

# **Reaching the Health MDGs in Ethiopia**

## **Financing Challenges and Prospects**

**OECD Global Forum on Development  
Aid Effectiveness in Health  
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# Country Profile

- 1.1 million sq.km
- 77.3 million population
- Population growth rate: 2.7% /year
- Rural population:85%
- Federal government :
  - 9 Regional States, and 2 City Administration
  - 624 Woredas (districts)
  - 15,000 kebeles (villages)





**Part 1 - Challenges:  
Mobilizing Domestic Resources and  
Improving Execution of External Funding**

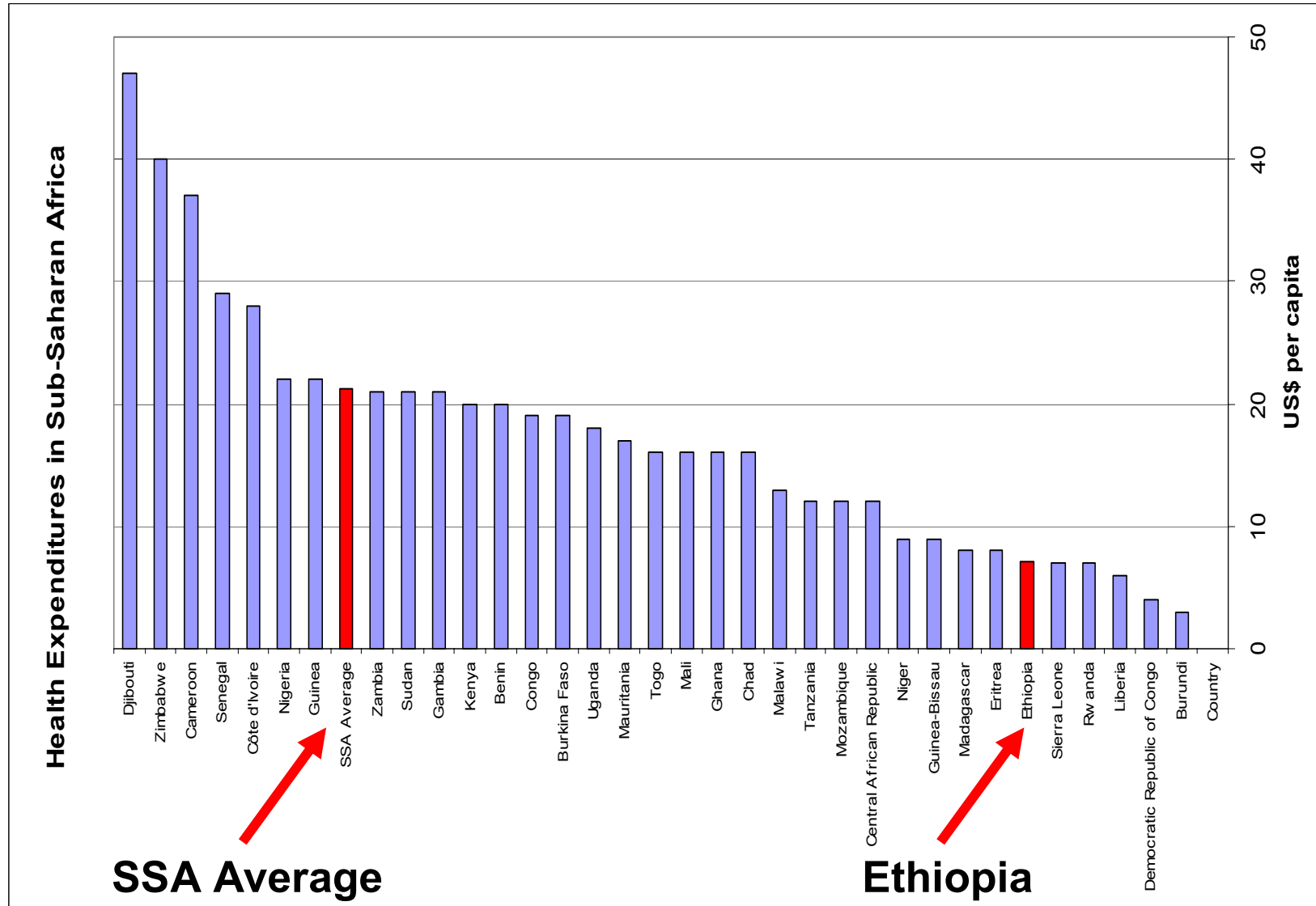




