



Federal Democratic
Republic of Ethiopia
Ministry of Health

ETHIOPIA'S FIFTH NATIONAL HEALTH ACCOUNTS HIGHLIGHT OF MAJOR FINDINGS BRIEFING NOTES

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I. BACKGROUND

Ethiopia has made remarkable progress in improving access to health services and quality of health care. However, similar to other low-income countries, the health sector in Ethiopia lacks the level of financial resources needed to buy good health care for all its citizens. Its per capita health spending of US\$16.10 in 2007/08 showed the extent to which health care is underfinanced, as this amount is well below the \$34 per capita that the World Health Organization (WHO) Commission on Macroeconomics and Health recommended should be spent in low-income countries to deliver essential health care services in 2001, an amount that has been revised upward to US\$60 by 2015.

Ethiopia is also trying to regularly track the flow of financial resources to and within the health sector using the National Health Accounts (NHA) framework. Understanding the flow of funds contributes to health policy decisions based on empirical evidence. This brief summarizes the findings of Ethiopia's fifth round of NHA, done for health care expenditures in Ethiopian fiscal year 2003 (2010/11).¹ Ethiopia's previous four rounds of NHA were conducted using data from 1995/96, 1999/00, 2004/05, and 2007/08. This fifth NHA was conducted with the aim of generating broader information about resource utilization on the overall health sector as well as on five priority areas: HIV/AIDS, tuberculosis (TB), malaria, reproductive health, and child health.

¹ Ethiopia follows the Julian calendar, which puts it 7/8 years behind the Gregorian calendar used by the rest of the world. The Ethiopian year starts on September 11 of the Gregorian year and ends on September 10 of the following year. The Ethiopian fiscal year starts on July 8 and ends on July 7 of the following year. For instance, EFY 2010/11 ran from July 8, 2010 to July 7, 2011.

2. NHA OVERVIEW AND CONCEPTUAL FRAMEWORK

NHA is a globally recognized and accepted framework/tool of health accounting used to track and measure health expenditures and resource flows in the health systems of low-and middle-income countries. In 2003, WHO, the World Bank, and the United States Agency for International Development (USAID) published the “Producers’ Guide” to assist low- and middle-income countries to measure their national health expenditures and resource flows. The NHA guide was developed based on the Organization for Economic Cooperation and Development’s System of Health Accounts (SHA). In 2011, SHA was revised to enable all countries to use similar standard methods regardless of their level of economic development and income.

As stated in the Producers Guide, in the NHA framework, health expenditures are defined as “all expenditures for activities whose primary purpose is to restore, improve and maintain health for the nation and for individuals during a defined period of time”. NHA indeed has well-defined boundaries of space and time. The space boundary is defined as all health expenditures made by a country’s citizens and by its residents that are temporarily abroad; it excludes health expenditures by foreign nationals in the country. Moreover, it includes all donor assistance except for donor spending on the planning and administration of health programs.

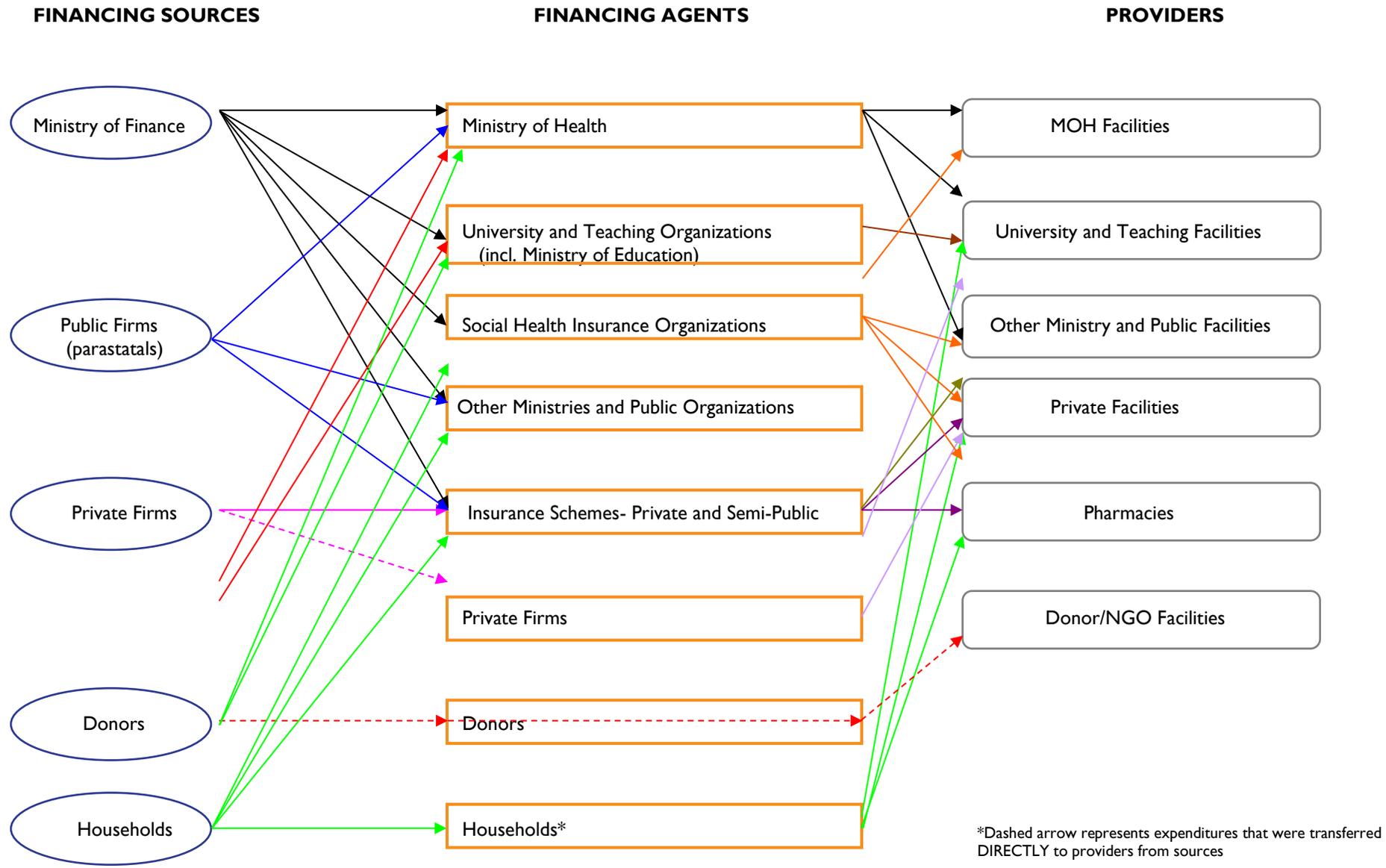
NHA studies the flow of funds through four “dimensions”:

