

Study Report #2

Ethiopia's Second National Health Accounts Report

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Acronyms

DPPC	Disaster Preparedness and Prevention Commission
EFY	Ethiopian Fiscal year
ERCS	Ethiopian Red Cross Society
ESHE	Essential Services for Health in Ethiopia
ESRDF	Ethiopian Social Rehabilitation and Development Fund
ETB	Ethiopian Birr/legal Tender
FMOH	Federal Ministry of Health
HC	Health Center
HICES	Household Income, Consumption and Expenditure Survey
HP	Health Post
HS	Health Station
HSDP	Health Sector Development Program
MOD	Ministry of Defense
MOE	Ministry of Education
NGOs	Non-Government Organizations
NHA	National health Accounts
PPHC	Preventive and public Health Care
R&D	Research and Development
RHA	Regional Health Accounts
RHB	Regional Health Bureau
SDPRP	Sustainable Development and Poverty Reduction Program
UNFPA	United Nations Fund for Population Activities
USD	United States Dollar
WMS	Welfare Monitoring Survey

1. Introduction

1.1 Background

National Health Accounts (NHA) has increasingly become a useful and practicable tool for controlling and managing the national health system in terms of planning and assisting in decision-making. These accounts may be used as a diagnostic instrument in order to describe the financing of the health system, identify resource allocation issues, investigate the fairness of financing (asses equity concerns) and suggest solutions, as well as evaluate the degree of progress toward a determined objective at a point in time as well as overtime. Using standard methodologies, it also helps any country to assess its resource allocations and utilization on health in comparison with other countries.

The Federal Ministry of Health of the Democratic Republic of Ethiopia, recognizing the importance of the tool organized a team and constructed the first NHA using the 1995/96 data in 2000. The first NHA was able to provide the level of total health expenditure, the magnitude of household out-of-pocket payment for health, and the spending on pharmaceuticals among others. It also provided the basis for comparison with other countries. Tracking achievements and weaknesses of health financing using this tool requires constructing NHA consistently over time. Learning from its usefulness from the first round and recognizing the need to construct NHA at least once in two-three years, the Federal Ministry of Health (FMOH) initiated the study on this second round of NHA.

The second NHA for Ethiopia is constructed using the EFY 1992 (1999/00) data. A national team was formed to construct these accounts. These teams was provided with the current internationally recognized tools and methodologies of constructing NHA through an in-country training facilitated by Abt Associates Inc. The training resulted not only in understanding the current tools and methodologies but also in agreeing on the basic classifications of the main four matrices as well as drafting the main data collecting instruments.

The national team has developed data collection instruments/questionnaires further after the training and two days training was also provided for data collectors. The questionnaires were pre-tested after the training and the findings of the pre-test have further improved the design of the questionnaires (see Annex 5). Data collectors were deployed for about a month in 7 of 11 regions in the country, a member of the national team leading the team in most cases. The regions that were not visited were Gambella, Benishangul-Gumuz, Somali and partially Afar. The reasons for not going to these regions are largely due to the absence of major private employers and insurance companies to administer the surveys. All necessary data on household, government and donation expenditures for these regions have been fully incorporated.

The Health Finance team of ESHE project has provided a technical support in backstopping the study. The resulting figures and the main issues encountered were shared with the national and regional teams during two days workshop conducted in Nazareth. The teams discussed in detail the concerns and reached an agreement on classification and extrapolation issues (See Annex 2). Based on these consensuses, an analysis is made on the data. This report summarizes the methodology used, the major findings and the main limiting factors during the analysis.

1.2 Methodology

The second NHA is constructed using the 1992 EFY (1999/00) expenditures. The main rationale for selecting 1992 was that it was in that year the two latest major data sets were available.

- audited account of government expenditure
- Central Statistical Authority's Household Income, Consumption and Expenditure Survey - a comprehensive data set used to estimate household out-of-pocket expenditures

Unfortunately, the year cannot be taken as one that is representative or a normal year. It was a year of Ethio-Eritrean war. Consequently, the government budget was affected (both from the central treasury and external assistance) negatively. If one looks health expenditures during the Health Sector Development Program (HSDP) period through budgetary allocations, it is clearly documented that 1992 was a year that broke the normal increasing nominal health expenditures trends over the years. Many external resources except those committed by the World Bank were put on hold.

Table 1.1: Expenditure trends over the HSDP years

	1989	1990	1991	1992	1993	1994
TOTAL	584,221,935	650,336,538	710,770,403	569,844,694	649,685,331	809,140,744
FEDERAL MOH	79,769,339	87,504,376	104,470,750	71,957,214	113,749,723	72,599,920
REGIONS	504,452,596	562,832,162	606,299,653	497,887,480	535,935,608	736,540,824

Source: FMOH, HSDP Evaluation Report. 2003

On the other hand, health expenditures related to the war could have increased. The health expenditures by the Ministry of Defense were significant. If we take the drug related expenditures alone, the expenditure for 1992 is more than a hundred million Birr. We can therefore say that the war has affected seriously resource flows to public health activities but it is generally difficult to estimate by how much. One must be extremely cautious in projecting health expenditures for future years based on these estimates.

Data collection instruments: The data were collected using two sets of instruments: surveys and secondary information. The government expenditures through budgetary processes have been collected from audited accounts of the Ministry of Finance and Economic Development (MOFED). The health expenditures captured in government accounts goes far beyond the traditional health budget calculations as it also includes health expenditures that are budgeted in other institutions or development programs like Ethiopian Social Rehabilitation and Development Fund (ESRDF). The government expenditures captured in this report also tried capturing channels two and three support by donors and NGOs. The contributions of local development associations towards health care also collected through secondary sources.

Sampling: Surveys have been administered on donors, employers, insurance companies, and NGOs (both international and local). 20 percent of all employers in Addis Ababa and 25 percent in other surveyed regions and in total 150 employers were taken as a sample. In total 29 donors (virtually all significant donors), 7 insurance companies, and 24 NGOs (major ones that have a good record of being involved in health sector) and faith-based organizations have been surveyed.

Extrapolation: Some of the data sets like insurance were censuses; the results were simply taken as such. Others are sample surveys and their results have to be projected to the population. The functional and provider classifications of expenditures have not been fully captured during the collection of information largely due to the problem of recording in the surveyed institutions. Functions that are related to the program areas

were seriously analyzed during categorizations. Government expenditure codes, donor/NGO classifications as well as sample invoices were used to arrive at provider/functional classifications. In some instances, all the above information sources were unable to lead into some type of classifications and consequently assumptions were made to classify general expenditure figures to either functions or providers.

Major classifications and definitions: The boundaries between the basic survival function (which includes food, access to drinking water, and shelter) and the health function (which includes community values, the ability to perform in society without impairments, handicaps and disability) are often difficult to distinguish. This study uses a definition of “health expenditures,” that includes only those expenditures for which the primary purpose is the improvement of the health of individuals or of the population. Expenditures on activities with multiple objectives, such as nutrition, water and sanitation projects are only included if their primary objective is the direct improvement of health status.

The methodology views the financing of the health sector in a comprehensive fashion, with funds flowing from financing sources, through intermediary organizations, and ending up with health service providers. For the *sources* of health sector funding, the study includes the following categories: the then Federal Ministry of Finance and regional finance bureaus (for all tax-based funds and other general revenues), public firms, private firms, NGOs (local and international as well as local development associations), households (health expenditures and contributions to health service expansion), and donors.

Data on public sector health expenditures that passes through the budgeting process is reliable. There is, however, a data gap within public health expenditures if they go through channels 2 and 3¹. To avoid double counting, utmost care and close check up was made to reconcile expenditure data from NGOs and donors on one hand, and government intermediaries on the other. The most significant data problems occur in estimating private health expenditures, specifically the expenditure size and composition of state and private firms, NGOs and of households.

Comparison between NHA I and II: Both NHA studies were conducted using the standard methodology adapted for developing countries’ health systems. However, there are certain variations in the comprehensiveness of data sources, sample size, and classification. Highlighting these changes would help to understand the strength and weaknesses of each. The following points are worth noting when making comparisons between the figures of the two NHAs.

¹ The HSDP Mid Term Review and Final evaluation has dwelt extensively on this issue and there is no need to further elaborate it here.