# Overview of Health Expenditures

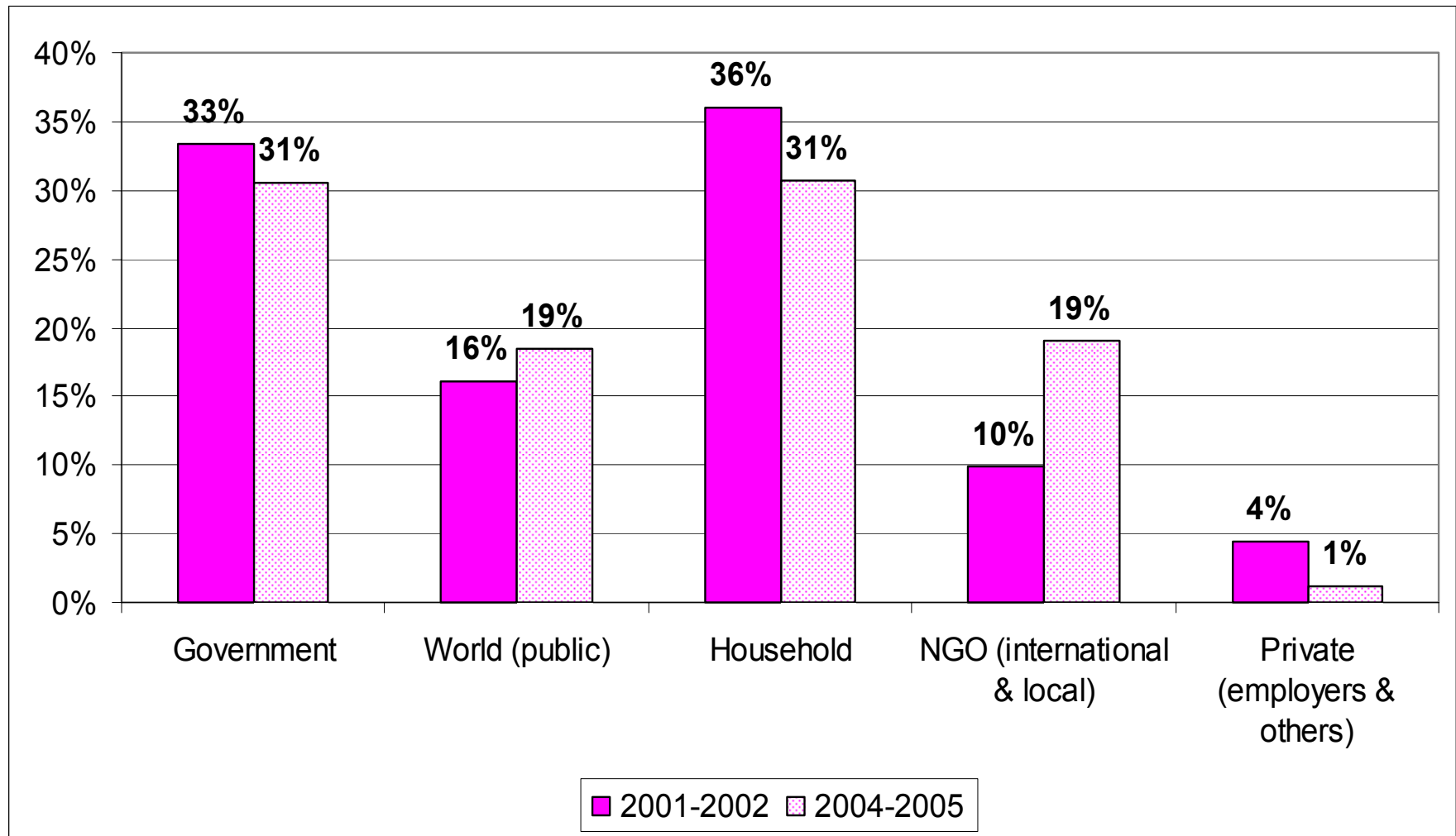


# Ethiopia still among the lowest spenders ...

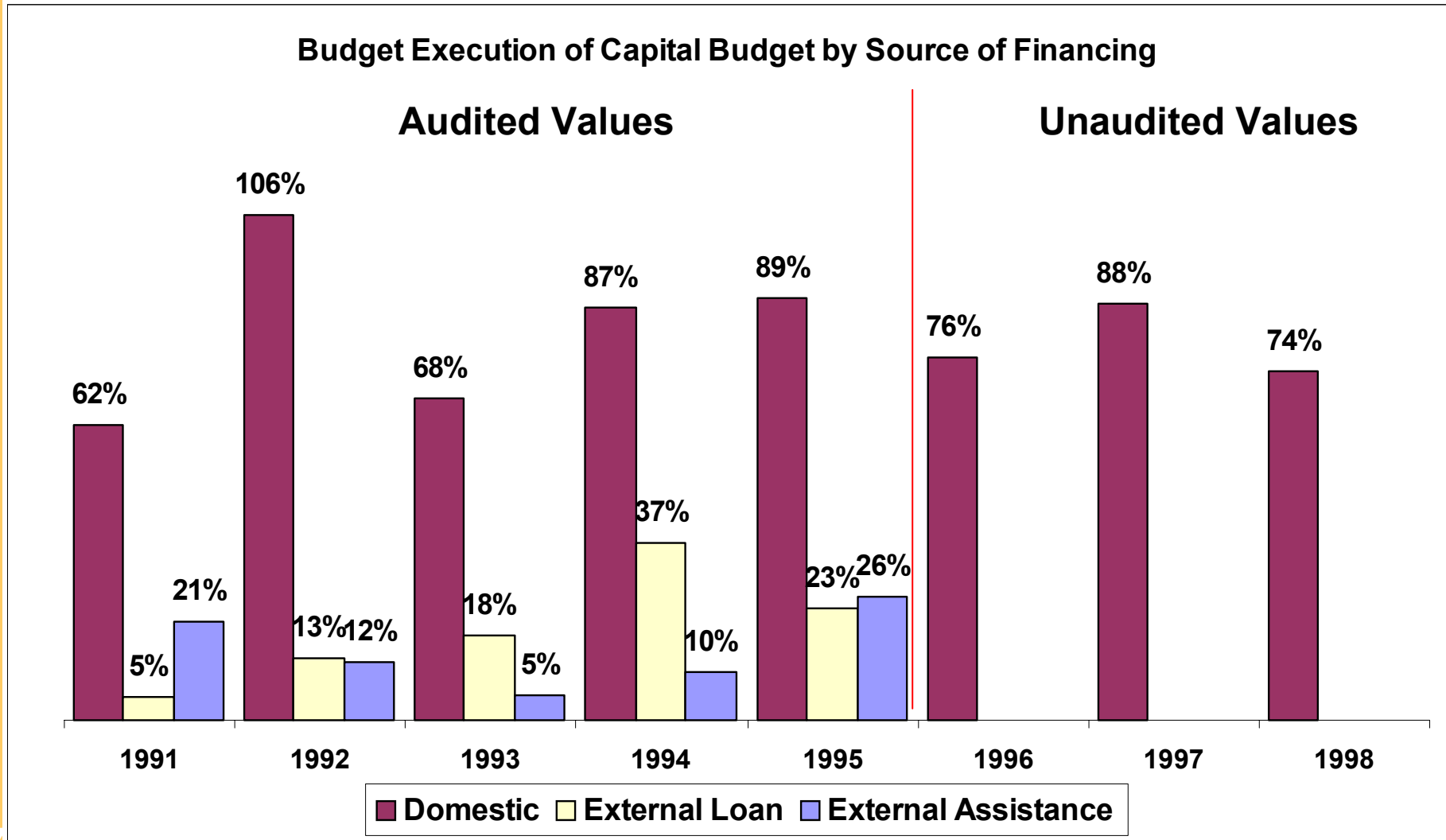


# The share of donors and NGOs has increased while the share of government and households has decreased

## Ethiopia Health Expenditures 2001/02-2004/05



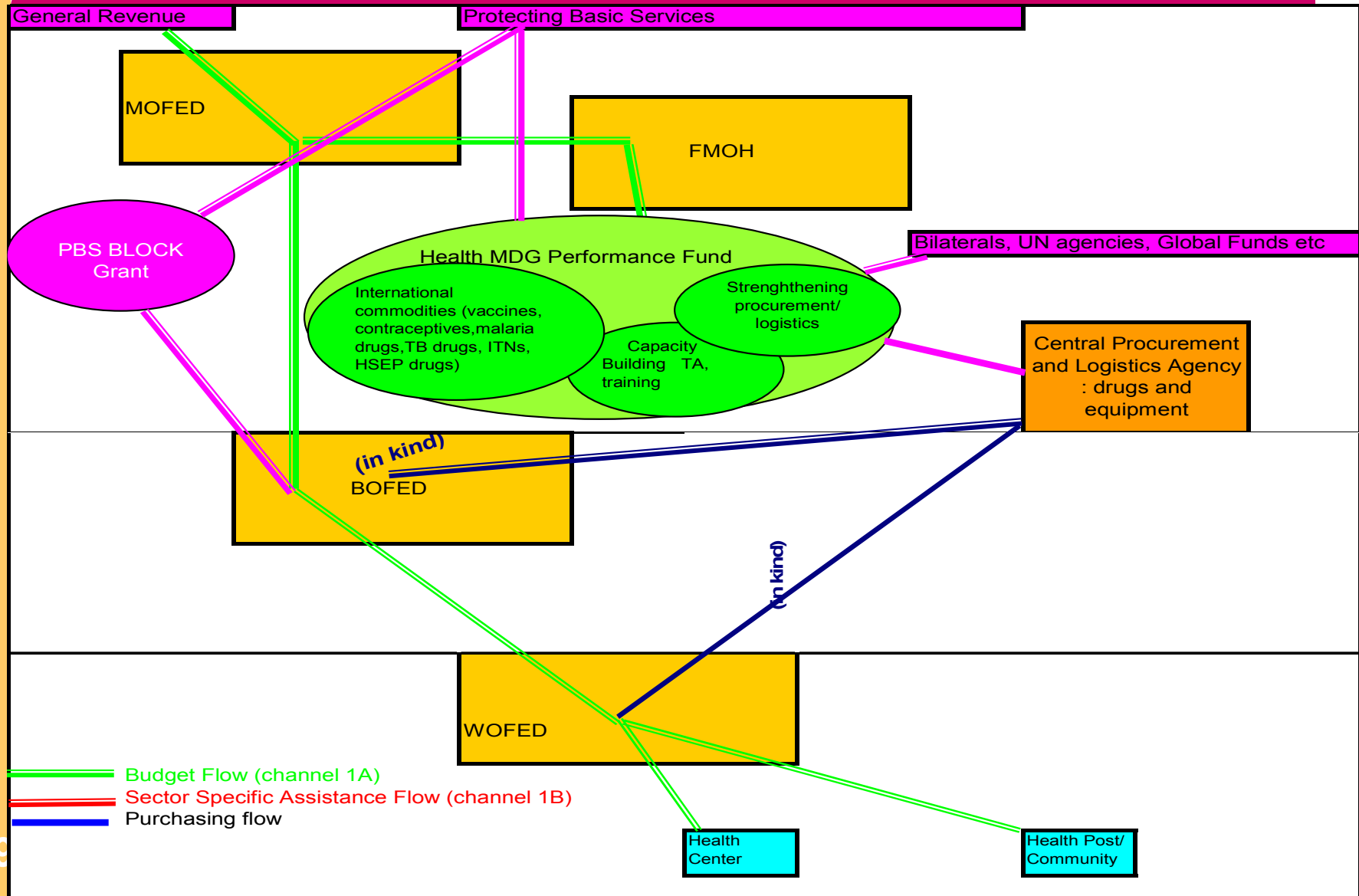
# Execution rates of capital budgets markedly lower for external assistance compared to domestic sources



# What explains the low execution rates of donor funds?

- **Fragmentation**
    - Large number of accounts with different rules
  - **Donor Procedures**
    - Different and cumbersome reporting systems
  - **Capacity**
- **SOLUTION: MDG Performance Fund**
- Early experience of PBS as a financing instrument has been positive, but there are huge disappointments with management procedures and procurement systems

# Strengthening the MDG Performance Fund



## The Three Key Questions

- How to **increase the share of domestic funding** as a share of total public spending?
- How to **improve the execution rate of donor funds**?
- How to **improve the public reporting system** to better capture the efficiency and equity of health spending?