- **Financing sources (FS)** are entities that provide funds or resources (e.g., Ministry of Finance, international donors)
- **Financing agents (HF)** are entities that manage and channel funds provided by financing sources (e.g., Ministry of Health)
- **Providers (HP)** are entities that receive money from the financing agents and provide health care services and goods in exchange for (and using) the money they receive from financing agents (e.g., hospitals)
- **Functions (HC)** are the end uses or the provided goods and services (e.g., preventive or curative care).

These flows are organized and presented in a standard set of tables. The NHA tables facilitate the estimation process. The NHA tables facilitate the estimation process by cross-tabulating the dimensions and they help answer the following critical questions:

- Who finances health in the country?
- How and by whom are resources managed?
- What goods and services are provided

Figure 1: A 'Spider Web': The Flow of Funds Through the Health Sector



3. OBJECTIVES AND SCOPE OF THIS NHA

The purposes of this fifth round of NHA are multiple and so its scope is broad. In addition to generating general health expenditure information, the study uses the NHA “subaccount” methodology to produce expenditure information on five selected health sector priorities: HIV/AIDS, reproductive health, child health, malaria, and TB.² These areas are policy priorities of the Ethiopian government (with specific performance targets in the Health Sector Development Program (HSDP)-IV), and they also have global targets and commitments that Ethiopia is committed to achieve.

The NHA subaccounts have their own methodological guidelines that were tested and have been used in several low-income countries in Africa and elsewhere. The TB subaccount is relatively new and not widely used. Ethiopia has now produced the TB subaccount for the second time; its experience should be useful for refining the TB guidelines. Another important aspect of this NHA is that data were collected from all relevant institutions as well as from households and people living with HIV/AIDS (PLHIV).

As stated above, the overall objective of an NHA is to generate up-to-date empirical evidence on the financial flows within a health care system. The specific objectives of this study in Ethiopia are to:

Gauge health financing trends, sources of financing, managerial responsibility, and at what level of the health system and on what type of health care services health expenditures are made;

Produce baseline data on health care financing for the HSDPs, as well as a projection of the cost of scaling up of health services. It was also the basis for initiation and successful implementation of the ongoing health care financing reforms including health insurance; and

Provide input for gauging future financing of HSDP-IV priority areas (HIV/AIDS, reproductive health, child health, malaria, and TB), and to generate evidence on the relationship between these health sector priorities and spending on health care by level and type of health care service.

² These five subaccounts were also conducted during the fourth round of Ethiopia’s NHA. This round excluded one additional subaccount done in the fourth round, health information systems.

4. SURVEY METHODOLOGY

Data were collected both from primary and secondary sources. The sources of data were identified first by inventorying key actors that have significant roles in the financing, channeling/managing, and actual spending of health resources. This information came from the records of previous NHA-related surveys and brainstorming done during training of the NHA technical team. All expenditures used in this NHA study were limited to 2010/11; they were calculated using the accrual method.³

4.1 Primary Surveys

The institutional survey covered all financiers and managers of health expenditure in Ethiopia: government, donors, NGOs, employers, and insurance companies. Table I shows the data each supplied.

Table I: Primary Data Collection Surveys and Data Sources

Type of Health Expenditure Data	Source of Data
Institutional surveys	
Government expenditure, at all levels	Ministry of Finance and Economic Development: Official audited account
Bilateral and multilateral donors expenditure	All 29 health sector donor partners
International and local NGOs expenditure	All 237 NGOs attempted (102 international reached, 115 of 135 local reached)
Private enterprises/ employers expenditure	258 private enterprises
Public enterprises expenditure	All 51 public enterprises, including 5 large public enterprises (banks, insurance companies, Ethiopian Airlines, Ethiopian Telecommunication and Electricity Agency)
Household surveys	
General Household Health Utilization and Expenditure Survey	10,060 households surveyed about general health and priority subaccount-related service use and expenditures
PLHIV Survey	4,000 PLHIV surveyed about health services utilization, and health and non-health expenditures for HIV/AIDS subaccounts.

4.2 Secondary Data Collection

The NHA team identified secondary sources of data on health status, health expenditure, disease prevalence, health service coverage and utilization, and so forth during the NHA training. On the list were health sector policy, strategic, and development plans; health sector evaluation and performance assessment reports; special studies and reports on specific diseases and health sector priorities; routine and special reports of health sector partners; and global documents. Most of these documents were collected and relevant data extracted.

³ Expenditures are attributed to the time period during which the economic value was created, not when actual cash disbursements took place.

4.3 Limitations of the Study

Public expenditure classifications: Government budget and expenditure reports do not directly match NHA data classifications. Therefore, as in previous NHA rounds, distribution keys⁴ were calculated and used to disaggregate government expenditure figures between outpatient and inpatient health services at various levels as well as to estimate government spending on the subaccounts.

Data not collected from some employers and local NGOs: A small number of employers and 20 (of 135) local NGOs could not be reached for the survey. This should only marginally underestimate the overall health spending estimates, as these organizations are relatively small and do limited or no health spending.

General household survey: Household survey data were collected between mid-December 2012 and January 21, 2013. The survey queried four weeks of expenditure for outpatient services and one year for inpatient services. After annualization, these figures were deflated to estimate expenditures for 2010/11.