		NHA I (1995/96)	NHA II (1999/00)
Context		The private sector has just started emerging.	The time of Ethio-Eritrean war and escalating defense expenditures.
Data Source	<i>Government</i>	Government expenditures on health were captured based on the 3 budget categories namely domestic, loan, and assistance. However, the study did not capture assistances that did not pas through the MOFED (ch.2 and 3 supports)	It has captures al the government expenditures included in NHA I. In addition, expenditures through channels 2 and 3, as well as expenditures budgeted outside of the MOH but that are essentially for health, that of ESRDF and RH expenditures in UNFPA
	<i>NGO</i>	The source of information on NGO health expenditures was DPPC and CRDA audited reports.	DPPC audited reports were used. At the same time, NGO survey was undertaken whereby 23 international NGOs and almost all faith based organizations (major providers of NGO facility based health care in Ethiopia) were included. This has revealed that the former source tends to underestimate expenditures and latter figure was taken.
	<i>Employers</i>	Only expenditures of government enterprises with 20% sample in Addis and enterprises found in regional capitals were captured.	Tried to include both public and private enterprises in all the surveyed regions (7) with 20% sample. It captured manufacturing, construction, service providers, and agricultural enterprises.
	<i>Donors</i>	Expenditure was not captured	Donor survey was undertaken and 29 major health sector donors included. Hence, donor support to government outside of the MOFED and to NGOs was captured.
Classification	<i>Provider</i>	Attempt was made to capture expenditures by major health care provider groups based on ownership and hence the major categories were hospitals, outpatient centers, drug retailers, research and training institutes, and traditional healers.	The provider desegregation has been much detailed with further breakdowns within the NHA I major categories based on the ICHA classification. In addition, expenditures by health administrators, public health service providers, and health related service providers have been shown separately.
	<i>Function</i>	Because of data and time constraints, functional breakdown of health expenditures was not captured at the source. The option used to disaggregate functions into primary, secondary, and tertiary care was by using the provider where expenditure was made as a proxy. Hence, all hospital expenditures were taken as secondary and tertiary care while that of lower tier facilities was taken as primary.	The detailed functional breakdown has been captured during the survey with few classifications being made based on assumptions.

1.3 Structure of the report

This report summarizes the findings of the second round NHA study. Section two would highlight the major findings in terms of the four basic NHA matrices. Section three would investigate deeper into functional classifications of health expenditures, although in a very general way, with the aim of analyzing how far these expenditures are in line with government policies and strategies, while section four dwells up on the composition and analysis of household out-of-pocket expenditures. Section five presents the conclusions as well as policy recommendations of the study.

2. Major findings of NHA II

2.1 Total health expenditures

The total health expenditure in EFY 1992 was estimated to be ETB 2.9 billion (355.5²million USD). The first NHA conducted using EFY 1988 data estimated the total health expenditures at ETB 1.45 billion or (230 million USD). The total nominal health expenditures doubled if one looks at domestic currency, and showed an increment of about 55 percent in USD. The per capital health expenditure has increased by about one dollar from 4.5 USD to 5.6 USD per person per year between the two estimates. As outlined in the introduction, EFY 1992 has been a year of low expenditure by the public sector because of Ethio-Eritrean war. The increment of contribution by households can explain some of the increment in the estimated figure. The main cause, however, was the better methodology used for data collection and verification in this round. First, the current estimate in government expenditures included some program expenditures like ESRDF and UNFPA's reproductive expenditures that were not included previously. Second, it also surveyed donors and found out a significant proportion of funding to government outside the normal budgeting processes and to international and local NGOs. Third, the first round used NGO expenditures from the DPPC records. In this round NGOs were surveyed and the findings were compared with DPPC records. There is a gross underestimation in DPPC records, as most NGOs did not submit their reports on time.

Table 2.1 Total and per capita health expenditure by major source classifications

Source	Amount in Birr	Amount in USD	Per capita USD	Percent
Government	978,960,122	118,731,993	1.87	33%
Rest of the World	471,443,092	57,178,404	0.90	16%
Household	1,057,826,612	128,297,219.	2.02	36%
NGO (local+Intl)	290,082,327	35,182,285	0.55	10%
Private	132,849,569	16,112,499	0.25	5%
Total	2,931,161,723	355,502,340	5.60	100%

It is important to compare these findings with other countries and see whether general health and government funding is adequate to provide quality service at all levels of the system. The average per capita total health spending in the least developed countries is twice as much as Ethiopia. Average per capita government spending on health in these countries again is three times higher. Average donor assistance for these countries is again more than three times than Ethiopia's access to external assistance (see table 2.1 in relation to table 2.2). The health sector in Ethiopia therefore can be described as essentially under funded not only to meet the growing health needs but also in comparison with other poor countries.

² The average exchange rate used to convert ETB to USD is a simple average of 1992 exchange rates, equals to 8.245125.

Table 2.2 Domestic Spending and Donor Assistance on Health 1997-1999

	Public spending on health (per person, 1997, USD)	Total Spending on health (per person, 1997, USD)	Donor Assistance for health (per person Average annual 1977-99)
Least developed countries	6	11	2.29
Other Low Income Countries	13	23	0.94
Lower Middle Income Countries	51	93	0.61
Upper Middle Income Countries	125	241	1.08
High Income Countries	1356	1907	-
All Countries			.85

Source: WHO, Commission for macroeconomics and health

What makes the resource mobilization effort very daunting in Ethiopia is when we see the level of health spending recommended for minimum and decent quality of health in selected services. According to the World Bank, the annual cost per capita of delivering the package of essential services³ would be \$12 (in 1990 US\$)⁴. The Commission on macro economics and health estimates that the incremental cost of ‘scaling up’ existing provision to 2015 target levels will be \$18 pa per capita at 2002 prices in low income countries (and \$26 pa per capita in the least developed countries where existing coverage is thinner)⁵.

2.2 Sources of funding

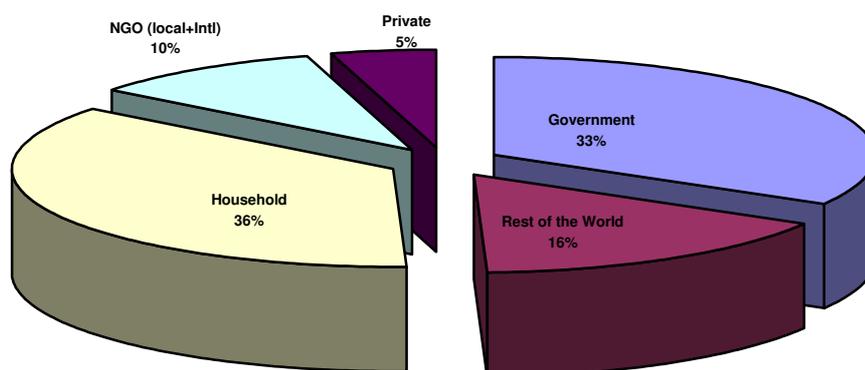
The major source of funding for health remains the same as in the first round in that households are still the lead financing sources accounting for 36 percent of the total health expenditures but their role significantly declined from about 53 percent in the first round. Government financing from taxes, general revenue and loans stood next by covering 33 percent of total health expenditures. The rest of the world through bilateral and multilateral assistance comes third with 16 percent. Since financing from the rest of the world mostly comes through government, the second round shows that about 50 percent of health expenditures are financed from public sources. The share of NGOs has also increased to about 10 percent from the previous 7 percent. If one looks to per capita expenditures, households spend 2.02, government 1.87 an, rest of the world 0.9 NGOs 0.55 and the private sector .25 USD per person per year.

³ The package defined by the World Bank include reduction of maternal mortality by deploying more extensive, professional, pre-natal, childbirth and postpartum care and better access to family planning services, provision of drug therapy for tuberculosis, control of STDs, prevention of and care for sufferers from common illnesses among children – measles, malaria, diarrhea, respiratory infections and malnutrition.

⁴ World Bank, 1993, “Investing In Health” World Development Report

⁵ WHO, 1999, Commission for Macroeconomics and Health.

Fig 2.1: Source of health expenditures, EFY1992 (%)



2.3 Health service actors (FA)

The category of *financial intermediaries*, usually referred as *financing agents* are the channels through which funding is managed since the sources of funding in most cases are not directly paying the providers of services. The category of financial intermediaries is therefore essential to have a clear understanding of health sector financing flows. In this study, financial intermediaries are divided into the following categories Federal Ministry of Health, Federal Ministry of Education, Ministry of Defense, regional health bureaus other ministries and bureaus, local NGOs and development associations, households (as own intermediary), public firms (as own intermediary), international NGOs and other institutions.

