapping exercise was not made available for the purposes of this analysis. Around the same time, the FMOH Policy and Planning Directorate conducts a review of last year’s financial performance (e.g., budget absorption) to inform needs in the coming fiscal year. These two inputs inform the development of a draft core plan—an annual work plan and accompanying budget. This core plan is discussed and agreed upon by the FMOH-RHB Joint

Figure 10. Stages of Budget Preparation



Steering Committee and then shared with the RHBs, zonal health bureaus (ZHBs), and WorHOs to support the development of their annual core plans (Box 15).

The core plan and budget focuses on the HSTP priorities and considers the MOFEC-communicated ceilings, but it is possible to request additional support. The same process happens at the regional and woreda level. Each RHB and WorHO conducts a resource mapping exercise and develops an annual plan, in line with their strategic plans. The RHBs and ZHBs develop a draft core plan that is shared with the WorHOs. The WorHOs use the regional plan to inform the development of their plans, which are reviewed by the Woreda Cabinet before being submitted to the regional or zonal level. The RHB, ZHBs, and WorHOs conduct a series of meetings to revise the regional core plan based on the needs in the zones and woredas. The ZHBs participate in these regional consultation meetings and play a coordination and facilitation role between the regions and the woreda level but otherwise are not active in the budget development process. The final regional core plan is shared with the FMOH, which revises their core plan based on lower-level health system inputs. Each level then uses these annual core plans to develop detailed annual plans, which include activities from all domestic and external stakeholders. The FMOH, RHBs, and WorHOs extract the activities to finance by the government and submit this information in a program-based budget (Box 16) to the respective finance institution at the federal, regional, and woreda levels.

Budget Approval

During the next phase, the FMOH, RHBs, and WorHOs participate in budget hearings with their respective finance institutions, occurring in April. These hearings involve a budget defense, in which each program presents and justifies their proposed activities and level of resources needed to fund them (Box 17). In their budget review, finance institutions weigh heavily on past budget execution and evidence of impact. Based on this review process and considering current national priorities, programs at each level (federal, regional, and woreda) revise their proposed budgets.

BOX 15.

KEY ENTRY POINT

Core Plan Development

The FMOH develops its core plan in or around February each year. The core plan provides a framework for health sector spending at all levels of government. Engagement at this stage can help to shape priorities and motivate specific funding requests.

BOX 16.

PROGRAM-BASED BUDGETING

Budgets at all levels of government are program- or activity-based, with program-based budgeting first piloted in 2004 and implemented by all federal ministries since 2012. As of late 2015, implementation of program-based budgeting remained inconsistent at the regional and local level (Moreda, 2015). The main challenges are the lack of capacity and training opportunities and staff turnover. There continues to be a lack of clarity and confusion between program-based budgeting and budgeting by organizational structure (directorate). The program-based budgeting manual is complex, and more training and capacity development is needed, particularly at the regional and woreda levels to better understand the definition and how to implement it. Without strong and continuous monitoring and evaluation of budget execution, it may not be immediately apparent that the funds are not being executed in accordance with the program-based budgeting guidelines. Inconsistent application of program-based budgeting results in funds not being executed according to their original allocation or in-line with program allocations at the national level, which could result in funding gaps or surpluses if not monitored and corrected.

BOX 17.**KEY ENTRY POINT****Budget Hearings and Defense**

In or around April of each year, financial institutions at each level of government convene budget hearings during which all sector offices, including the FMOH, RHBs, and WorHOs, present and justify their budget proposal. This is a critical opportunity for the health institution at each level to make its case for additional spending on health and priority programs.

The reviewed and revised budget for all sectors is then consolidated by the respective finance institution. At the regional level, BOFED develops a budget with allocations to regional sector offices (including RHBs), zonal offices, and woredas. The allocation to sector offices is based on the previous year's expenditure and new recurrent activities or capital projects. Approximately two-thirds of the regional budget is allocated to the woredas. These allocations are based on the regional transfer formula, which itself is based on the population size of the region; the resources needed to provide each region with equal access to health, education, clean water, agricultural development, and accessible roads; and the local revenue-generation potential (MOFED, 2009). The transfer formula is approved by the Regional Cabinet and Council and is subject to change each year.