Targeted HIV/AIDS survey: Although the universe for the HIV/AIDS targeted survey was all HIV-positive adults, there was no way to obtain a list of all PLHIV in an ethically acceptable way. Thus, the PLHIV association was used as entry point and the sample frame has some bias; all the randomly selected members were either under antiretroviral treatment (ART) or in need of ART. The sample size distributed to regions may not reflect the regional situation, particularly where regional sample sizes are small. Therefore, the data cannot be used for regional-level generalization.

Community contributions: It is very common for communities in Ethiopia to make in-kind (labor and material) contributions to health facility construction and community health promotion/disease prevention programs. Moreover, activities mainly performed by the Health Development Army, capacity-building efforts by different ministries with high spillover effects on the health sector, and other unreported expenditures are worth mentioning. Unfortunately, the lack of rigor in adhering to formal accounting and financial reporting rules means reliable data on these items are unavailable. Hence, the NHA study does not capture these contributions.

⁴ In constructing the distribution keys, the NHA team consulted health services utilization reports (such as Health and Health related Indicators, 2003, published by the Federal Ministry of Health in 2011, and the Social Health Insurance Unit Cost Study 2007(FMOH 2007), as well as previous NHA survey findings, expert opinion, and so forth.

5. FIFTH ROUND NHA FINDINGS

5.1 General NHA Findings

National health expenditure (NHE) increased substantially between 2007/08 and 2010/11 in both absolute and per capita terms, but it still is not adequate to buy better health for all Ethiopians. This fifth round of NHA revealed that there has been a tremendous increment in health spending both in nominal and per capita terms. Nominally, NHE increased from Birr 11.1 billion (US\$1.2 billion) in 2007/08 to over Birr 26.5 billion (US\$1.6 billion) in 2010/11 (Table 2).⁵ Per capita NHE increased modestly, from US\$16.09 per capita in 2007/08 to US\$20.77 in 2010/11.⁶ This figure is far below the HSDP-IV per capita spending target of US\$32. The amount is also low compared with Ethiopia's peer countries; for instance, 49 low-income countries on average spent \$22 per capita in 2006 (WHO 2010⁷). As noted above, it also is by far much less than the US\$34 per capita recommended by WHO in 2001 and more recently updated by WHO for the high-level Taskforce on Innovative International Financing for Health Systems; the update suggested that the 49 low-income countries including Ethiopia need to spend just less than US\$44 per capita in 2009, rising to a little more than US\$60 per capita by 2015. Thus, health is still underfinanced and there is strong need for making more resources available to the sector to improve health service delivery and ultimately the health status of the population.

Table 2: NHA General Health Expenditures, 2007/08 and 2010/11

Source of Finance	Fourth NHA 2007/08 (Birr)	Fifth NHA 2010/11 (Birr)	% Change
Government (including parastatals)	2,476,381,390	4,126,681,043	67%
Households	4,125,367,110	8,926,754,560	116%
Rest of the world*	4,364,465,742	13,193,919,360	202%
All others	156,807,872	217,511,290	39%
Total NHE	11,123,022,114	26,464,866,253	138%

*Rest of the world= donors and international NGOs

Source: Ethiopia Fourth NHA (FMOH 2010) and Ethiopia Fifth NHA (FMOH 14)

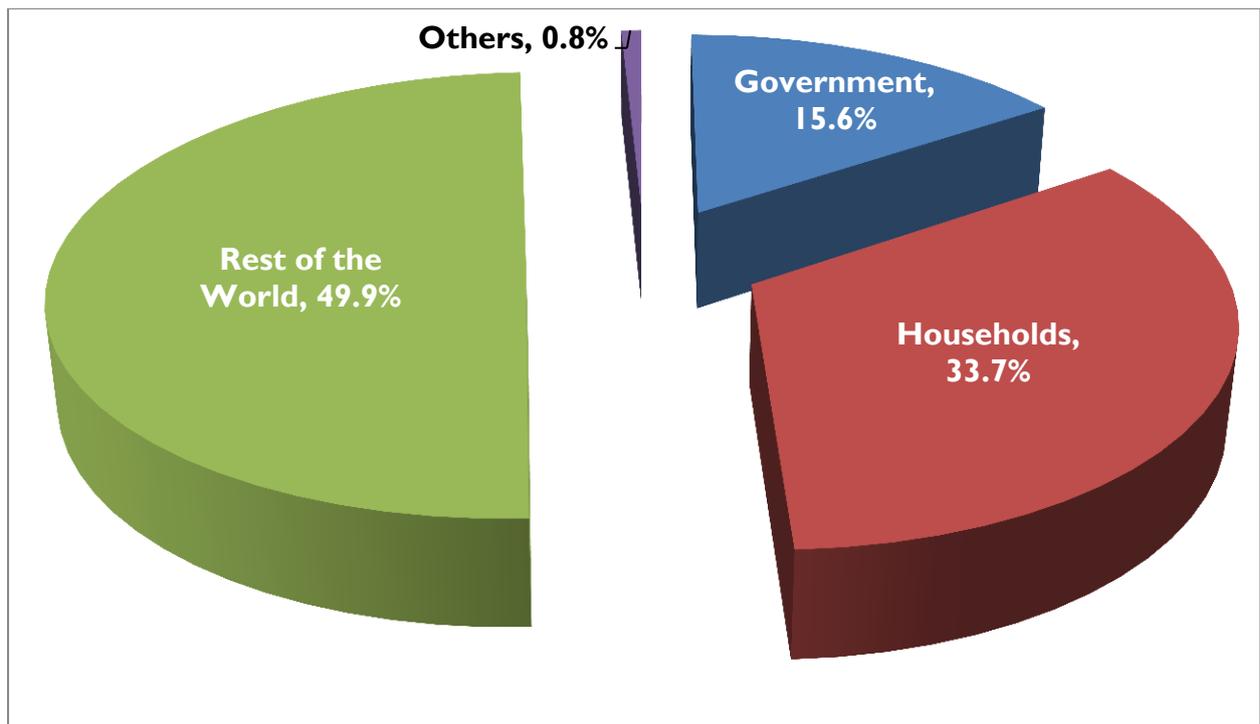
The contributions of all major financiers (government, households, and the rest of the world) substantially increased. The overall spending on health, at the current market price, increased by 138 percent between 2007/08 and 2010/11, from Birr 11.1 billion to Birr 26.5 billion. The government contribution grew by 67 percent in the same period. However, most of the increment came mainly from the rest of the world and households; their respective contributions grew by 202 percent and 116 percent. Figure 2 illustrates the breakdown of NHE by these major financing sources.