The major financing agent that managed the health resources flows was the government, controlling about 46 percent of the total resource flow. This clearly shows that although it remains to be the major controller of resources, the majority of health expenditures are being spent outside the span of control of the government. Of the total government funding, regional health bureaus control about 50 percent while the federal financing agents managed 46 percent. FMOH managed and controlled only 44 percent of those channeled through federal financing agents. Here again, it can be said that RHB have a better say and control over the regional health resources vis-a vis MOH in the federal government.

The second major category that managed and controlled the health expenditures was the private sector, accounting for about 45 percent. In this category household managed nearly 80 percent of the sub group's share.

Table 2.2: Expenditures by major categories of financing agents

Financing Agent	Expenditure		Percentage Share
	In Birr	In USD	
Government Actors	1,344,482,428.57	163,063,923.05	46
<i>Federal</i>	<i>623,577,168.74</i>	<i>75,629,801.70</i>	<i>21</i>
MOH	272,518,341.39	33,052,056.99	
MOD & Police	188,771,283.63	22,894,896.52	
MOE	65,559,473.56	7,951,301.35	
National HIV/AIDS Sec.	596,413.80	72,335.33	
ESRDF	64,194,523.90	7,785,755.09	
Gov. Insurance Companies	6,986,241.12	847,317.79	
Other Fed. Gov.	24,950,891.34	3,026,138.64	
<i>Regional</i>	<i>672,528,951.58</i>	<i>81,566,859.40</i>	<i>23</i>
RHB	611,948,659.16	74,219,452.00	
Other Reg. Gov.	60,580,292.42	7,347,407.40	
<i>Parastatals</i>	<i>48,376,308.26</i>	<i>5,867,261.96</i>	<i>2</i>
Private	1,331,279,875.03	161,462,667.34	45
Insurances	6,513,256.22	789,952.39	
Households	1,053,609,530.25	127,785,755.86	
Non-Profit Institutions	140,467,438.65	17,036,423.18	
Enterprises	130,689,649.91	15,850,535.91	
Rest of the World	255,399,419.18	30,975,809.24	9
International Agencies	255,399,419.18	30,975,809.24	
Grand Total	2,931,161,722.78	355,502,399.63	100%

2.4 Functional distribution

The Ethiopian health expenditure is dominated by expenditures on curative care. Expenditures on pharmaceuticals including vaccines consumed about 39 percent of the total health expenditures. Curative care as a service took about 19 percent of the total expenditures. If we exclude vaccines from pharmaceutical expenditures and consider the rest as curative treatment, then the share of curative care increases to about 57 percent of the total expenditures. Overall, expenditure on primary care accounted for about 16 percent and if we include vaccines, sanitation, and environmental health functions that are categorized under health related, it will increase to 18 percent. The share of health administration stands at a reasonable level of eight percent. Health facility expansion, as related to capital formation took about 15 percent of the total health expenditure. The analysis of classification of expenditures as related to policy (government resource allocation and expenditure) is important and treated in the next section.

Table 2.3: Functional breakdown of expenditures

Function	Amount in Birr	Amount in USD	Per Capita USD	Proportion
Curative care	549,681,727.06	66,667,482.55	1.05	19%
Pharmaceuticals (excluding vaccine)	1,123,670,832.92	136,283,056.10	2.15	38%
Vaccine	39,955,530.85	4,845,958.17	0.08	1%
PPHC	460,386,264.69	55,837,390.54	0.88	16%
Health administration	221,213,385.29	26,829,597.52	0.42	8%
Capital formation	440,756,737.45	53,456,647.10	0.84	15%
Training	57,455,171.64	6,968,380.91	0.11	2%
R&D	21,498,331.34	2,607,399.08	0.04	1%
Sanitation & envt health	16,543,741.54	2,006,487.66	0.03	1%
Total	2,931,161,722.78	355,502,399.63	5.60	100%

2.5 Provider analysis

For the fourth type of categorization, *service providers*, or users of health sector financing, the following categories are included: national referral hospitals, zonal hospitals, district hospitals, health centers and health posts, pharmaceutical retail outlets, public health service delivery institutions, health service management and, providers of health related services. Of the total resources flowing into the health sector, public health care providers consumed 68 percent of expenditure spent in the sector while the private sector (both private for profit and NGOs) providers shared the remaining third.

Table 2.4: Summary of Expenditure By Providers

Provider	Expenditure in Birr	Expenditure in USD.	Percentage Share	Per Capita USD
Public	1,980,901,503	240,251,240	68%	3.78
Private	937,499,270	113,703,464	32%	1.79
For Profit	593,106,628	71,934,219	20%	1.13
For-Not-Profit	344,392,643	41,769,245	12%	0.66
Rest of the World	12,526,256	1,519,232	0.4%	0.02
Miscellaneous	234,693	28,464	0.01%	0.00
Total	2,931,161,723	355,502,400	100%	5.60

3. Classification- a Closer Look

NHA findings help to understand the actual resource allocation and monitor the discrepancy between what is intended and what is achieved. There are two main levels of analysis focused in this section: composition of expenditures by providers and by functions. This part of the report will closely look at some of the findings on classifications and see how much policy intentions are matched with resource allocations and expenditures. This analysis could also serve as a baseline for subsequent NHA studies in terms of assessing the impact of deepening decentralization to wereda levels, Sustainable Development and Poverty Reduction Program (SPDRP) resource flows and implementation on sub-sectoral allocations as well as trends for evaluating effectiveness of policy interventions.

3.1 Resource Allocation by Health Care Functions

Administration costs, which mainly include those of federal and regional health administration, took 8 percent of total spending. This in general seems to be an acceptable composition between health service delivery and management costs as these costs are less than ten percent. The remaining 92 percent were spent on expansion of and equipment for health facilities as well as delivering service. When one looks at the proportion of the total health expenditure composition between health service delivery and expansion, about 85 percent of health expenditures are spent on service delivery. Of the total expenditure on health, 38 percent were spent on drugs, 64 percent on total curative⁶ care, and 25 percent on promotive and preventive⁷ health care.

Table 3.1 Expenditure by Major Functions (amount and as % Total Expenditures)

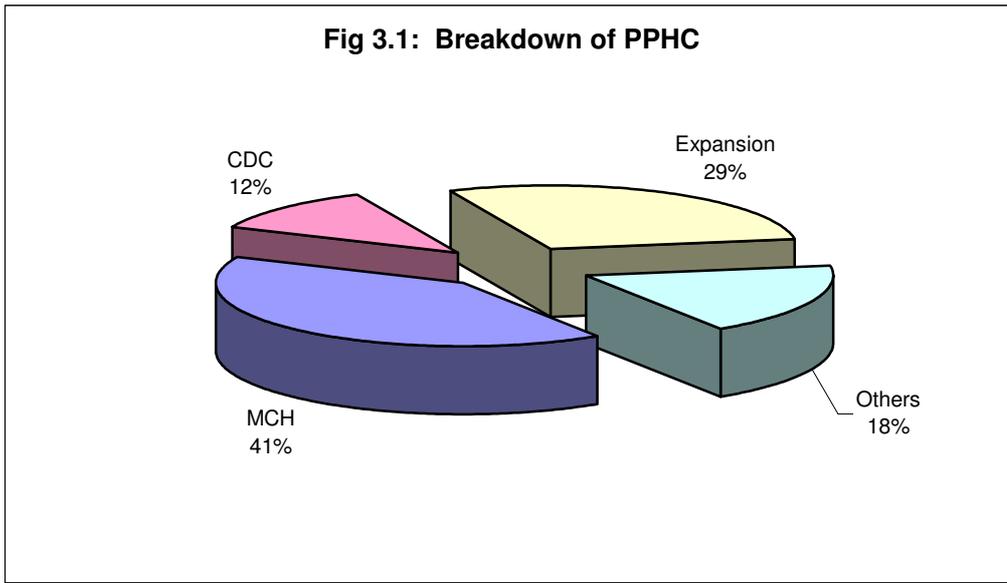
Functional Classifications	In millions of Birr			In percent		
	Service Delivery	Expansion	Total	Service Delivery	Expansion	Total
Administrative Expenditure	221.2	7.0	228.2	97%	3%	8%
Curative Expenditure	1673.4	211.2	1884.6	89%	11%	64%
Inpatient	254.3	153.9	408.2	62%	38%	14%
Outpatient	295.4	57.3	352.7	84%	16%	12%
Pharmaceuticals	1,123.7		1,123.7	100%	0%	38%
PPHC	516.9	214.0	730.9	71%	29%	25%
R&D	21.5		21.5	100%	0%	1%
Training	57.5	8.5	66.0	87%	13%	2%
Total	2,490.4	440.8	2,931.2	85%	15%	100%