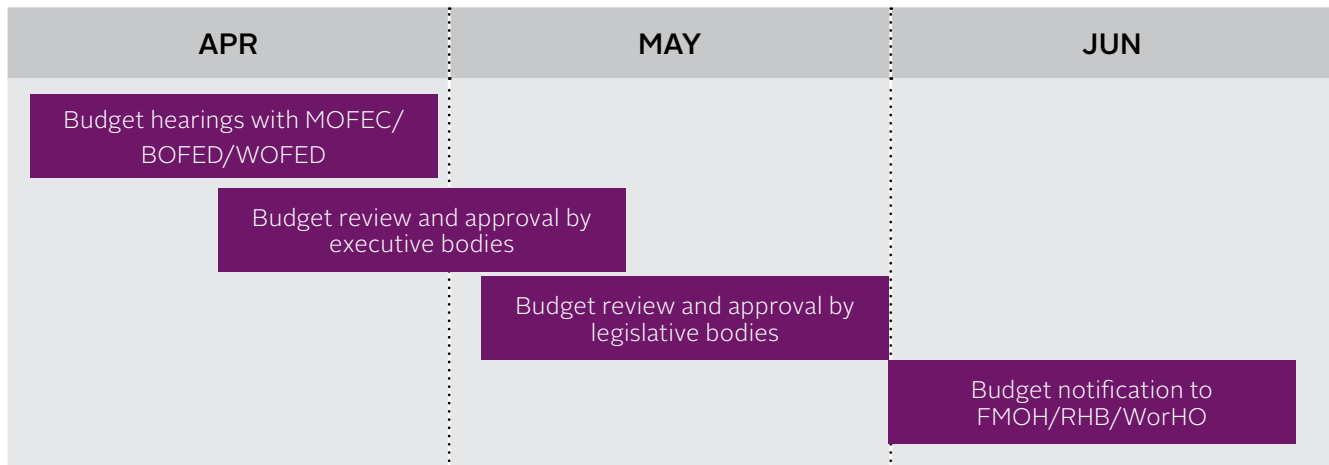
Once the recommended budgets are compiled, the respective finance institution presents the budget to each level of government's relevant executive and legislative body (see Box 18). At the federal level, the budget (including regional block grants) is first sent to the Council of Ministers (chaired by the Prime Minister) for

BOX 18.**KEY ENTRY POINT****Executive and Legislative Review**

In May, the executive and legislative bodies at each level of government review and formally approved the annual budget. This review is particularly important at the regional and woreda level where locally elected councils play a more active role in approving the budget. It is necessary to sensitize and inform these decision makers of the needs as well as the impact, particularly economic impact, of the health sector before they have an opportunity to review the budget.

approval. The budget is then sent to the Federal Parliament for approval. At the regional level, BOFED submits the budget to the regional cabinet (consisting of an administrator and the heads of the sector bureaus) for endorsement before it is passed to the Regional Council (consisting of elected representatives from woredas and urban administrations) for approval. If the council rejects the budget proposal, the budget is returned to BOFED for revision. After council approval, WOFEDs are notified of their approved budget allocations. WOFEDs then submit their budgets, within the approved budget ceiling, to the Woreda Cabinet, which reviews the budget proposal and makes the necessary adjustments. The Woreda Cabinet submits the agreed-upon budget to the Woreda Council, which approves the final allocation.

The majority of the regional and woreda funding comes from the federal budget subsidy, therefore, their budget processes are highly influenced by the timeframe and budget ceiling amount provided by the MOFEC to regions.

Figure 11: Stages of Budget Approval

Budget Execution and Disbursement

As soon as the budgets are officially approved, the respective finance institution informs the FMOH, RHBs, and WorHOs of their final budget to execute during the fiscal year. Each health institution then may revise and adjust allocations across programs or activities as needed within a month. Regions develop financial action plans, indicating monthly disbursement requirements, and submit them to MOFEC to guide the budget execution process.

Based on the action plans, budgets are disbursed by MOFEC to BOFED and to the different central-level ministries on a monthly basis. Similarly, BOFED disburses funds to the regional sector bureaus, woredas, and urban administrations on a monthly basis. Monthly reports on expenditure are sent by FMOH, BOFED, and WorHOs to their respective finance and development institutions. If there is a delay in approving the new budget, the budget law allows MOFEC and BOFED to disburse the same recurrent budget as the previous financial year, as well as funds for previously approved capital projects, until a new budget is approved. WOFED makes monthly payments based on requests from the sector offices. Each

woreda may manage its disbursement differently. For example, salaries can be provided at the kebele (subdistrict) level, at a central kebele, or at the WOFED office.

Budget Reporting and Control

Each implementing entity—FMOH, RHB, or WorHO—is responsible for regular expenditure reporting to the relevant finance institution—MOFEC, BOFED, or WOFED. Expenditures are tracked and reported according to their activity budget line. The implementing entity submits statements of expenditure reports for each budget line transferred to them on a monthly basis.

The general auditor within MOFEC is responsible for auditing the public institutions to ensure they are complying with government procedures in their execution of the budget. The general auditor presents any findings before the House of People's Representatives. Internal auditors at the regional and woreda levels are also responsible for reviewing the accounts regularly—weekly, monthly, or quarterly—depending on the woreda.

KEY TAKEAWAYS: BUDGET ADVOCACY OPPORTUNITIES

Based on the budget process described, Palladium identified three main entry points for advocacy:

- **During the development of the annual core workplans at each level** (federal, regional, and woreda)—engage with the planning department of the respective health institutions to prioritize health and specific priority areas.
- **During the budget hearing**—advocate to the relevant finance institution at each level of government (federal, regional, and woreda) to present clear arguments of the economic and population-based impact of specific programs/interventions that require prioritization.
- **Before the executive and legislative bodies review the budget**—sensitize the individuals to health sector needs and impact, especially at the regional and woreda levels where these public bodies approve the allocation to the health sector.