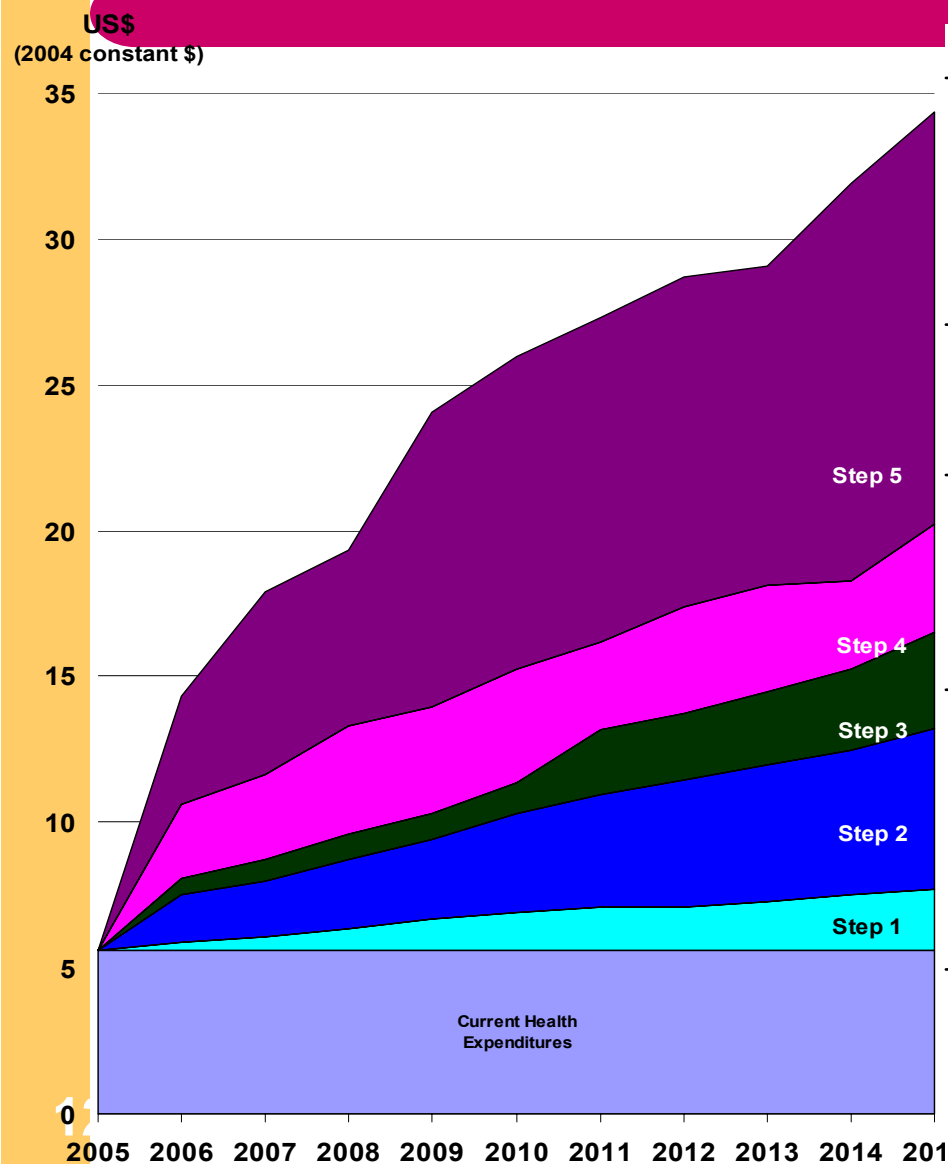


**Scaling up: what can be achieved and  
at what cost?**



# Cost of scaling up health services

## incremental cost per capita 2005-2015 for reaching the MDGs



Scale Up Strategy	Health Outcomes	MDGs reached
Step 5 : Expansion and Upgrade of Referral Care	Further decrease of : child mortality, maternal mortality, HIV MTC transmission Provision of HAART , multi-drug resistant TB and severe malaria treatment	
Step 4: Expansion and Upgrade of Emergency Obstetrical care	Further decrease of : child mortality maternal mortality HIV MTC transmission	Reduced MM by 75%
Step 3: First level clinical upgrade	Further decrease of: Child mortality Maternal Mortality Malaria, morbidity & mortality TB	Reduced malaria mortality by 50% Increase TB DOTS coverage
Step 2: Health Services Extension Program	Decrease in child mortality Reduction in HIV Mother To Child Transmission Reduction of deaths due to pregnancy by 40% Reduce malaria mortality morbidity Reduce Child malnutrition	Reduced child mortality by two third
Step 1: Information and Social Mobilization for Behavior change	Decrease in child mortality due to HIV, malaria, diarrhea diseases Reduced HIV transmission Reduced malaria morbidity and mortality	Reversed trend in HIV incidence and stabilized trend in HIV prevalence