The outpatient and inpatient services, with out pharmaceuticals, which include diagnostic procedures, as opposed to the preventive health care consume as much as PPHC. In EFY 1992, the expenditure for outpatient and inpatient services including rehabilitative care

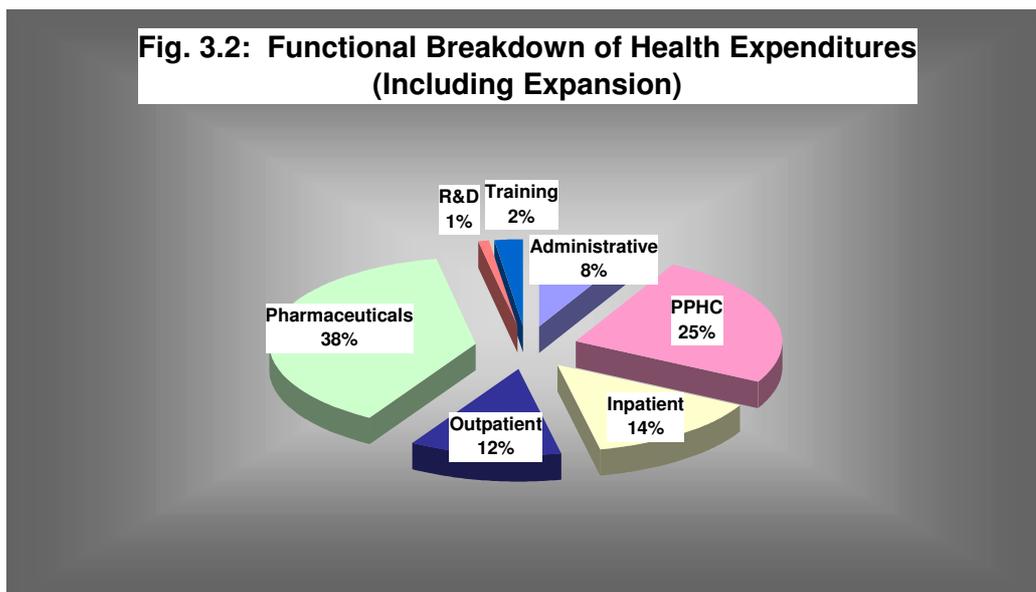
⁶ Curative care in this case is composed of inpatient and outpatient services including consultations, diagnostics and treatment using pharmaceuticals or other procedures.

⁷ promotive and preventive care comprise provision of vaccines for the Expanded Program of Immunization (EPI), maternal and child health containing vertical program like Family Planning, Adolescent and Reproductive health (ARH), Integrated Management of Childhood Illness (IMCI), nutrition and safe motherhood, prevention of non-communicable diseases, information, Communication and Education (IEC) etc

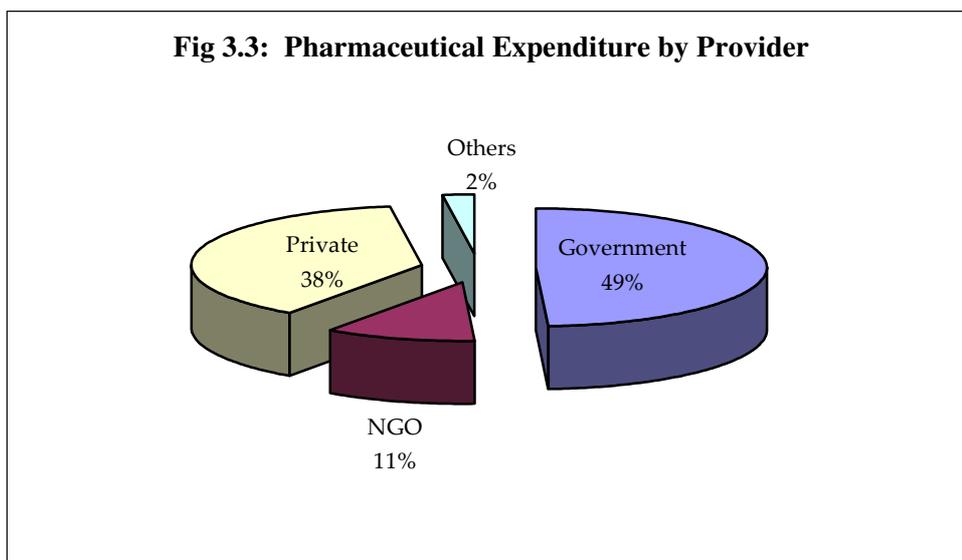
amounted to ETB 549.7 million which is 22 percent of the total health expenditure on service delivery. The major source of financing for these treatments comes from the households out of pocket expenditures. In contrast, the amount of total expenditure estimated at being used in the primary health care activities is Birr 517 million or about 21 percent of the total health expenditures on health service delivery. If one looks at the detailed compositions on PPHC, about 41 percent was spent on mother and child health while 29 percent was used for expansion of primary health care 12% for controlling communicable diseases. There are other services like IEC, non-communicable disease control, sanitation and environmental health that together consume 18% of resources.



The other major area of health expenditure is for the consumption drug and medical supplies. The total expenditure for drugs and medical supplies amounted to ETB 1.1 billion, which is 38 percent of the total health expenditure. Of these total drug expenditures, 833.5 million (74 percent) were financed by households.



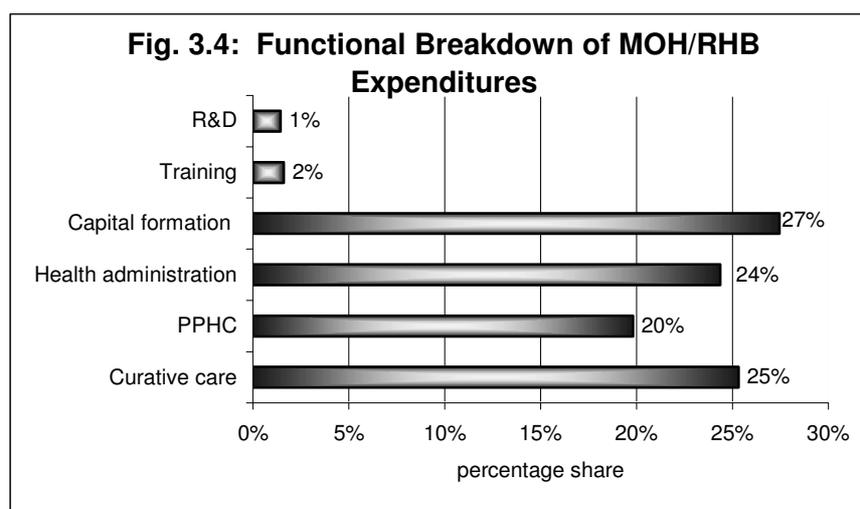
The analysis of the composition of health expenditures in health by various elements showed not only the importance pharmaceuticals in the health service delivery, but also the role that private drug outlets played in accessing households with drugs. Most of the household's out-of-pocket expenditures not only went into drugs but it was also spent on drugs supplied by private drug outlets. More than 74 percent of drug expenditures came from the private sector. This clearly shows that influencing availability, affordability and efficacy of drugs by the government largely rests more on its regulatory rather than delivery functions.



The analysis of functional distribution of expenditures has a completely different picture if we analyze public expenditures separately (see fig 3.3). Capital formation⁸ (expansion of health facilities as well as equipment) comes as category that takes the biggest share from total expenditures with 27 percent. This analysis largely supports the conclusions reached during the evaluation of HSDP I which states that “HSDP I implementation gave insufficient attention to the composition of expenditures and strategic shifts in funding were not achieved. Neither were important balances particularly between capital and recurrent expenditures maintained”⁹

⁸ Data on depreciation is hard to find and therefore capital formation of that year was simply taken as expenditure on health in the same year

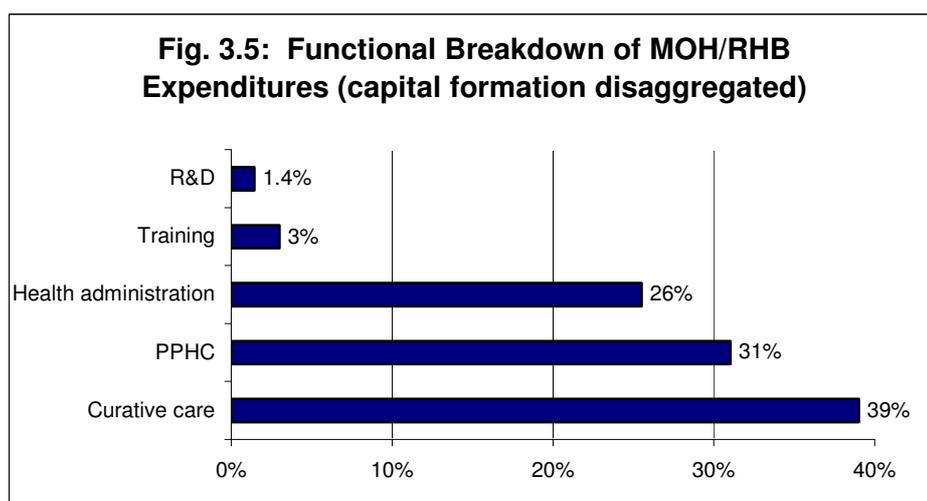
⁹ FMOH, 2003, Report on the Evaluation of HSDP I, Final report, volume 1, pp xv.