⁵ In 2010/11, the annual average exchange rate was US\$1 = Birr 16.1178 (National Bank of Ethiopia 2010). This rate was applied to convert Birr into U.S. dollars, and vice versa.

⁶ The total population used for per capita estimation is 79,045,498, the Central Statistical Agency population projection for 2010/11.

⁷ WHO 2010. Constraints to scaling up the Health Millennium Development Goals: costing and financing gap analysis.

Figure 2: Financing Sources of General Health Care, 2010/11



The government is the major manager of health resources, but households also play a significant role. All government (federal, regional, and parastatal) together managed nearly half (48.9 percent) of NHE in 2010/11. This is a change in the lead managerial responsibility from the private sector in 2007/08. This is because major donor programs such as the Global Fund to Fight AIDS, Tuberculosis and Malaria, the Protection of Basic Services (PBS), and the GAVI Alliance are using the government system and management. Government and partners also created the Millennium Development Goals (MDG) Performance Pool Fund, which is managed within the government system. In 2010/11, households together with other private sector financing sources managed only 34.4 percent of NHE. Donors and international NGOs managed 14 percent of NHE.

Government health facilities are the major recipients of health spending. Government health facilities were major recipients of the 2010/11 spending, accounting for nearly 34 percent: public primary health care units (PHCUs), which include government health centers and health posts, accounted for nearly 15 percent and hospitals for nearly 19 percent. Public health programs were also major recipients of health resources, accounting for 27 percent of the overall spending. Private providers (both for-profit and nonprofit) received 16 percent of NHE.

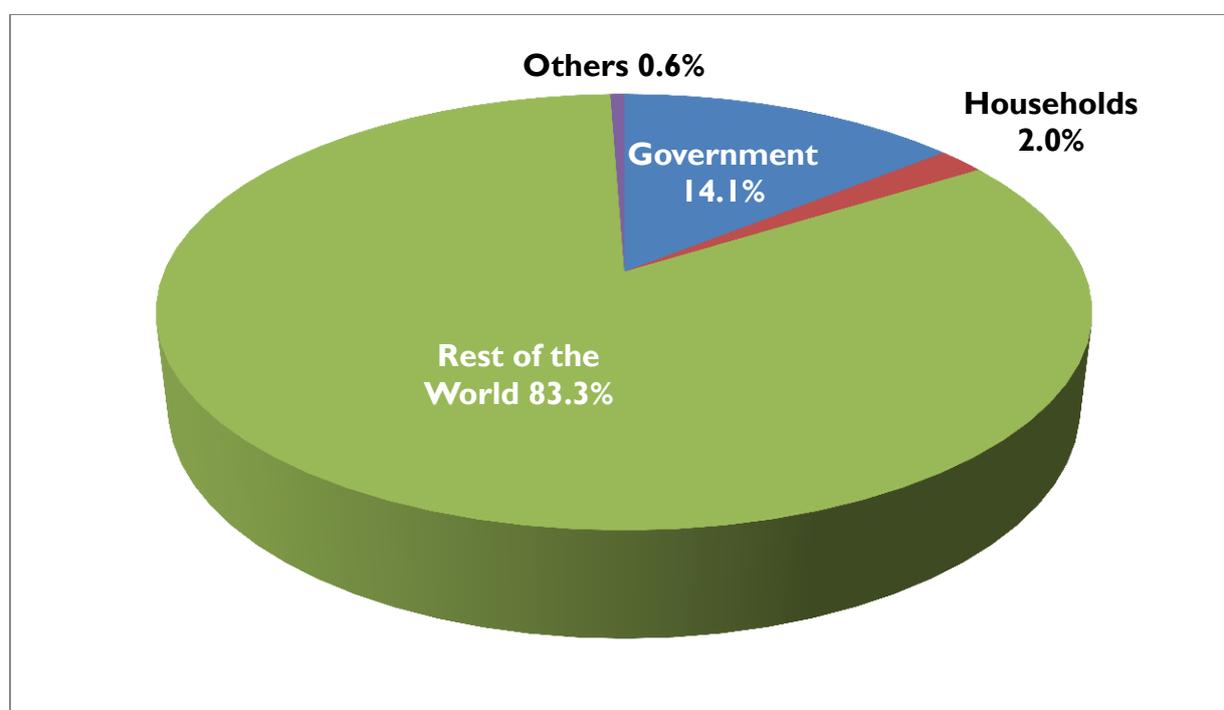
Curative care services are still the major functions on which health resources are spent. Curative care services remained the major target of health expenditures, accounting for 51.6 percent of NHE; 43.8 percent went to outpatient services and 7.8 percent to inpatient. Prevention of communicable diseases including prevention efforts related to maternal and child health accounted for 27 percent. Expenditures on general health administration was estimated at nearly 8 percent. Capital formation in the health sector – investments in health facility construction, equipment and vehicle purchase, and so forth – as well as education, in-service training, and research together accounted for 7 percent and 5 percent of NHE, respectively. Spending on pharmaceuticals and other medical nondurables through independent pharmacies was found to be negligible; it is believed that households might have reported their spending for medicines as part of outpatient and inpatient spending. Future rounds of NHA should pay particular attention to health spending for pharmaceuticals in independent pharmacies, for policy use.

5.2 HIV/AIDS Subaccount Findings

The total national HIV/AIDS expenditure more than doubled in nominal terms, from Birr 2.3 billion (US\$248 million) in 2007/08 to Birr 4.9 billion (US\$306.7 million) in 2010/11. It now accounts for more than 19 percent of NHE, the largest amount spent on a single disease. The per capita HIV/AIDS spending over the total population of the country was Birr 62.53 (US\$3.88), while the per capita HIV/AIDS spending over total population of PLHIV was Birr 4,062 (\$252), an increase from Birr 1,684 (US\$180) in 2007/08.