# Volume, speed and quality

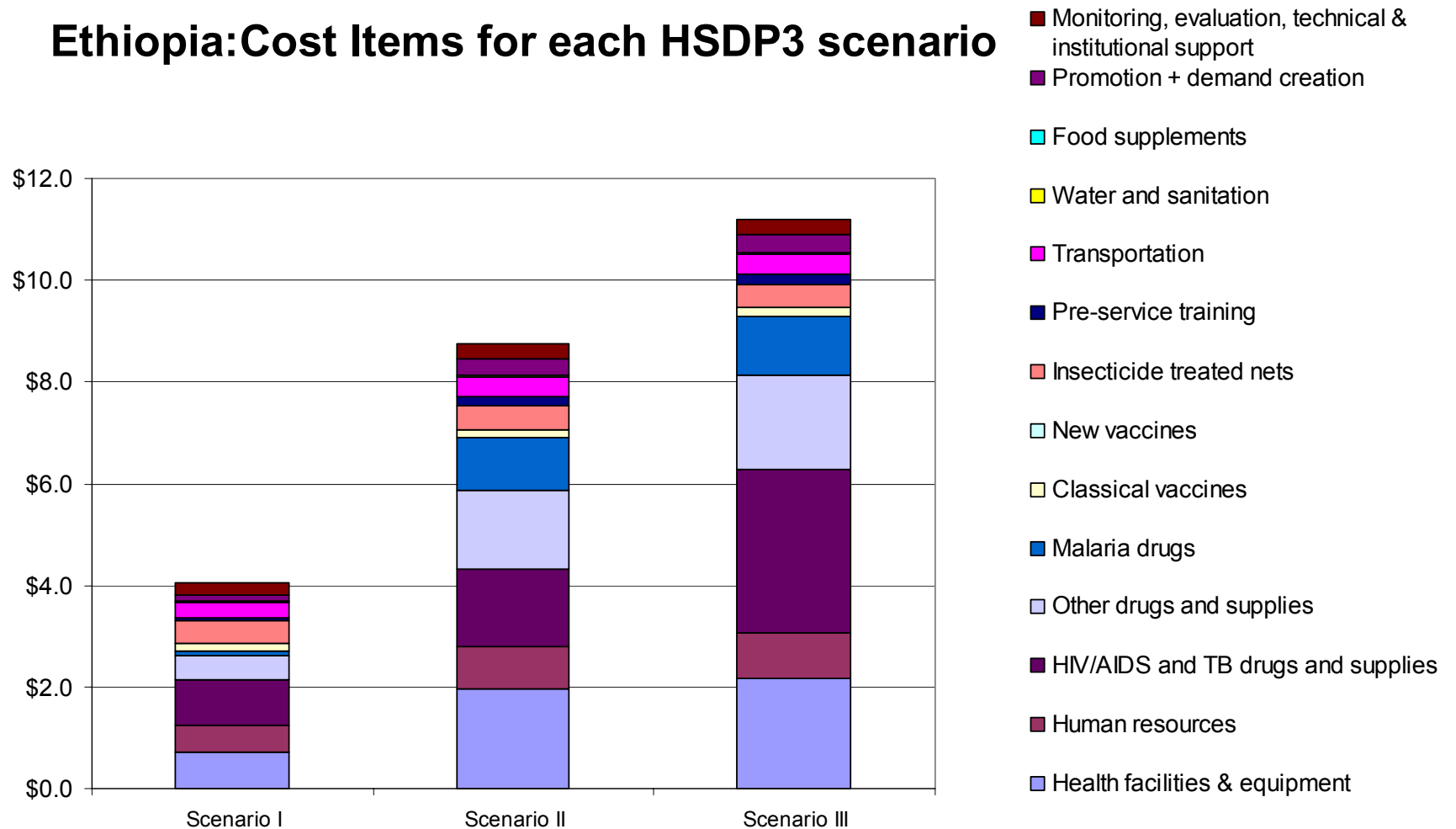
Focus areas	Outcome	Targets	Vehicles	Bloodlines
Maternal Health	MMR 871 to 600	CPR > 60%	<b>Health Post: 13,635</b>	HMIS  Logistic system  Financing system  Harmonization
Child Health	U5MR 123 to 85 IMR 77 to 45	Immunization > 80%	<b>Health Center: 3,135</b>	
HIV/TB	Maintain HIV prevalence at 3.5  Reduce mortality attributed to TB from 7% to 4% of all treated cases	Reach every household ART 263,000	<b>Health Extension Workers: 30,000</b>	
Malaria	Reduce morbidity attributed to malaria from 22% to 10%	20 million ITNs	<b>Health Officers: 5,000</b>	

# Three implementation scenarios for HSDP3

- **Scenario 1: Full implementation of the HSEP**
  - access to health post 100% (13,635 HP, HR, essential inputs)
  - access to health center 80% (2,229 HC, HR, essential inputs, functional B-EOC)
- **Scenario 2:**
  - **Full implementation of accelerated expansion of PHC**
    - access to health post 100% (13,635 HP, HR, essential inputs)
    - access to health center 94% (3,135 HC, HR, essential inputs, functional B-EOC)
    - Increased coverage of clinical services
- **Scenario 3: No resource constraints**
  - full implementation of accelerated expansion of PHC
  - functional C-EOC
  - higher coverage targets for clinical care
  - all health MDGs achieved

# Facilities, human resources, HIV and malaria drugs represent the largest share of HSDP3 cost

## Ethiopia: Cost Items for each HSDP3 scenario



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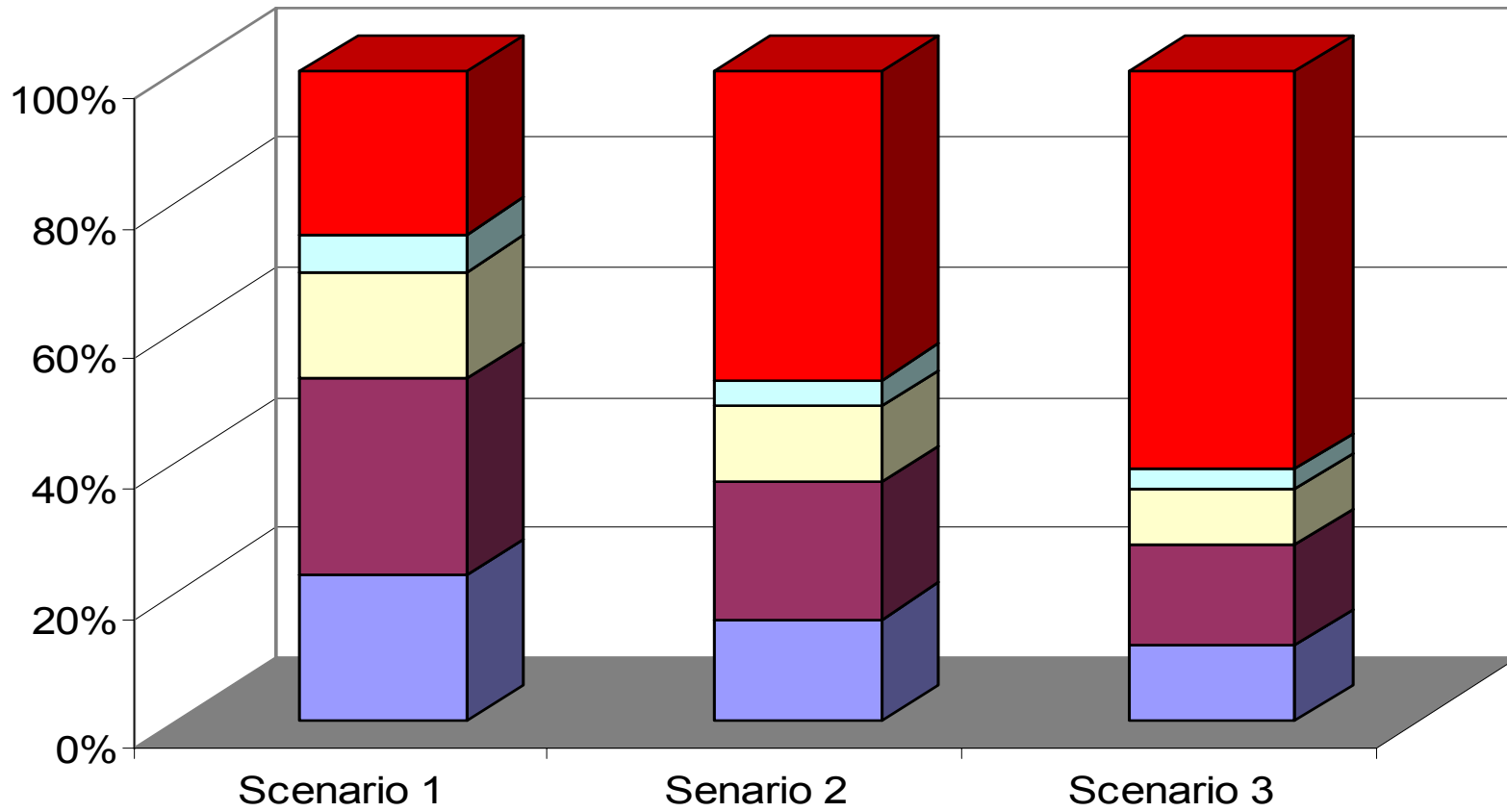
## **Financing outlook**