The second important factor that needs to be raised here is that although general health administration cost over all has been very low, public sector management cost has been found significantly high. It ranked third overall and consumed nearly 25 percent of total government expenditures. This has been the case in spite of questions and doubts on the quality and effectiveness of health management at all levels. With deepening decentralization to wereda levels to improve delivery of services and capacity building being undertaken since 2002, the health management expenditure is likely to increase. This could be verified by subsequent NHA studies.

So, what is left is distributed essentially between the primary and curative care. Curative care took about 25 percent of total health expenditures while preventive and promotive care did have a share of about 20 percent of total expenditures.

If we disaggregate capital formation into its functions (i.e. curative, preventive and administrative support), the functional distribution will have a slight improvement towards the proportion of primary care as many of the constructions are on facilities that are at or below the health center levels.



The one conclusion that emerged from the above analysis is that, in spite of the fact that the government's priority and area of focus remains on preventive and promotive health

care, the majority of the health expenditures and in particular government funding still goes to the curative care. This will continue to be the case until curative care providing health institutions, particularly hospitals, start generating and utilizing resources for their own use. Shifting resources to primary care therefore requires an articulated hospital financing strategy that clearly outlines the short to long term plan to bring market forces and efficiency into the hospital setting and release funds to PPHC. It also calls for committing any future expansions and delivery primarily on PPHC and stop expanding the expensive tertiary care.

3.2 Resource Allocation by Health Care Providers

The analysis according to provider types also displays the flow of funds by level of provider: hospitals, health centers and clinics, pharmacies, etc. The allocation across facility types, such as hospitals, clinics, shows where financial resources are consumed in the delivery system. The breakdown of facilities by ownership categories highlights the relative financial importance of the different actors in delivering health care. The analysis displays the flow of funds from the different financing intermediaries to the different types of providers classified by ownership: government-owned facilities, private-for-profit and not-for-profit owned facilities and diagnostic centers (See table 3.2). Government-owned providers accounted for about 68 percent of total spending in 1992, while hospitals and clinics owned and operated by the private sector (for profit and not for profit) took the remaining share.

Table 3.2: Total and percentage share of expenditures by ownership and level of providers

Provider	Expenditure in Birr	Percentage Share
Hospitals	798,314,144	27%
<i>Government Hospitals</i>	757,365,154	95%
<i>NGO Hospitals</i>	28,882,023	3.6%
<i>Private Hospitals</i>	12,066,967	1.5%
Providers of Ambulatory Care	395,940,144	14%
<i>Government (HP, HS, HC, parastatal clinics)</i>	231,050,646	58%
<i>NGO (HP, HS, HC)*</i>	51,371,439	13%
<i>Private Clinics** (small to specialized)</i>	100,720,368	25%
Drugs & Other med. Good Providers	581,898,896	20%
Public Health Providers	468,296,095	16%
<i>Government</i>	290,579,834	62%
<i>NGO</i>	177,716,261	38%
General Health Administrators	187,666,911	6%
<i>Government</i>	185,439,606	99%
<i>Private</i>	2,227,304	1%
Providers of Health Related Services	486,284,584	17%

<i>Research Institutes</i>	17,514,755	3.6%
<i>Training Institutes</i>	57,251,564	11.8%
<i>Others</i>	411,518,265	84.6%
Rest of the World	12,526,256	0.4%
Miscellaneous Providers	234,693	0.01%
GRAND TOTAL	2,931,161,723	100%

* include also some other government providers

** ERCS's ambulance and blood bank as well as FGAE's family planning centers are included in this category

4. Household Expenditure

This section uses data from a national household surveys in Ethiopia conducted by Central Statistical Authority (CSA) in an attempt to link household health expenditures to level total expenditures as well as relate household expenditure group with health seeking behavior.

Ethiopia is a low-income country with a per capita GNP of \$120. The restructuring of the economy and the redefinition of the role the state since 1994 has led the government to examine more closely its role in the financing and provision of social services such as health and education. This examination resulted in, first, the devolution of power to regions and, second, to the relative shift of resource allocations and expenditures towards social and economic infrastructures including education and health.

Ethiopian health care system has multiple sources of financing and provision (section 2). The government uses general revenues to provide health services for citizens through a network of health facilities it owns and manages. The government has a nationwide network of more than 3200 primary, 78 secondary and tertiary health care facilities¹⁰. In addition, some employers (government, private and NGOs) cover the cost of care for their employees. Many NGOs are involved in financing different types of health services. This section would single out the contribution of household in financing health services.

4.1 The Data

In 2000 the Central Statistics Authority conducted a nation wide Household Income, Consumption and expenditure (HICES) as well as Welfare Monitoring Surveys (WMS). The survey collected data on households' socio-demographic characteristics, health status, factors affecting the decision to seek care, utilization of outpatient and inpatient services, choice of provider, and out-of-pocket expenditures. The population sample is representative at national and regional levels. The HICES was collected in 1,264 enumeration areas in all regions with 17,332 sampled households. The WMS similarly was collected from 1984 enumeration areas in sedentary areas of nine regional states with 25,928 sampled households.

4.2 Health Seeking Behaviors and Choice of Providers

We analyze demand and utilization for health care services along two dimensions: patterns of illness reporting, and trends in seeking care (Figure 1). Out of the total 55.6 million people covered in the survey, twenty seven percent or 15.1 million individuals in the sample report an illness event within the previous two weeks. This indicates low morbidity levels in Ethiopia, probably due to lower propensity to report illness episodes.

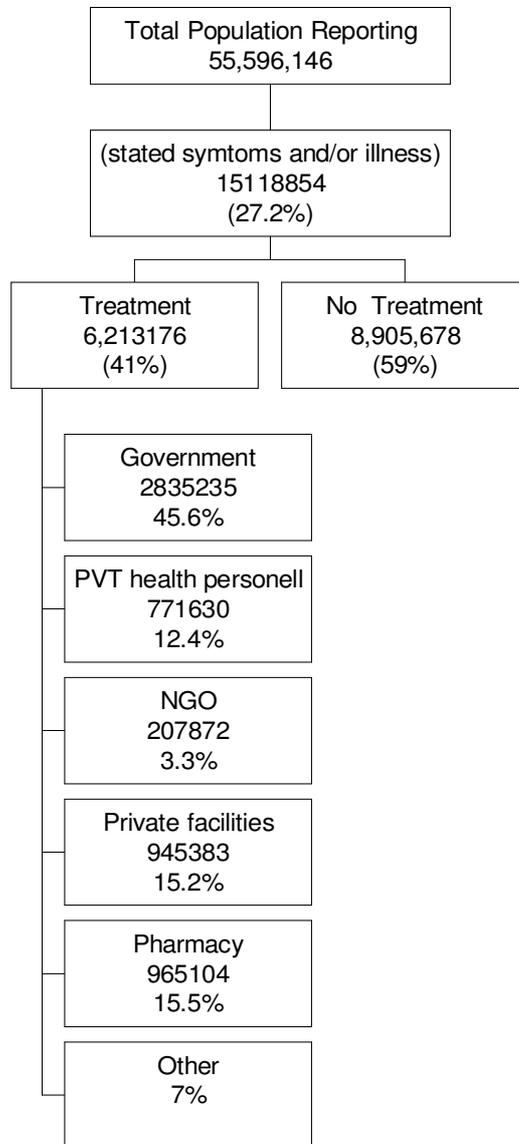
Of those reported illness, only 41%, or 6.2 million people sought any kind of formal medical treatment. This shows that the majority of people in spite of being ill did not seek any form of treatment. This low health seeking behavior should be one area of concern as it may have implications in improving the health status of the populations and thereby meeting millennium development goals. It may therefore be important to look in detail the determinants of health seeking behavior and capacitate people to seek care by taking actions based on the findings of the study.

