



Opportunities to align supply chain, market shaping and health financing functions and policies

ETHIOPIA



Access to essential medicines and other health products is fundamental to achieving Universal Health Coverage (UHC) and improving population health¹. To successfully ensure that people receive the medicines and health products they need, governments must take a complex set of actions that span health financing, supply chain and market shaping policy. They must:

- Set priorities about which services and products they will fund
- Forecast the amount of products to buy based on population health needs
- Use market shaping tools to promote adequate supply of quality products at the best prices
- Ensure that enough resources are allocated in budgets
- Ensure that funds flow effectively through the various health financing arrangements to cover the costs of medicines and products
- Ensure that the procurement and distribution of commodities functions well and the products reach the end users
- Ensure the flow of funds, pricing and payment to providers align with the flow of products through supply chains

This brief examines how Ethiopia's health financing, supply chain, and market shaping functions align and intersect — and where they fall short in reinforcing each other and working together — to inform strategies, policies, and learning aimed at ensuring more reliable, better-financed access to essential medicines and health products.

Strengthening alignment between health financing, supply chain, and market shaping functions and policies is vital to ensure that the flow of financing aligns with the flow of products for reliable and affordable access to quality primary health care (PHC).



GOVERNANCE

Ethiopia has a National Drug Policy (NDP) that provides the overarching policy and regulatory framework to ensure the safe, effective, and affordable availability of essential medicines, while regulating their use and distribution. The NDP was first established in 1993 and while it has been revised over time, it is considered to be outdated and inconsistent with Ethiopia's current health system realities². Ethiopia's NDP does not explicitly address financing modalities or align with the current health financing arrangements, but there are efforts to harmonize across essential service/benefits packages, the essential medicines list (EML), and procurement lists. When the Essential Health Services Package was defined and costed, the medicines, commodities, and supplies required to deliver the interventions were identified through clinical guidelines and quantified, and unit price information was added from the Ethiopian Pharmaceutical Supply Agency (EPSS) and the Logistics Department of the Ministry of Health (MOH)³.

SOURCES OF FINANCING FOR ESSENTIAL MEDICINES

Ethiopia's essential medicines financing landscape is characterized by a mix of government budgets, donor contributions, household out-of-pocket (OOP) spending, and Community Based Health Insurance (CBHI). These sources differ in their predictability, flexibility, and vulnerability to delays — creating fragmentation and undermining supply chain efficiency. Health facilities maintain a Revolving Drug Fund (RDF) in which essential medicines funding is maintained.

ESSENTIAL MEDICINES FINANCING SOURCES⁴:

Government Treasury (32.2% of Current Health Expenditure (CHE); 2.6% of which is spent on essential medicines)	Funds are allocated using input-based line-item budgets. While relatively stable, budgets are often subject to delayed release and are rarely adjusted for inflation or actual facility needs.
CBHI (0.9 % of CHE; 60% of which is spent on essential medicines)	CBHI claims payments are a flexible source of revenue but unpredictable. Paper-based claims processing and delayed payments reduce the reliability of this funding stream.
Donors (33.9% of CHE; 7% of which is spent on essential medicines)	Donor funds are typically earmarked for specific programs (HIV, tuberculosis (TB), malaria, vaccines, nutrition, family planning, and maternal and child health) and managed through vertical mechanisms. These are poorly integrated with national systems and subject to disbursement delays due to reporting and compliance requirements.
Out of Pocket (OOP) (30.5% of CHE; 65% of which is spent on essential medicines)	A large share of essential medicines spending comes directly from patients through RDFs, particularly during stockouts. Medicines procured through private channels can cost up to 3–5 times more than EPSS rates, placing a heavy burden on families.

Methods

Results for Development (R4D), with support from the Gates Foundation, conducted a multi-country rapid analysis in Ghana, Ethiopia, Nigeria, and Tanzania to examine existing linkages between supply chain, health financing, and market shaping functions and policies. An opportunistic qualitative analysis was conducted, guided by a set of analytical questions focused on the following themes: forecasting and budget formulation, budget execution, pricing, funds flow and provider payments, and data systems. Data was gathered through document reviews and key informant interviews with technical staff from relevant MOH departments, Ethiopia's public pooled procurement entity, regulatory authorities, health financing agencies, regional and district health management teams, and health care facilities.

FORECASTING AND BUDGETING



Forecasting

PHC facilities use past consumption, population size, patient load, and disease burden to forecast essential medicine needs. The Ethiopia Pharmaceutical Supply Service (EPSS – public pooled procurer) issues a costing guideline with price estimations used to determine the budget per the forecasted need. Requests are compiled by Woreda Health Offices (WoHO) and rolled up to Regional Health Bureaus (RHB). There is variation in how facilities complete forecasts and the quality of the estimates. Challenges include the lack of a standardized forecasting framework, limited capacity at facility level to conduct forecasting, data gaps from outdated population figures, poor consumption records, and limited capture of service expansions. Few facilities document forecasts, and weak digital systems — such as limited Electronic Community Health Information System (eCHIS) use at health posts — further undermine reliability. While WoHOs and RHBs compile the bottom-up requests of facilities, they often adjust them based on historical spending.



