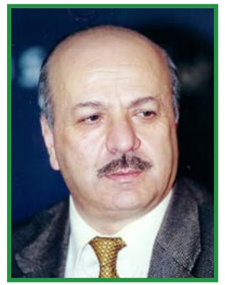
Health System in Ethiopia: Highlights



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Ethiopia is a country in the horn of Africa region and one of the oldest states, Ethiopia has poor health outcomes even by sub-Saharan Africa's standards characterized by many decades without a national health policy, weak healthcare system infrastructure and low government spending. This paper overviews key health measures of Ethiopia and discusses some of the challenges as well as prospects for improvements of the country's health outcomes.

Health Situation in Ethiopia

Ethiopia is a country of diverse cultures, traditions and histories. In spite of its ancient civilizations and being the only other country in the continent that was not colonized as well as one of the oldest territorially integral nation in the world, Ethiopia today is one of the least developed countries with low development indicators. With a population of about 70 million, it is also the third most populous country in Africa. Eighty-two percent of the population lives under a dollar a day, 44% living below the national poverty line.

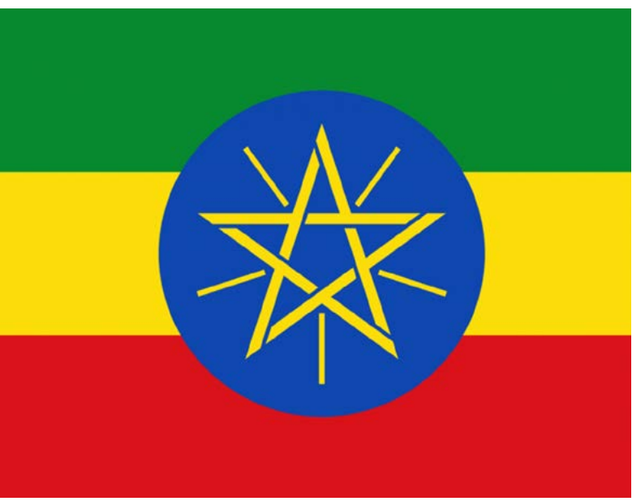

Table 1 Key socio-demographic and health indicators, Ethiopia (various years)

Indicator	Ethiopia
Population (mil) (2004)	75
Pop. growth rate %	2.5
Life expectancy (2007)	48
Under 5 mortality rate per 1,000 (2005)	123
Maternal mortality rate (2005)	673
Poverty rate ($/d) % (2000)	82
GNI per capita $ (2007)	160
Overseas dev. assistance % GNP	21.6
ODA per capita (2005)	27
Pop. with HIV % (2007)	2.1
Health expenditure % of GDP	3.5
Health expenditure per capita (2003)	5.6
Health personnel total (2007)	46,666
Physician/population (2007)	42,706
Health facilities total (2007)	14,041
Health facilities/ population (2007)	5,493

Sources: Ethiopia DHS 2005[4]; The Little Book of Data 2007[5]; DFID 2007[6]; Ethiopia 3rd National Health Accounts 2006[7]; Ethiopia Health Sector Strategic Plan III, 2005[8]; Ethiopia Health and Health Indicator 2007.[9]

Table 1 shows the key country's health related demographic and socio-economic indicators.

Ethiopia is a democracy with a federal system of government comprising 9 regions and two administrative councils. In 1993 the government published the country's first health policy in 50 years setting the vision for the healthcare sector development for the next two decades. Major aspects of this policy focus on fiscal and political decentralization, expanding the primary health care system, and encouraging partnerships and the participation of nongovernmental actors.