HIV/AIDS is highly donor financed. In 2010/11, most expenditure (over 83 percent) on HIV/AIDS, Birr 4.1 billion (US\$255.6 million), originated from the rest of the world (Figure 3). This is essentially the same as it was in 2007/08, 84 percent. This was followed by contributions from government (federal, regional, and parastatals): Birr 698.1 million (US\$43.3 million) (about 14 percent).

Figure 3: Financing Sources of HIV/AIDS Health Care



PLHIV spent out-of-pocket US\$5.99 million (2.0 percent) of the total US\$306.7 million spent on HIV/AIDS in 2010/11. Though this share is less than the 3.6 percent in 2007/08, the financial burden it imposes cannot be overlooked. It means that on average each of the 400,251 PLHIV in need of ART represented in this round of NHA spent about US\$15 in 2010/11 – an amount more than twice the per capita out-of-pocket spending of the general population on overall health care (US\$7.25). This burden on HIV-positive Ethiopians is far more than the group can afford, given the socioeconomic situation of those infected.

As in 2007/08, although PLHIV get ART drugs for free, they still spend appreciable amount at both government and private pharmacies for drugs to treat HIV-related health problems such as skin lesions and infections, gastro-intestinal infections, prolonged fever, stomach ache, chronic diarrhea, coughing up blood, and white patches on tongue.

PLHIV also make expenditures on HIV-preventive products and on both outpatient and inpatient services at the time of illness. Their purchases include condoms, consultations, lab tests, X-rays, treatment of sexually transmitted infections, TB, voluntary counseling and testing, HIV-related information, education and communication, psychological support, antenatal care, and deliveries.

They also spent a significant amount on care-related transportation, lodging, and food, including for caregivers.

Government is the major manager of HIV/AIDS resources. The major financing agent of HIV/AIDS funds in 2010/11 was the government, which managed more than two-thirds (68 percent) of the expenditures; the federal government managed 57 percent, regional and local governments 9 percent, and parastatals 2 percent. The government share was followed, distantly, by the rest of the world (16 percent). Other entities, such as international and local NGOs, managed 14 percent of total HIV/AIDS expenditures. PLHIV out-of-pocket payments accounted for 2 percent. Finally, private entities (employers and insurance) accounted for less than 1 percent.

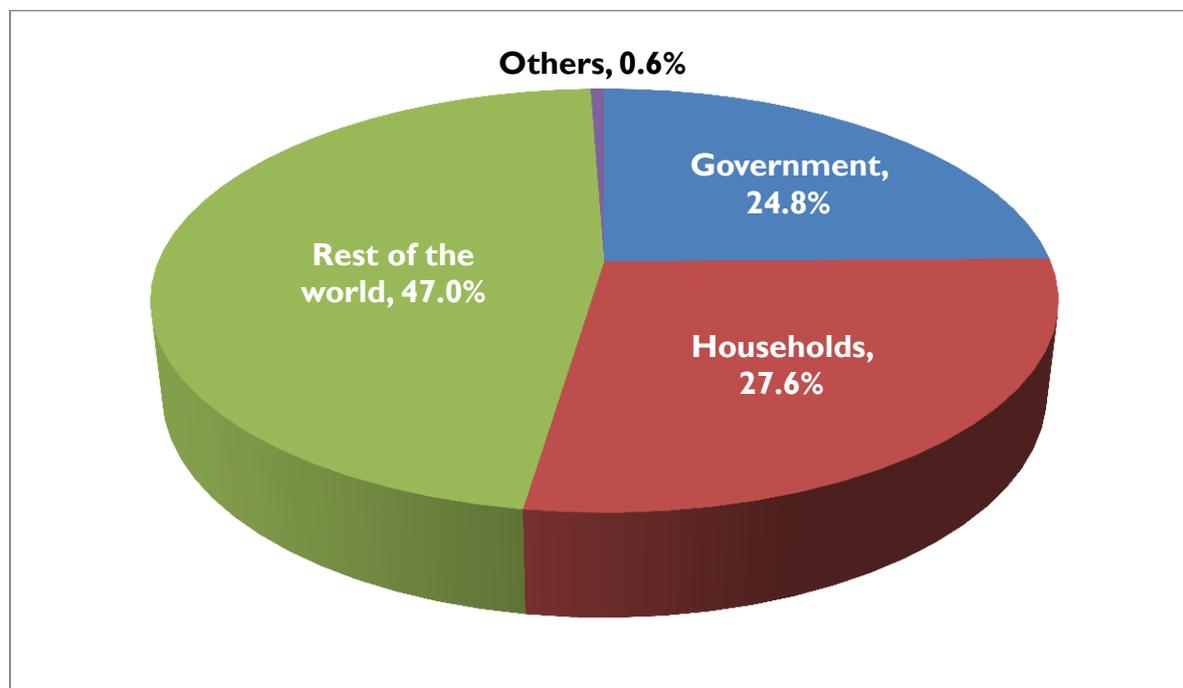
The bulk of HIV/AIDS resources goes to providers of public health programs. Provision and administration of public health programs received just over half of total HIV/AIDS spending, 51 percent, in 2010/11. The second largest share of spending (15 percent) went to general health administration (government and others). Public PHCUs got 10 percent; public hospitals 9 percent; education, training, and research institutions 3 percent; and all other providers get about 12 percent.

5.3 Reproductive Health Subaccount Findings

Reproductive health spending totaled Birr 3.6 billion (US\$224.1 million) in 2010/11, representing 14 percent of the total NHE and an increase of 1 percentage point from the share registered by the fourth NHA in 2007/08. Spending per woman of reproductive age (15–49 years) increased to \$12.12 from \$8.00 in 2007/08 and \$3.60 in 2004/05.

Donors and international NGOs contribute the highest proportion of reproductive health funding. The three main sources of reproductive health care in Ethiopia were the rest of the world (47.0 percent), followed by households (27.6 percent) and government revenue (24.8 percent) (Figure 4). The contribution from others was less than 1 percent.