About forty six percent of those who sought treatment visited government health facilities (hospitals, health centers, clinics and health posts). The second types of

¹⁰ FMOH, 1992, health and health related indicators, p 17.

providers those sought treatment visited were pharmacies that provided services for about 16 percent. Private facilities, private health personnel, and NGOs provided care to 15, 12, and 3 percent respectively. See figure 1 for details.

Fig 4.1: Reporting Illness and Outpatient Treatment by Provider



Overall, utilization rates of outpatient health services generally show better picture with 0.59 visits per person per year as compared to the usual 0.27 visits per person per year generated from routine reports. The utilization rates that are often reported using routine data are known to be incomplete and may have flaws in recording and reporting. This finding, which doubled the per capita visit per year, cast further doubt on the credibility of usual reports. It is therefore important to look for ways to improve data collections and analysis systems (to include non government service providers) to produce comprehensive and accurate reports.

Table 4.1: Estimation of per capita visit per year

Expenditure Quintile	Total Population	No. of Visits	Visit/person/year
1	8,576,182	4,485,920	52%
2	11,875,180	6,700,470	56%
3	11,075,165	6,249,016	56%
4	12,441,495	7,850,319	63%
5	11,628,12	7,643,893	66%
Average	55,596,149	2,926,617	59%

*In estimating per capita visit per year, a simple average were used in each visit category to arrive at the total visits. Ranges given in the WMS for frequency of visits were 1-3, 4-7, above 7 and not stated. It is assumed that the above categories have average visits of 2, 5.5, 8 and one visit per person respectively. Obviously, this is not likely to overestimate utilization, as the assumed averages are conservative.

Although the actual empirical determinants of health seeking behavior is a subject of future study, at least theory suggests that several factors, such as age, income, family size, education, gender and marital status, accessibility and quality of health services are likely to affect an individual's decision to report an illness. This study does not attempt to estimate the effect of these variables on the probability of reporting illness. This is beyond the scope set for the study. Nevertheless, attempt is made whether an income variation has significant impact on reporting illness and seeking care.

Findings from the survey show that there are no large variations across income groups in reporting sickness. It shows that the variation lies between 25 and 30 percent with the lowest income group reporting illness. When it comes to seeking treatment, however, the proportion of people who sought treatment increases with increasing expenditure quintile, reaching to 50 percent from that of 32. The reasons for this reverse relationship between reported illness and seeking care can be many including lower physical accessibility, high transaction cost to reach nearest facility as well as financial barriers for accessing necessary treatment. This, however, requires an independent and deeper analysis.

Table 4.2: Illness Reporting and Seeking Treatment by Expenditure Quartile

Expenditure Quintile	Total Persons	Reported Illness	Seeking Treatment	Proportion Reported	Proportion treated
1 st	8,576,182	2,614,943	847,478	30%	32%
2 nd	11,875,180	3,299,365	1,275,038	28%	39%
3 rd	11,075,165	2,950,266	1,166,447	27%	40%
4 th	12,441,495	3,356,034	1,485,665	27%	44%
5 th	11,628,127	2,898,246	1,438,548	25%	50%

When household income reaches a certain threshold, individuals prefer the private sector for outpatient care. Even though households have access to low cost government provided health services, the majority of outpatients with better income visit private sector providers. This probably reflects the better-perceived quality of services in the private sector, and the impersonal and poorly perceived quality of services in the government health sector.

4.3 Towards estimating Household Expenditure in Ethiopia

Health financing by Household expenditures clearly comprise one of the largest and most important sources of financing in Ethiopia's health care system. However, it is not easy to obtain an accurate estimate of the actual level of spending. Total household spending on health services can be estimated either from the revenues of health care providers collected or from surveys of households themselves. There are no reliable data available to estimate household expenditures from the supply side (revenues from health providing institutions) since revenue by private providers and a large number of drug outlets is difficult to obtain. The only feasible alternative left, therefore, is to use household surveys. However, these household survey data are not without limitation. Under or over reporting can be significant problem, in addition to other problems associated with sampling and non-sampling errors. For estimation of household health expenditures for the FY 1992 NHA, only one major source of information was available and used: data from the HICE of 1999/2000.

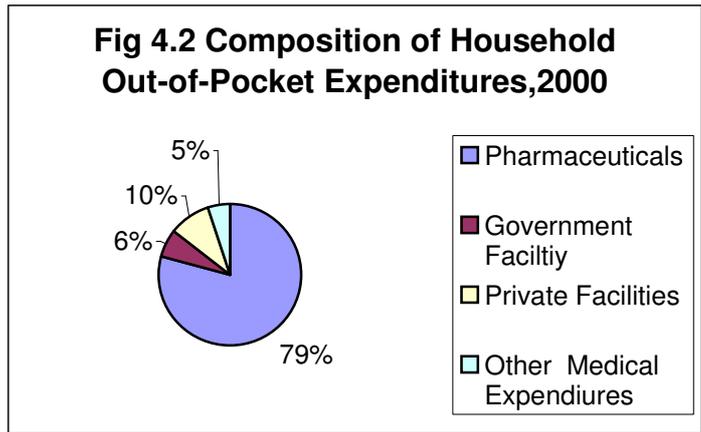
The estimated household expenditure from the survey should be taken with two important caveats. First, health expenditures are reported for 55.6 million people out of 63.4 million. This is essentially a result of exclusion of some areas (mainly pastoral) in the data collection. In order to take account of this, it is assumed that the average of rural expenditures can approximate the overall average of these communities. This may result in some underestimation. Second, the overall average health expenditure calculated from general totals does not agree with the estimated figure worked out based on averages given by expenditure category from the same source. It is therefore assumed that the details that are classified on expenditure categories are correct and are used in the estimation process.

With the above two important caveats, total household expenditure for 1992 is estimated at Birr 1.1 billion. This makes households as important as the government in financing health expenditures. Households account for 36.2 percent of total health expenditures.

When one looks at the composition of household expenditures, pharmaceuticals account for the lion's share (about 79 percent) in Ethiopia. With the exception of the production by few firms, which according to Drug Use Study¹¹ does not account for more than 13 percent of the pharmaceutical market share, all drugs are imported. The bulk of drugs consumed in Ethiopia are distributed through private pharmacies, and they account for a large proportion of total household spending on health. Any attempt to influence the affordability and availability of pharmaceuticals can significantly improve the welfare of households.

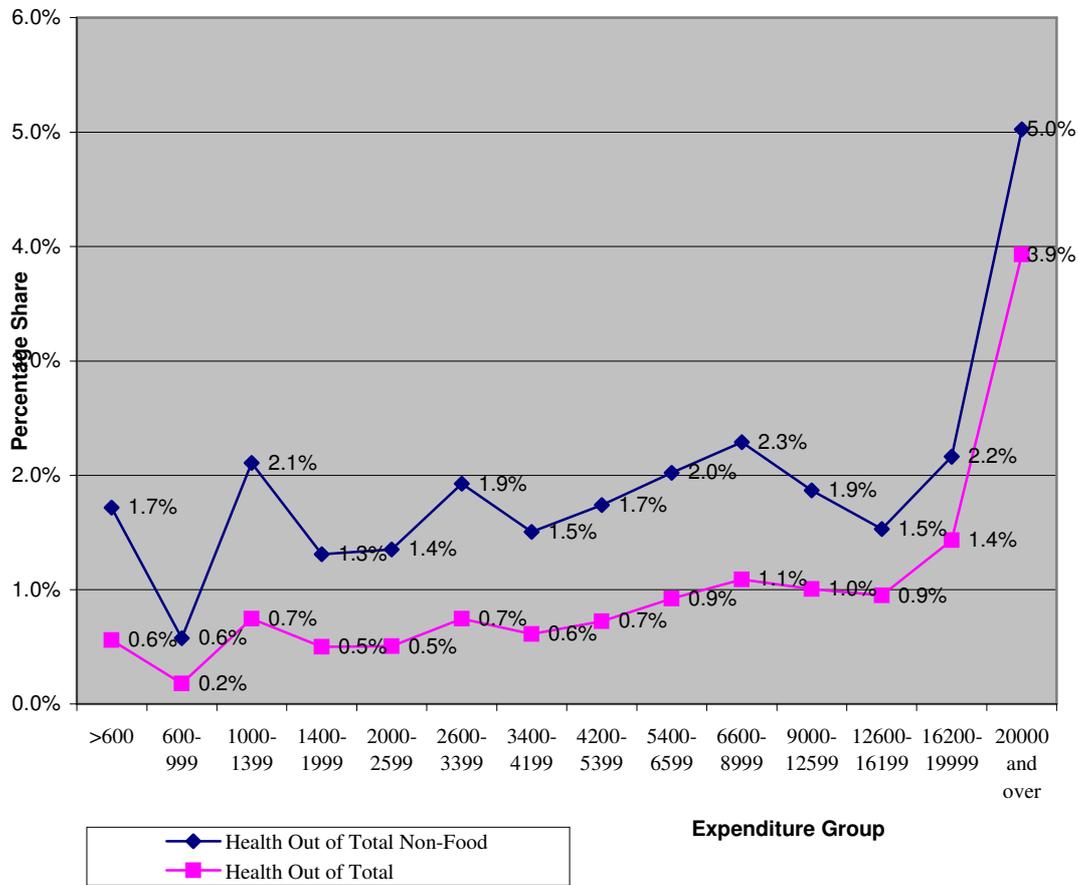
Expenditures for consultations and diagnosis on private facilities stand out a very far second with 10 percent. Expenditures on government facilities accounted for only 7 percent of household expenditures.