# HSDP III Financing Gap



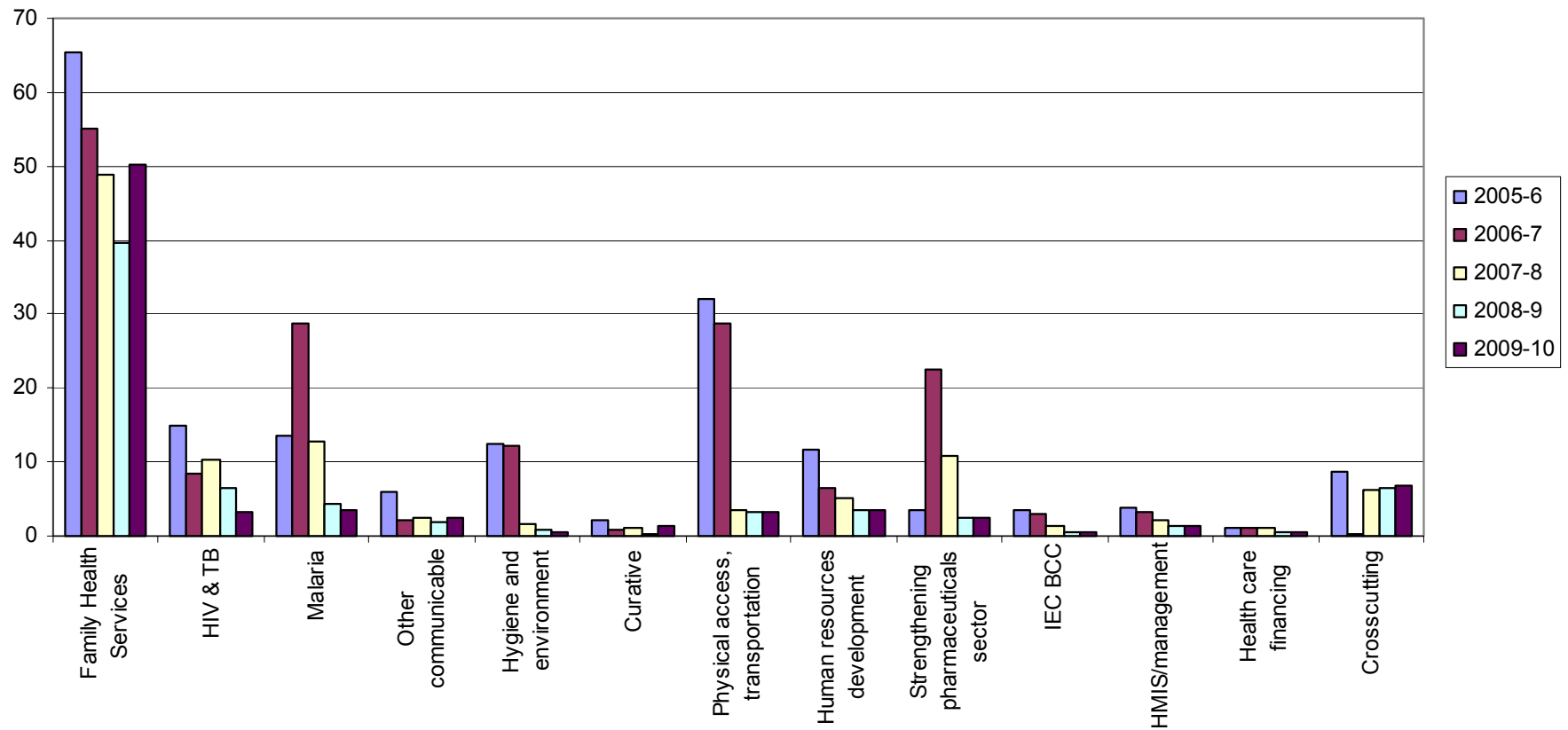
HSDP III Financing Gap with HIV/Aids funding