Figure 4: Financing Sources of Reproductive Health Care



Government manage the bulk of reproductive health resources. In 2010/11, the government managed the largest share (52.2 percent) of reproductive health expenditures in Ethiopia, of which the federal government ministries managed 32.1 percent, regional and local governments 17.8 percent, and parastatal companies 2.3 percent. Rest of the world, local NGOs, and all others together managed 19.7 percent, a decline from 28 percent in 2007/08.

Public facilities are the major recipient of reproductive health resources. The fifth round of NHA revealed that public hospitals were the major recipients (23 percent) of reproductive health resources. Public health programs got 16 percent, government health administration 15 percent, public PHCUs 14 percent, NGO PHCUs and private clinics 7 percent, private hospitals 5 percent, training and research 3 percent, and all other service providers 17 percent. Of the 23 percent of reproductive health spending that goes to public hospitals, general hospitals received a little over half (51 percent).

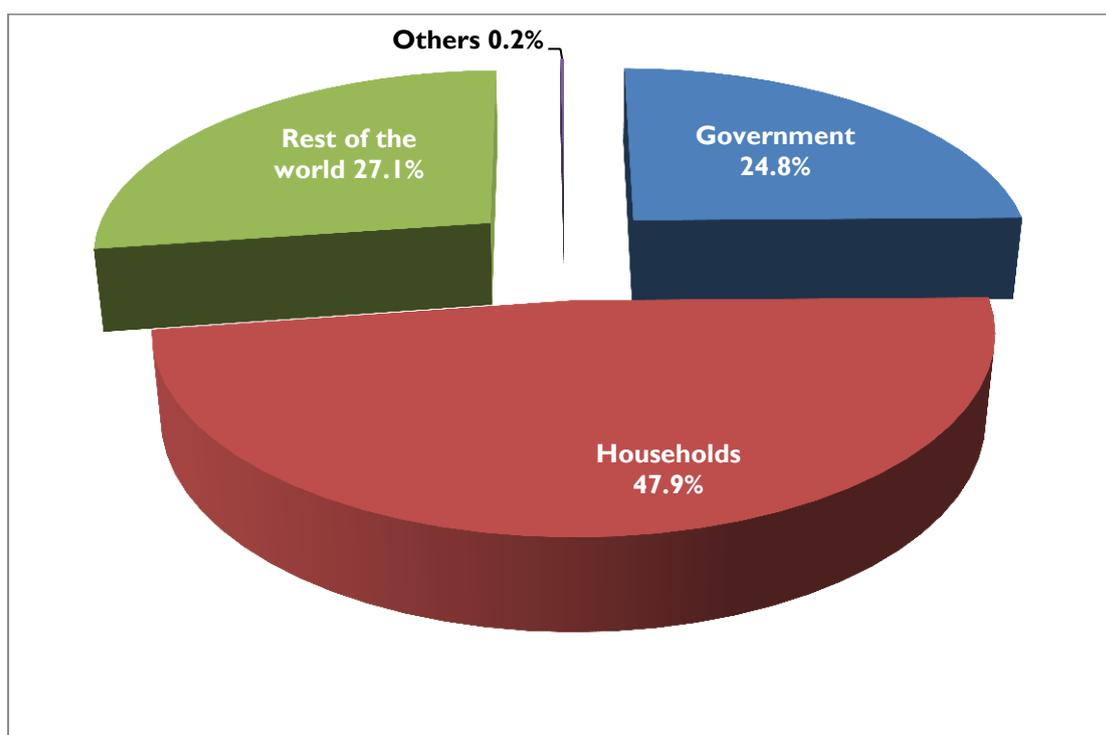
Outpatient care is the major reproductive health service. Forty-two percent of the 2010/11 funding went to maternal health outpatient services, followed by prevention and public health programs of reproductive health (16 percent). General health administration and capital formation each received 15 percent. Maternal health inpatient care consumed (10 percent), and education, training, and research consumed (2 percent).

5.4 Child Health Subaccounts Findings

Child health care expenditures accounted for about 11 percent of NHE in 2010/11, an increase from 10 percent in 2007/08. Overall spending increased from Birr 1.1 billion (US\$114 million) in 2007/08 to approximately Birr 3.0 billion (US\$184 million) in 2010/11. The per capita spending per under-five child increased from Birr 82.5 (US\$8.8) in 2007/08 to Birr 258 (US\$16.0) in 2010/11.

Child health **is predominantly household financed.** Household out-of-pocket spending, the rest of the world, and the government were the main financing sources of child health expenditure in 2010/11, accounting for 47.9 percent, 27.1 percent, and 24.8 percent, respectively. Other contributors, private companies, local NGOs, and other private funds, contributed less than 1 percent of the child health spending (Figure 5).

Figure 5: Financing Sources of Child Health Care



Households manage the bulk of child health resources. Households managed the largest share of child health care resources (48 percent) in 2010/11, double their 24 percent in 2007/08. Government managed 39 percent (federal 27 percent, regional and local 12 percent), less than its 47 percent in 2007/08. The rest of the world managed 8 percent, international NGOs 4 percent, and local NGOs 1 percent.

Public facilities are the major recipients of child health resources. The largest share of child health expenditure (24.8 percent) went to government hospitals, followed by public PHCUs (23.3 percent), providers of public health programs (14.6 percent), and private clinics (for-profit and not for-profit) (13.9 percent). Smaller percentages went to private hospitals (9.5 percent), all other providers (7.5 percent), health administration (4.7 percent), and health-related research and education (1.8 percent).