Given Ethiopia's decentralized government system, many decisions around the allocation of funds to health are made at the subnational level, and subnational governments play a key role in ensuring the sufficiency of financing for the health sector as a whole. However, initial advocacy efforts may choose to focus on the federal level, which controls a greater share of financing for specific, priority disease programs and for commodities and supplies for exempted services.

Conclusion

Overall, Ethiopia has undertaken significant health financing reforms over the past decade, which have improved budget performance and efficiency and expanded prospects for new resource mobilization. There is an opportunity to leverage Ethiopia's strong and sustained economic growth to increase domestic financing for and ownership of Ethiopia's health sector, particularly priority health programs including HIV, TB, and malaria. However, doing so will require a concerted effort to ensure that health receives a constant, and perhaps growing, share of government resources. The pervasive perception within higher levels of government that health programs are well-financed with donor support has resulted in hesitance to allocate additional domestically generated resources to the sector.

One of greatest challenges or weakness within the current system is the lack of coordination and collaboration between the FMOH and MOFEC. Such coordination has, historically, been confined to the budget and financial reporting process. From the standpoint of resource mobilization, the FMOH does not demonstrate a strong understanding of how MOFEC operates and its priorities. This is, in large part, due to the fact that the FMOH views development partners, not MOFEC, as its primary funding source. The FMOH must adopt a new approach to MOFEC, learning what evidence MOFEC responds to by increasing allocations to the sector. Regular, sustained, and two-way engagement is needed to ensure the FMOH is responsive to MOFEC requirements and that MOFEC is well-versed in health sector success and impacts and the changing financing landscape. Advocacy efforts toward MOFEC and other key decision-makers must be strengthened and should focus on three areas:

- **Sensitizing** MOFEC, cabinet members, and parliament to external financing levels, program implications, and impact of reduced financing on health outcomes;

- **Demonstrating** clearly where additional funds will be used and that they will be used effectively, based on tailored historical evidence and clear plans for improved efficiency; and
- **Justifying** these investments based on outcomes, not only on reduced morbidity and mortality, but also on long-term health sector savings and contribution toward cross-sectoral development goals.

Given Ethiopia's highly decentralized system of governance, with regions, zones, and districts (woredas) playing a key role in decision making and financing for health services, there is a need for multilevel advocacy. It is critical to develop the FMOH's capacity to effectively advocate for additional health resources and for the FMOH to cascade that capacity to subnational levels. With regions and woredas controlling a significant share of overall public resources—and already playing a significant role in health financing—advocacy capacity must be devolved to unlock further resources. This should be coupled with ongoing efforts to improve planning, budgeting, execution, and tracking of health resources at subnational levels. The pending Healthcare Financing Strategy rightly identifies this “negotiation capacity” at all levels as a key component of resource mobilization efforts.

These advocacy and negotiation efforts must be cognizant of the country's macro-fiscal and economic context, with its strong positive trends in economic and revenue growth and persistent challenges related to monetary policy and foreign exchange weakness and restrictions. Reasonably positioning financing requests in this context will help to clearly demonstrate available fiscal space and from where new funding can be mobilized. At the same time, efforts to mobilize resources for priority health programs (HIV, TB, malaria, maternal and child health, and family planning) that have been historically externally financed

must be cognizant of, and leverage, prevailing health financing initiatives. CBHI and SHI are two of the most promising, and most focused on, mechanisms for mobilizing new health sector resources. However, priority health programs risk being excluded from them if there is not early engagement between the FMOH, EHIA, and development partners to ensure their smooth integration.

In making the case for new money for health, FMOH and other partners must also place a greater focus on efficiency. Efficiency gains and cost savings can not only be a source of new fiscal space, by freeing existing but ineffective resources, but also help to better demonstrate to MOFEC that funds for health are effectively used and have a positive return on investment. These cost savings can be achieved in a number of key areas, including through more efficient resource allocation that targets priority and high-impact populations and by addressing leakages in:

- **Testing and treatment** through more accurate diagnostics that reduce the number of missed or misdiagnosed cases, and improved patient retention strategies that reduce loss to follow-up and treatment failure rates;
- **Budget execution** by better tracking funds and all levels of the health system and ensuring that they are being executed appropriately and used for programs and populations that demonstrate high impact; and
- **Workforce retention** by addressing the incentive structures that lead to high rates of health worker turnover and emigration, to ensure that the government's substantial investments in the health system (e.g., through health worker training) yield higher returns.

Overall, the pathway to sustainable, domestic health financing will be multifaceted and involve efforts across many areas and among many partners to identify, mobilize, and execute new domestic funding. Strategic coordination will be a critical piece of these efforts, and close engagement must be fostered not only across different government levels and institutions but also across development partners, civil society, and the private sector. The transition from donor reliance will be a potentially lengthy process and require patience. Efforts must begin now to ensure that Ethiopia is well-positioned to ensure sustained, long-term financing for all health services.

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