¹¹ FMOH, 2002, National Baseline Study on Drug Supply and Use in Ethiopia, Health Care Financing Secretariat



The general structure of household health expenditures in to different functions becomes more interesting when one analyzes it in relation to expenditures categories. In general, household health expenditures increase with increasing expenditure of households. On average, households spend about 1 percent of their total expenditures and 1.7 percent of non-food expenditures on health. There is, nevertheless, a very huge difference among households on the proportion of their expenditures on health. It varies from 0.2 to 4 percent of household expenditures, with most households spending between 0.5 to 0.9 percent of their expenditures on health.

Fig 4.3: Share of Health Expenditure Out of Total & Non-Food Discretionary Expenditure of Households by Expenditure Group



Individuals at the lower expenditure quintile often visit government facilities. This is understandable for three reasons. First, it may probably be the nearest health facility available; second, the waiver certificates only guarantee access to government health facilities; and finally, it is relatively affordable as compared to other providers.

Table 4.3: Share of Components out of Total Health Expenditure (By Expenditure Groups)

Annual Expenditure	Pharmaceuticals	Government Facility	Private Facility	Other med. Exp
>600	100%	0%	0%	0%
600-999	94%	1%	0%	5%
1000-1399	94%	4%	0%	2%
1400-1999	81%	9%	2%	8%
2000-2599	82%	4%	10%	5%
2600-3399	69%	4%	13%	13%
3400-4199	80%	7%	4%	9%
4200-5399	74%	5%	12%	9%
5400-6599	71%	5%	17%	6%
6600-8999	80%	5%	8%	6%
9000-12599	70%	11%	17%	2%
12600-16199	81%	8%	8%	3%
16200-19999	67%	15%	15%	4%
20000 and over	92%	5%	3%	1%
Total	79%	6%	10%	5%

People who spend less than 4200 Birr Per annum account for about 35 percent of the total population. These expenditure groups spend more than 80 percent of their health expenditures (more than the overall average) on drugs. With the exception of one category, one can generally say the poor spend disproportionately on pharmaceuticals. Those spending less than 1500 virtually spend it on drugs and those spending less than 2000 did not pay any thing to private facilities. People with expenditures less than 9000 (with the exception of two groups) spend less or equal to 5 percent of their health expenditures in government facilities. This may have resulted from the functioning fee waiver system that allowed many to have access to free consultations and probably diagnosis. What we observe as expenditures in this category is the expenditures of those who do not produce waiver certificates and pay at a very subsidized fees.

5. Conclusion and Policy Recommendations

Policy implications: IS GOVERNMENT spending its own drug budget efficiently and equitably? Is it maximizing the impact of its pharmaceutical budget? What instruments does it have in influencing other actors?

- ✓ Defining and updating realistic and cost-effective, evidence-based, performance-oriented and costed health strategies that give priority to tackling the major causes of ill health. These strategies should avoid the mistakes of superficial planning and poor estimating, and they should make clear the distribution of administrative responsibilities for their execution.
- ✓ Fundamental resource re-allocation ('zero-based budgeting'). The hold of some existing claimants on health budgets may need to be broken, requiring non-poor beneficiaries of subsidies to pay a higher share of their costs of treatment. Resources should be directed instead to disease prevention, to life-threatening childhood conditions and to livelihood threatening ill health of the poor. Public expenditure should not provide routine curative services that (a suitably regulated and encouraged) private sector can provide. There need s to be a clear articulated strategy on how to shift resource allocations towards primary care through improved hospital reform/financing. Budget allocations should be realistically related to performance targets.
- ✓ Tackling causes of waste and inefficiency, including overstaffing in headquarters and unsound procurement and supply practices.
- ✓ Instituting active performance management through timely and accurate reporting, monitoring, performance assessment, and use of assessments in resource allocation decisions.
- ✓ Improving skills in outsourcing clinical and non-clinical services. Major efficiency improvements have be achieved by contracting for services with non-governmental providers, e.g. for the provision of family planning, birth attendance and immunization services and for the supply and social marketing of drugs and consumables. But this is predicated on an ability to manage contracts and monitor their execution.

Annex I: Four basic Matrices

- a. How much did your firm provide to employees in direct reimbursement?
Birr.....
- b. How much did your firm pay for contractual agreements with providers?
Birr.....
- c. Which types of health care services does your firm reimburse?

To fill out the detailed expenditure by function, take samples of the last months of each quarter of the EFY i.e. September/Meskerem, December/Tahsas, March/Megabit, and June/Sene, record it on a separate sheet and attach it.

Functions	Amount in Birr	
	Reimbursement	Contract with provider
Services of Curative Care		
Inpatient Curative Care		
Outpatient curative care		
Services of rehabilitative care		
Services of long-term nursing care		
Ancillary Services to medical care		
Medical goods dispensed to outpatients		
Pharmaceuticals and other medical supplies		
Therapeutic Appliance and Other Medical Non-durables		
Prevention and public health services		
Health Administration and Health Insurance		
Health related functions		
Capital formation for health care institutions		
Education and training of health personnel		
Food, Hygiene and Drinking Water Control		
Research and development in health		
Environmental health		
Others		

- d. Does your firm keep records of the amount spent to reimburse for services purchased at private, NGO and public health care facilities?
- e.
 1. YES (If yes, please indicate the amount in the table below)
 2. NO

To fill out the detailed expenditure by function, take samples of the last months of each quarter of the EFY i.e. September/Meskerem, December/Tahsas, March/Megabit, and June/Sene, record it on a separate sheet and attach it.

Types of providers	Amount In Birr		
	Government	Private	NGO
Hospitals			
Nursing and residential care facilities			
Providers of ambulatory health care (outpatient care)			
Retail Sale and other providers of medical goods			
Provision and administration of public health programs			
General health administration and insurance			
<i>Institutions providing health related services</i>			
Treatment Abroad			

Functions	Amount in Birr							
	Providers							
	Hospitals	Nursing and residential care facilities	Providers of ambulatory care (clinics & health centers)	Retail Sale and other providers of medical goods (e.g. Pharmacy)	Provision and administration of public health programs	General health administration and insurance	Institutions providing health related services	Treatment Abroad
Services of Curative Care								
Inpatient Curative Care								
Outpatient curative care								
Ancillary Services to medical care								
Medical goods dispensed to outpatients								
Pharmaceuticals and other medical non-durables								
Therapeutic Appliance and Other Medical Non-durables								
Prevention and public health services								
Health Administration and Health Insurance								
Health related functions								
Capital formation for health care institutions								
Education and training of health personnel								
Food, Hygiene and Drinking Water Control								
Environmental health								

Annex 5.B. NATIONAL HEALTH ACCOUNTS: HEALTH INSURANCE QUESTIONNAIRE

Name of interviewer _____
Date _____
Verified by _____
Date _____

Form ID
No. ___/___

Instructions: The Ministry of Health is conducting the 1992 EFY (1999/2000) National Health Accounts (NHA) study to estimate the total amount of health financing in Ethiopia and how health funds flow from sources to uses. This information is being collected in order to assist the government of Ethiopia in policy, strategy and program design, implementation, monitoring and evaluation. In the space below, please indicate the amount of money that your organization received and then spent on health including administration in the year 1999/00 (1992 EFY).

The information provided will be treated with strict confidentiality.