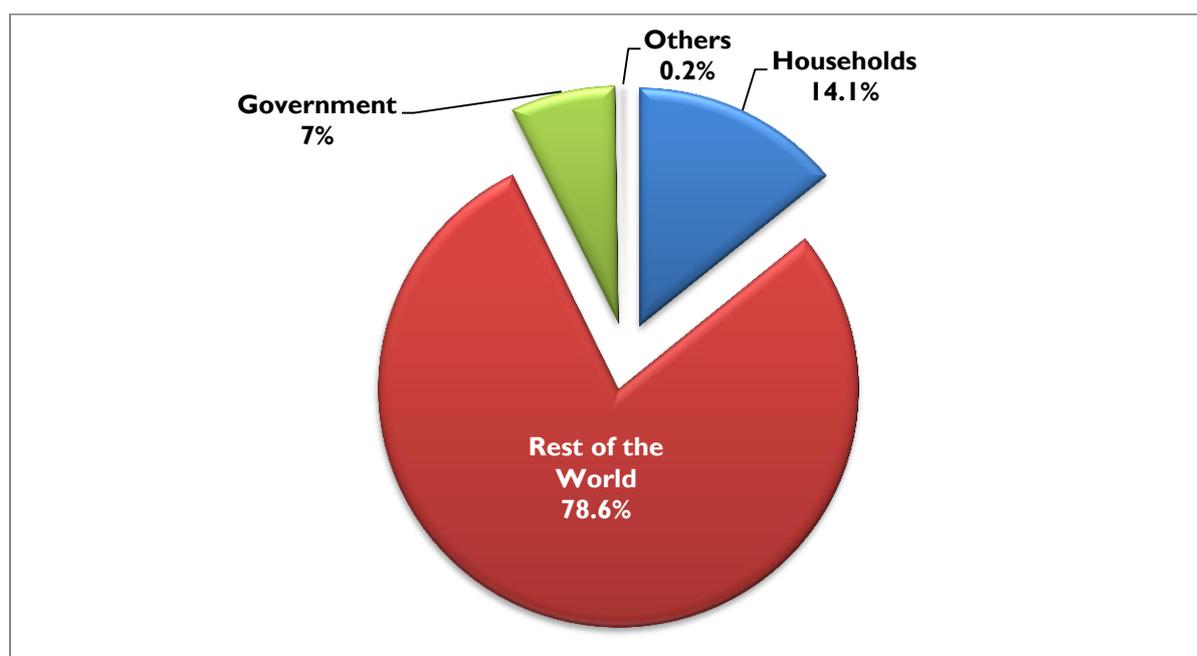
Outpatient services consume a significant portion of child health spending. A significant portion (63.0 percent) of child health resources was spent on outpatient services, followed by prevention and public health services (14.6 percent). Child health-related inpatient curative care, capital formation, and general health administration accounted for 10.3 percent, 5.2 percent, and 4.7 percent of the child health spending, respectively. The balance (1.8 percent) was spent on child health-related education, training and research.

5.5 Malaria Subaccount Findings

In 2010/11, Birr 3.9 billion (US\$241.5 million) was spent on malaria. This is a substantial increase (more than sevenfold) from the mere Birr 519.5 million (US\$55.5 million) spent on malaria in 2007/08. The share of NHE spent on malaria reached 15 percent in 2010/11, from only 5 percent in 2007/08. This increase is mainly because of substantial donor funding for malaria programs including for procurement of insecticide-treated nets.

Malaria is predominantly donor financed. In 2010/11, donors funded 79 percent of the total spending on malaria, followed by households and government, which contributed 14 and 7 percent, respectively (Figure 6). The spending by government almost doubled in absolute terms and households spending more than doubled from 2007/08.

Figure 6: Financing Sources of Malaria Prevention and Control



The managerial role of government substantially increased. Government (Federal Ministry of Health (FMOH), regional health bureaus, woreda health offices, and parastatals) managed 82 percent of the overall resources spent on malaria in 2010/11. This is understandable because major malaria spending financed by PBS and the Global Fund is managed by the FMOH. Households managed all of their spending on malaria (14 percent). The rest of the world managed only 2 percent of the total spending, while local and international NGOs managed 1 percent of the total spending.

The bulk of malaria spending goes to public health program administrators. In 2010/11, close to 69 percent of total malaria spending went to administrators and implementers of public health programs. Public PHCUs received about 11 percent of malaria spending. Government hospitals received 4.3 percent. Private clinics and hospitals (for-profit and not for-profit) received 5.5 and 1.2 percent, respectively. The share of health administration was estimated at only 2.9 percent.

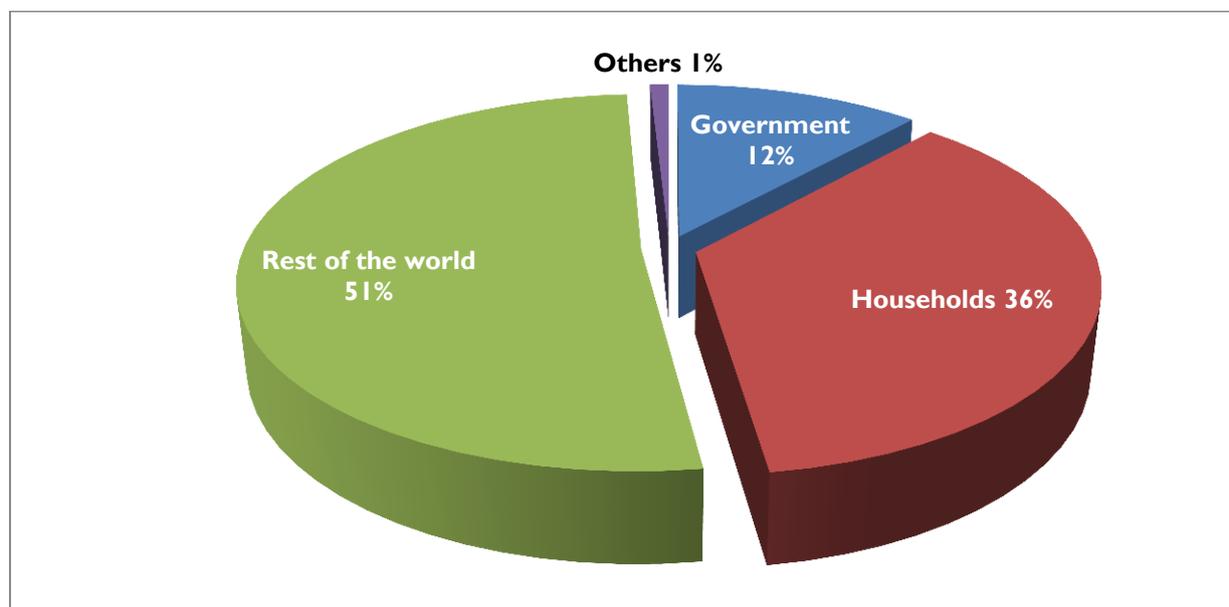
Malaria-related prevention and public health programs get the lion's share of total malaria spending. In 2010/11, 69 percent of the total malaria spending was made on malaria prevention and public health program. In fact, more than half of total malaria spending (52 percent) was on bed net procurement and distribution programs. The second largest consumer of spending on malaria was curative care services (21 percent outpatient care and 2 percent inpatient care).