■ Government budget ■ Global Fund ■ Bilateral and multilateral ■ GAVI ■ Gap

# Pledges generally cover partially the cost of each component ... When PEPFAR and Global Fund are not included

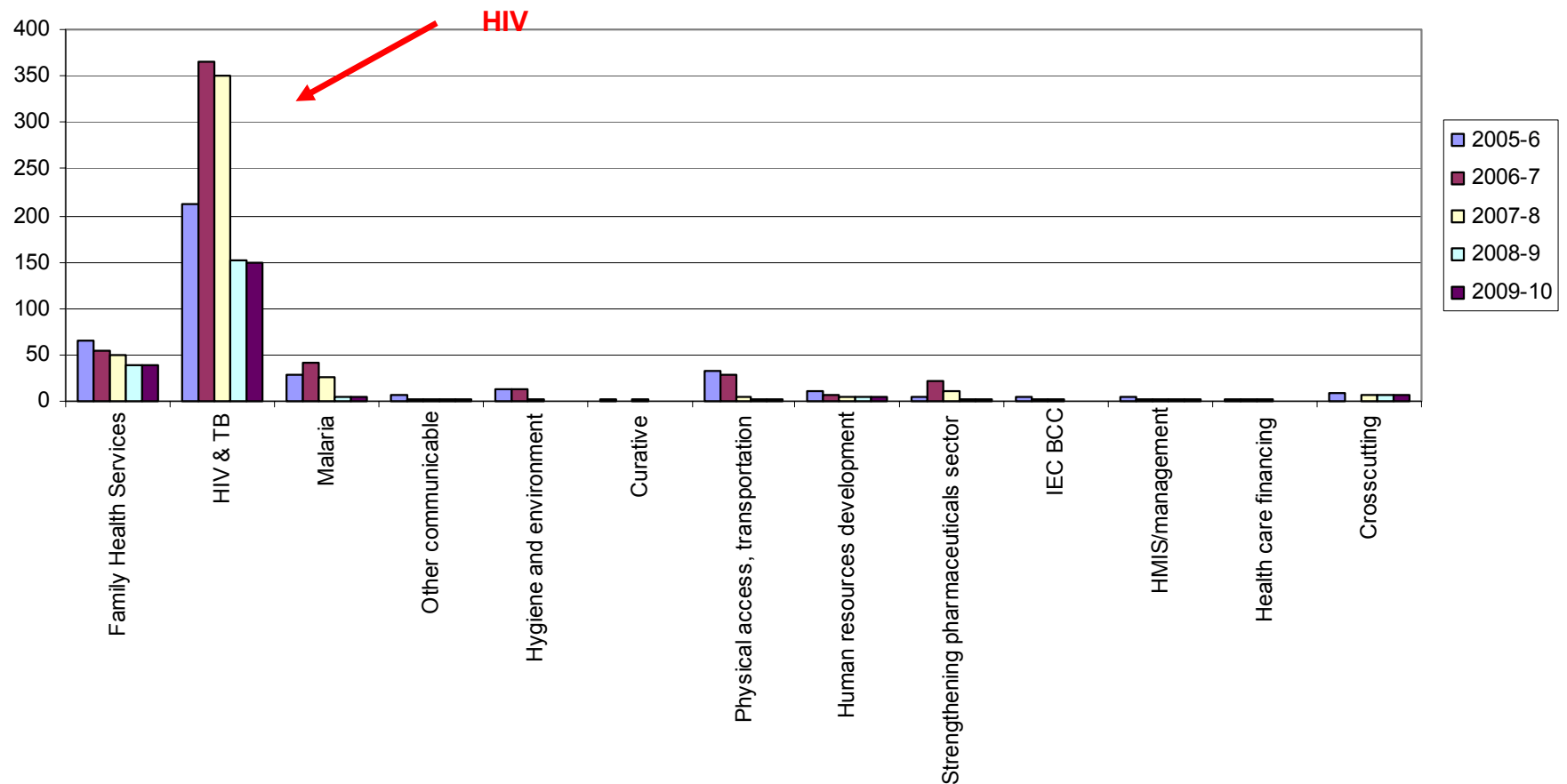
Ethiopia: Donor Pledges by HSDP3 component and sub-component (including PBS excluding Global Fund and PEPFAR)



Source: Health Care Financing Study

# But very large amounts for HIV/AIDS treatment distort the picture

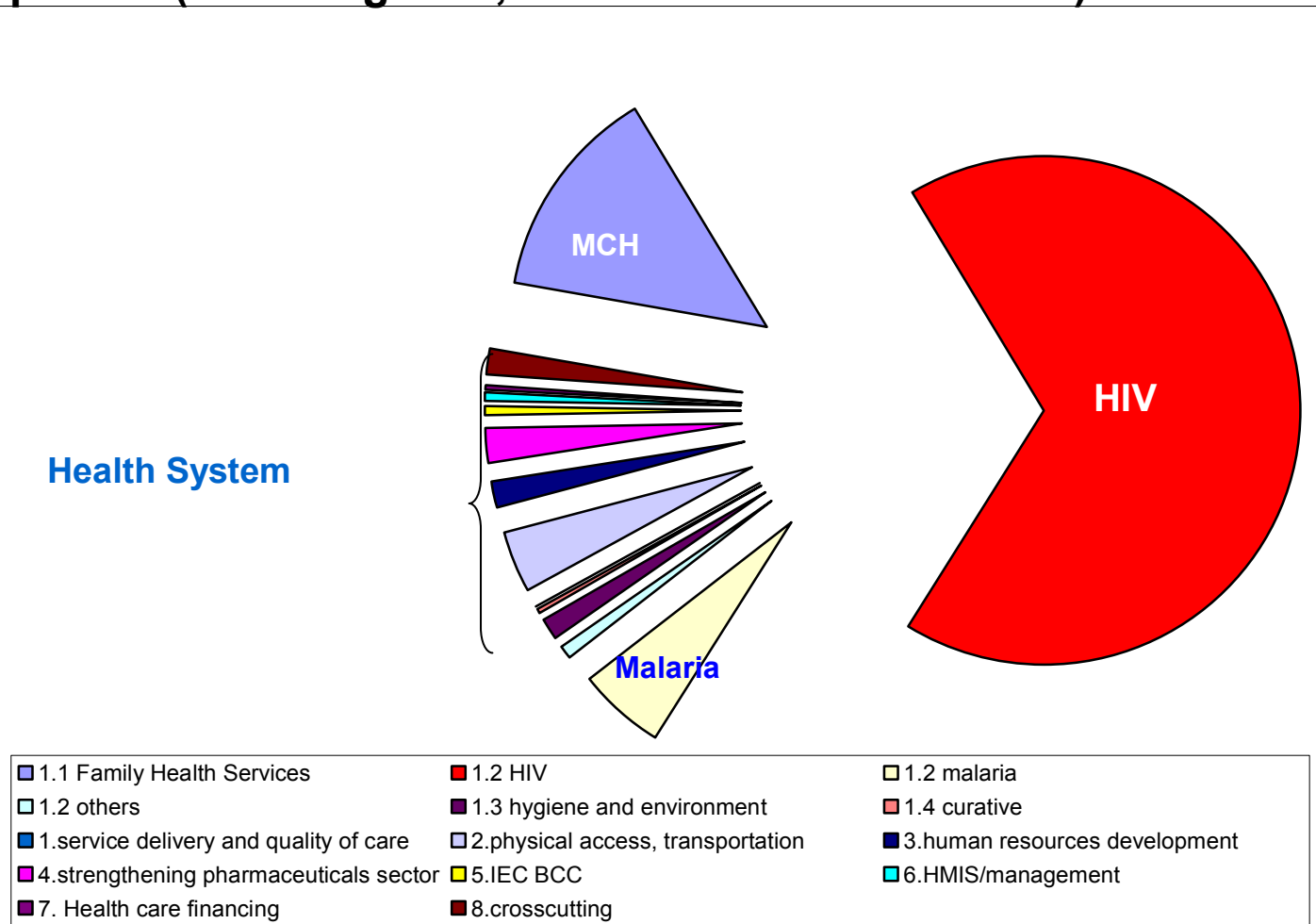
Ethiopia: Donor Pledges 2005-2010 by HSDP3 component and sub-component (including PBS, Global Fund and PEPFAR)