Situational Analysis of the Health Care System

The health service system in Ethiopia is federally decentralized along the nine regions. The infrastructure comprises a total of about 14,000 health facilities which include 143 hospitals, 690 health centers, and 1,662 health stations of which 62%, 97% and 77%, respectively, were owned by the Ministry of Health. The differentiation of the various service levels is made typically by population size. According to calculations given by the Federal Ministry of Health (FMOH), a health center serves an estimated 25,000 persons, a health station 10,000, and a health post and private clinic 5,000. In recent years the national health delivery infrastructure has grown significantly. The growth of the health infrastructure has raised the average national health coverage to 64%. Nevertheless, annual utilization per capita remains very low at only 0.36 (36%) for the national average as at 2004. And while antenatal coverage has grown from 34% in 2002 to 52% in 2007, supervised deliveries have remained low at 7% and 19% in the same period. There are over 46,000 health workers who include physicians and all cadres of nurses, laboratory technicians, environmental health workers, and traditional birth attendants. The physician to population ratio, one for about 42,000, is well below the WHO standard of 1:10,000 and is over five times below the average for sub-Saharan Africa. There is a wide variation in the distribution of health care facilities, health personnel and health expenditures across the different regions of the country. Such variations exacerbate the health inequalities in the country.

Health Care Financing

The state of healthcare financing in Ethiopia has over the years been characterized by low government spending and minimal participation of the private sector. With the government having the major responsibility changes in the political regimes has meant that the politics of the day have had much influence on the financing policy environment. Per capita spending has remained below the sub-Saharan Africa average of US$12.

In 1991, government spending amounted to only 1% of the GDP. With the new government that came to power in the mid-1990s, this increased slightly to about 2.7% in 1996 and to 5% during 2004/05. Health financing in Ethiopia comes from a variety of sources as shown in Table 2.

Table 2 Total and per capita health expenditure by major source classifications (Fiscal year, 1997 EC; 2004/05 GC)

Source	Amount in USD	Per capita USD	Percent
Government	159,297,649	2.18	31
Donors and NGOs (inter + local)	192,293,175	2.63	37
Household	160,042,854	2.19	31
Private employers and private funds	10,095,901	0.13	2
Total	521,729,581	7.14	100%

Source: Ethiopia 3rd NHA.[7]
Note: EC stands for Ethiopian Calendar and GC for Gregorian Calendar.

According to these data from the 3rd National Health Accounts (NHA), the government and other public enterprises provide 31% of the financing, donors and NGOs 37%, households 31% and other private employers and funds about 2%. The share of government and households financing has decreased, in 1999/00. On the other hand, the share of foreign financing and NGOs has grown, the average national per capita spending in 2004/05 was US$7.14. Seventy six percent of the expenditure is in curative services with a slight increase in preventive health spending from 17% in 2000 to 24% in 2005.

Major Health Concerns Despite Improvements

Ethiopia has seen positive developments in many health indicators since the democratic government process began in the early 1990s: the health service system has expanded; overall and per capita health spending has increased significantly; and there is a policy and program for health improvements in the country focusing on expanding primary health coverage universally. Despite these improvements and with a rapidly increasing population, Ethiopia faces major health concerns. Constraints in the delivery of services include: the low number of health care facilities which are ill-equipped, mal-distributed and in a state of disrepair; an ineffective health care delivery system which is inefficient and biased towards the curative service. Ethiopia has a long way to go to reach the level of health spending recommended for a minimum and decent quality of essential health services.

Conclusion

As the World Bank admits, sub-Saharan Africa will not reach the malnutrition and child mortality targets, as well as some areas in communicable diseases at current pace of implementation. There is need to accelerate improvements in the country's healthcare system if Ethiopia expects to reach its health targets. In addition to a concerted focus for primary health system development and strengthening as recommended by the WHO. Hence, improving health will require increasing health service utilization, particularly the critical maternal and child health services, as a matter of priority, and this cannot be done by merely increasing services availability but by providing quality and reliable services. Secondly, there is need to rethink the organization and management of the service system. A third area critical to improving health in Ethiopia is in human resources for health. There needs to be a focus on training and retaining skilled personnel such as physicians, nurses and skilled birth attendants in the health system. At 5.6% of the GDP health spending remains extremely low in Ethiopia even by sub-Saharan African levels. At the same time, to avoid skewed developments in health outcomes across the regional levels, minimum levels of budgetary allocations through earmarking or other obligations may help standardize spending. Finally, improvements in the health outcomes can be made by proactive and concerted interventions by all the stakeholders in a sector-wide approach that is deliberate and collaborative.

Towards this end, the government needs to provide the needed leadership, governance framework and stewardship in this area. Without harmonization and leadership a responsive and effective health system meeting the right to health for Ethiopians cannot emerge.