5.6 TB Subaccount Findings

The current round of NHA found that Birr 824.6 million (US\$51.2 million) was spent on TB care. This amount accounted for about 3 percent of the country's total NHE, down from 4 percent in the fourth round. Per capita TB spending was estimated to be Birr 10.43 (US\$0.65) against Birr 6.05 (US\$0.65) during the fourth NHA.

The rest of the world as the major source of financing spent on TB. In 2010/11, the rest of the world was the major financing source for TB care, contributing 51 percent of the total spending on TB (Figure 7). Household out-of-pocket spending was the second financing source, at 36 percent. Other sources were the government (12 percent) and private employers (1 percent).

Figure 7: Financing Sources of Tuberculosis Care



Government is the major manager of TB resources. In 2010/11, government had managerial responsibility for about half of the total spending. Understandably, households managed all the resources originating from them (36 percent), making them the second major financing agent. The rest of the world managed about 12 percent and the remaining 3 percent was managed by other agents.

Public PHCUs receive about one-third of TB resources. The major recipients of TB resources were public PHCUs, which in 2010/11 received about 30 percent of the total TB spending. Public hospitals received about 14 percent. Private for-profit and not-for-profit hospitals received 15 percent of the total TB expenditure, followed by providers and managers of public health programs (6 percent). All other non-specified providers received 25 percent of the spending.

The bulk of TB spending are used for outpatient curative care. About 61 percent of TB funds were used for TB outpatient care, followed by TB prevention and public health programs, which accounted for 20 percent, inpatient care for 8 percent, general health administration for 7 percent, and capital formation, education, training, and research for 4 percent.

6. POLICY RECOMMENDATIONS

Increase health spending focusing on increasing domestic financing: As noted above, Ethiopia's overall per capita spending as well as spending on selected priority areas remains inadequate. There is a great need to mobilize more resources for health to continue improving the quality of health care, and equity and access to care. While Ethiopia needs continued donor support in the short term, the country also needs in the long term to reduce its donor dependency by increasing domestic resource mobilization as the country's economy transitions to that of a middle-income country. The Ethiopian government needs to meet the Abuja target/commitment by African leaders of spending 15 percent of the total government budget on health. Additionally, Ethiopia needs to explore innovative financing mechanisms to increase domestic financing for health.

Continue generation and use of evidence for policy initiation and use: In addition to the need for further exploration and use of the household, PLHIV, and institutional survey data gathered for this round of NHA, the FMOH in collaboration with other stakeholders may need to do studies to gain an even more in-depth understanding of spending on health care. Conducting Public Expenditure Tracking Surveys to examine health spending thoroughly at the woreda and facility level, to see if there are some leakages and wastages where the sector can have some efficiency gains, is of paramount importance.

Continue building a more efficient and responsive health system: In light of the still-inadequate level of per capita spending on health, the progress in bringing change and improving health status of Ethiopians is very impressive. However, WHO estimated a global 20 to 40 percent inefficiency-related loss of resources in the health sector, and it underlined that every country has room for improving efficiency in the health sector. Efficient use of resources is also an important case to make when arguing for increased investments in health from government, private sector, and development partners.

Continue integration of different health programs and vertical support mechanisms: In Ethiopia, the various vertical programs are well integrated with the overall health system, in line with the principle of three ones, i.e., "One Plan, One Budget and One Report." This is increasingly possible, as the government system is being used by more programs such as the Global Fund, GAVI, MDG Performance Pool Fund, Technical Assistance Pool Fund, and PBS. The FMOH and health sector partners need to continue building on this experience.

Reduce the financial burden and barriers to household use of care: Household spending is very high both in absolute terms and on a per capita basis. Given the level of income and high poverty, health spending can be prohibitive for many households and catastrophic for others. In view of this, the health insurance initiative in Ethiopia is commendable. In addition, in the short-term, government should ensure that the fee waiver system is strengthened in terms of effectiveness and equity in all regions and woredas.

Track and estimate voluntary contributions and other health expenditure: In the future, Ethiopia should try to estimate financial values of the wide range of community contributions including through the Health Development Army initiative.

Increase understanding of non-communicable diseases and other diseases: Half of the total spending in 2010/11 was consumed by health services and programs outside the four subaccounts (HIV/AIDS, reproductive health, malaria, and TB), as child health overlaps with three of the subaccounts and other health services and programs. The household survey done for this NHA study revealed that 5 percent of total outpatient visits, 7 percent of total inpatient admissions and 13 percent of deaths were attributable to non-communicable diseases (NCDs), in particular, cancer, diabetes, hypertension and mental illness. It also found that 13 percent of deaths were related to

these diseases. In view of this, there is strong need to better understand the magnitude and resource implications of financing NCD services.

Continue institutionalization of health expenditure tracking: Health expenditure tracking is critical for policies decisions on health financing and health investments. Ethiopia's FMOH and health sector partners have used the findings of earlier rounds of NHA in the design of a wide range of health financing reforms, in the initiation of health insurance, as a baseline for HSDPs, and in tracking spending against major health sector priority areas and at different levels of the health sector. However, doing an NHA study is a huge undertaking in terms of time and labor, as well as technical and financial resources, and it is not certain that donor resources will be available in future years.

Therefore, Ethiopia needs to be sure to complete steps it has already started taking so that it can generate health expenditure data regularly and in less expensive ways. The FMOH is trying to institutionalize NHA by creating an ongoing structure and trained staff to do such studies. It also needs to have the capacity for and to make use of the more streamlined SHA 2011 framework and WHO's updated Resource Tracking Production Tool. It is commendable that Ethiopia is incorporating health economics/ financing in the postgraduate programs of selected universities as one way to lay the foundation for such capacity.