1. General information:

Name of Insurance Company:.....
 Name of respondent:.....
 Position of respondent:.....
 Date of interview:.....
 Location:.....
 Reporting period-calendar year 1992 (1999/00)

Type of insurance company (*circle one*) 1= state-owned/parastatal
 2=Private-for-profit

2. In the table below, please indicate the number of subscribers (*for health insurance only*) to your organization at the end of the 1992 EFY. If health insurance is included as part of other insurance policies, please include those subscribers in your figure.

Number of subscribers:	
Group/Company	Individual/Family

3. In the table provided below, indicate your organization's total revenues for EFY 1992. If possible, use earned figures rather than cash figures.

Type of Revenue	Amount in Birr		
	Total	Group/ Company	Individual/ Family
Premium,			
Health Insurance			
Group Personal Accident (GPA)			
Workman's Compensation			
Total (<i>health business only</i>)			

Select the reporting basis: 1. Accrual*

2. Cash

note the period the activity was undertaken and not the time period the payment is/was made*

4. In the case of GPA or workman's compensation, have you paid compensation for partial/permanent disability?
 - a. Yes, if so please what amount in birr
 - (i). GPA _____ (ii) Workman's Compensation _____
 - b. No.

5. In the table provided below, indicate your organization's total expenditures (claims) on health for 1992 EFY on the following provider (*If possible use incurred figures rather than cash figures*):

Total claims: _____

Group/Company Claims: _____

Individual/Family Claims: _____

To fill out the detailed expenditure by provider type, take samples of the last months of each quarter of the EFY i.e. September/Meskerem, December/Tahsas, March/Megabit, and June/Sene, record it on a separate sheet and attach it.

Types of providers	Amount In Birr		
	Total	Group/Company	Individual/Family
Hospitals			
General Hospitals			
Central Government-owned general hospitals			
Regional/Zonal/District General Hospitals-- Government-owned			
Government-owned military general hospitals			
Government-owned police general hospitals			
NGO-owned general hospitals			
Private for-profit general hospitals			
Federal Mental Health Hospital (Mental Health and Substance Abuse Hospitals)			
Specialty Hospitals (other than mental health and substance abuse)			
Federal Government-owned specialty hospitals			
Regional/Zonal Government-owned specialty hospitals			
NGO-owned specialty hospitals			
Private for-profit specialty hospitals			
Nursing and residential care facilities			
Government-owned facilities for the elderly			
NGO Nursing Facilities			
Providers of ambulatory health care (outpatient care)			
Private Clinics (Offices of Physicians)			
Medium general clinics			
Higher general clinics			
ENT specialized private clinics			
Dermatology specialized private clinics			
Obstetric specialized private clinics			
Ophthalmologist specialized private clinics			
Pediatrics specialized private clinics			
Orthopedist specialized private clinics			

Types of providers	Amount In Birr		
	Total	Group/ Company	Individual/ Family
Outpatient care centers			
Family Guidance Association (Family Planning Centers)			
Medical and Diagnostic Laboratories			
Government-owned medical and diagnostic centers			
Private-owned medical and diagnostic centers			
NGO-owned medical and diagnostic centers			
Retail Sale and other providers of medical goods			
Pharmacies (Dispensing Chemists)			
Private pharmacies (pharmacy, drug shops, and rural drug vendors)			
Public (PHARMID and KENEMA) pharmacies			
Special Pharmacies			
Red Cross (NGO pharmacy)			
Retail sale and other suppliers or optical glasses and other vision products			
Retail sale and other suppliers of hearing aids			
Retail sale and other suppliers of medical appliances (other than optical glasses and hearing aids)			
All other miscellaneous sale and other suppliers of pharmaceuticals and medical goods			
General health administration and insurance			
Government administration of health			
Federal administration of health			
Regional administration of health			
Other (private) insurance			
Treatment Abroad			
Provider expenditure not specified by classifications			

Select reporting basis:

1. Accrual*
2. Cash

note the period the activity was undertaken and not the time period the payment is/was made*

6. Which types of health care services did you spend money on in 1992 EFY? and indicate amount in ETB

To fill out the detailed expenditure by function, take samples of the last months of each quarter of the EFY i.e. September/Meskerem, December/Tahsas, March/Megabit, and June/Sene, record it on a separate sheet and attach it.

Functions	Amount In Birr		
	Total	Groups/ Company	Individual/ Family
Services of Curative Care			
Inpatient Curative Care			
Outpatient curative care			
Basic Medical and Diagnostic Services			
Outpatient dental Care			
All Other Specialized Medical Services			
All Other Outpatient Curative Care			
Services of rehabilitative care			
Outpatient rehabilitative care			

Functions	Amount In Birr		
	Total	Groups/ Company	Individual/ Family
Services of long-term nursing care			
Inpatient long-term nursing care			
Ancillary Services to medical care			
Clinical Laboratory			
Diagnostic Imaging			
Patient Transport and Emergency Rescue			
All Other Miscellaneous Services			
Medical goods dispensed to outpatients			
Pharmaceuticals and other medical non-durables			
Prescribed medicines			
Over-the-counter medicines			
Other medical non-durables			
Therapeutic Appliance and Other Medical Non-durables			
Glass and Other Vision Products			
Orthopedic Appliance and other Prosthetics			
Hearing Aids			
Medico-technical devices including Wheelchairs			
All other miscellaneous Medical goods			
Health Administration and Health Insurance			
General Government Administration of Health			
Health administration of private insurance			
Health related functions			
Capital formation for health care institutions			
Education and training of health personnel			
Food, Hygiene and Drinking Water Control			
Environmental health			

7. Do the revenue figures above include the portion of premiums for combined life/health policies?
- a. Not applicable
 - b. No (*If no, please enter total benefits paid under such combined policies in the table below for (year/s of focus of the study)*)
 - c. Yes
8. In the table provided below, indicate your organization's total expenditures (claims) for 1992 EFY by branch (*If possible use incurred figures rather than cash figures*):

8. Please summarize in the table below the supports your organization provided to various parties by type of provider in the 1992 EFY (1999/00).

Provider	Amount (in birr)
Federal Hospitals, Training and Research Institutions	
Private for Profit out patient centers	
NGO facilities	
Pharmacies	
Regional hospitals, out patient centers, training and research institutions	
Armed force hospitals	
Police general hospitals	
Employer facilities	
Administrative and general services	
Others	

* Program area is here defined as area of focus of the project (for details see page 5)

Note: Please provide value of in kind contributions as well.

Program Areas*:

- Services of Curative Care (Inpatient, outpatient and basic medical diagnostic services)
- Ancillary Services to medical care
- Medical goods dispensed (Pharmaceuticals, medical supplies, and therapeutic appliance)
- Prevention and Public Health Services
- Health Related Functions
 - Capital investment (construction of health care facilities)
 - Education and training of health personnel
 - Food, hygiene, and drinking water control
 - Research and development
 - Environmental health

Annex 6: List of NHA Team Members

Annex II: The Nazreth Consensus

Annex III: Projections from samples and incomplete data

3.1 Employer Expenditures

- Manufacturing industries: the Central statistical office has provided data on the number of people engaged in the manufacturing industry for 1992. The sample survey provided an average expenditure of Birr ... per employee. The total health expenditures are then projected to be the same on per capita basis for the selected firms for projection. It is important to note that not all firms included in the manufacturing survey cover health expenditures as benefits to employees. Consequently, firms with employment level of 50 and below are excluded in the sample and in the projection processes. The functional and provider classifications of expenditures for this source are projected from the sample of actual invoices collected from sampled employers in sampled month from each quarter
- Construction sector: 200
- Agricultural firms: 100
- Service sector: 25
- NGOs:
 - Local 10
 - International 100

3.2 NGO Health Program Expenditures:

In total about 23 international and local NGOs were surveyed. According to the reports from DPPC, the organ instructed with the power to coordinate NGOs. About ... international and ...national NGOs were operating in the health sector.

Projections are made separately. It is assumed that international NGOs (INGOs) are comparable in there level of expenditures, on the average. The average level of health expenditures from surveyed INGOs can therefore be extended to the non surveyed ones. The total number of INGOS that did not respond to the survey were 13 and projection are made for these INGOS.

When it comes to national NGOs (NNGOs), most of the major NGOs (in terms of significance of expenditures) are captured in the survey. Although there were more than 100 NNGOS that were not surveyed, most of them were assumed to have little contribution to health expenditures. Only ... NNGOs were considered as playing a role in the delivery of health services. The average of these NGO expenditures is considered half of the average of the sampled ones.

3.3 Donor Expenditures: 25 percent

Annex IV: Assumptions used in functions and provider classifications

Annex V: Questionnaires

Annex VI: List of NHA Team Members