Source: Health Care Financing Study

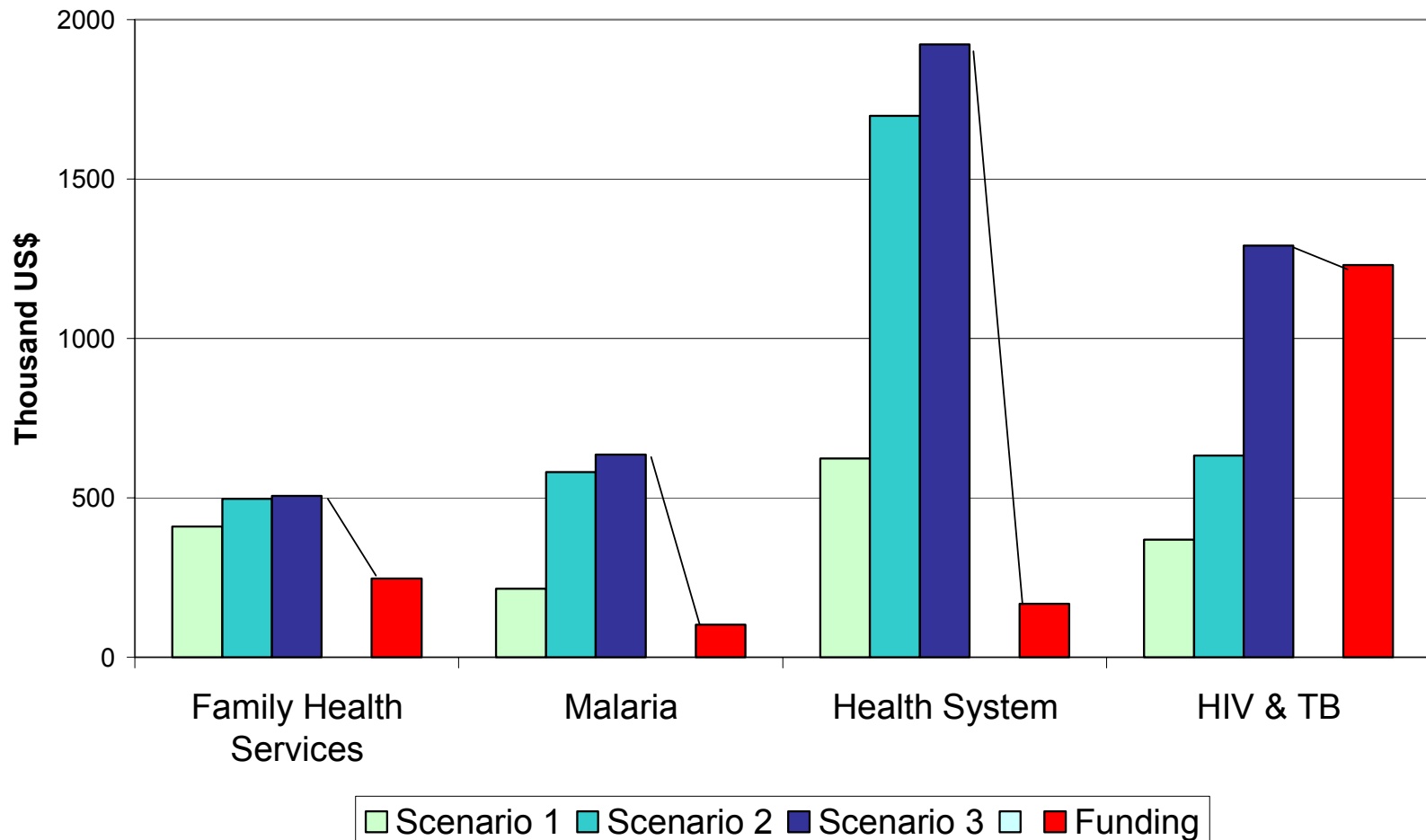
# Health System receives less attention from donors

Ethiopia: Donor Pledges 2005-2010 by HSDP3 component and sub-component (including PBS, Global Fund and PEPFAR)



...but gap still large form child health, malaria and health systems even for scenario 1

### Funding Gap per HSDP3 component



## The Three Key Questions

- How to **mobilize domestic funding** –from the **current 5% to 10-15%** of total public spending? (in line with the Abuja commitment)
- How to **reestablish some balance between donor funding sources** and most efficiently use the large amounts available for HIV/AIDS treatments?
- Which **resources mobilization strategy** to address the health system and child health gap?



**Thank you**