Budgeting

Budgeting follows Ethiopia's federal–regional structure.

- The Ministry of Finance (MOF) sets overall health sector ceilings through the Macroeconomic Framework (MEF).
- At the federal level, the MOH develops budgets for its direct functions, including for co-financing program commodities (HIV, TB, malaria, vaccines, nutrition, family planning, and maternal and child health) that are heavily donor-financed.
- At the regional level, RHBs develop comprehensive health budgets, incorporating estimates from WoHOs and health facilities.

In theory, facility and Woreda forecasts should guide budget allocations. In practice, historical spending patterns and top-down directives dominate budget decisions, and allocations rarely reflect facility-level estimates. This creates challenges particularly for rural and remote health facilities, which face larger gaps due to allocation formulas that favor more urban, densely populated regions.

For program commodities, budget allocations from the MOF also tend not to match the gaps identified in national forecasts once donor contributions are factored in. Overall, there is little to no integration between RDF-managed essential medicines and donor-supported program commodities in the budgeting process.



Misalignments Between Forecasting and Budgeting

There is a persistent disconnect between forecasting and budgeting:

- Facility and Woreda-level estimates are often revised downward by regional and federal authorities to align with available ceilings.
- Final budget allocations rarely reflect the true demand documented through bottom-up forecasts.
- Budget ceilings, set by MOF, prioritize macro-fiscal stability rather than health sector needs, leading to systematic under-budgeting for essential medicines.

The misalignments between forecasting and budgeting mean that essential medicines are chronically under-financed, with procurement plans shaped by budget envelopes rather than epidemiological or consumption-based needs. Program commodities fare somewhat better due to donor co-financing but remain siloed. The absence of a unified, gap-driven budgeting process undermines the ability to match commodity financing with actual demand, perpetuating stock-outs, inequitable allocation (especially in rural areas), and dependence on donor-led systems for critical public health programs.

Ethiopia has recently introduced the Committed Demand and Supply System (CDSS), a government-led approach that directly links demand forecasting, financing, and procurement to ensure supplies match committed budgets. By reconciling facility-level forecasts with available funding and integrating tools like forlab+ (electronic forecasting and supply planning tool) and the national eLMIS (“Dagu”), CDSS creates binding commitments that drive procurement, reduce stockouts, and enhance transparency. This reform represents a major step toward a more efficient, data-driven, and sustainable supply system that strengthens access to essential medicines.

BUDGET EXECUTION

Delays in the release and execution of funds for essential medicines and health products are widespread across all financing sources. Fund flows are slowed by rigid public financial management (PFM) procedures, multi-layered approval chains, and lack of real-time data integration. Donor and CBHI funding are particularly prone to delays due to compliance requirements, documentation burden, and limited digitization. Although domestic funds are earmarked for essential medicines, fragmented planning and siloed revenue streams often result in partial or delayed allocations that are poorly aligned with actual needs. Donor co-financing flows are typically managed at the national level through the MOH, bypassing subnational actors and further complicating timely execution.

These constraints leave facilities and EPSS operating with cash flow gaps, deplete RDFs, and force reliance on open (private) market procurement at significantly higher prices — eroding value for money and exacerbating inequities in access.

Source	Key Constraints
MOF Releases (Federal and Regional Budgets)	Budget releases to RHBs and WoHOs are often delayed or partial due to fiscal constraints, lengthy approval processes, and weak cash forecasting.
Government Co-financing (Program Commodities)	Co-financing commitments are unpredictable and frequently revised downward during execution; not synchronized with regional or facility-level needs, leading to procurement delays and shortfalls.
CBHI Funding	Delays in claims reimbursements and fragmented fund management limit the ability of facilities to maintain stock levels and meet demand.
Donor Funding	Donor procurement cycles and national-level management of commodities are often out of sync with local needs; flows bypass subnational systems, creating parallel channels and misalignment with domestic timelines.
Revolving Drug Funds (RDFs)	RDFs are depleted due to delayed reimbursements and cost escalation; limited mechanisms exist to replenish or adjust prices in line with inflation.

Table 1: Sources of essential medicine financing in Ethiopia and budget execution delays

Delayed budget execution has led to stockouts of essential commodities due to late procurement and disbursement, while the erosion of purchasing power from inflation further reduces the value of released funds. These constraints have forced increased reliance on emergency private procurement—sometimes at prices up to 500% higher — draining limited health budgets and exposing patients to additional costs. As a result, service disruptions are frequent, particularly in maternal and child health programs that depend on the consistent availability of essential medicines and health products.

POOLED PROCUREMENT: ETHIOPIA PHARMACEUTICALS SUPPLY SERVICE

EPSS is the central public pooled procurement and distribution agency for essential medicines in Ethiopia. It manages pooled procurement for facility-level RDFs, leveraging bulk purchasing to achieve lower prices. EPSS serves as the primary supplier to all public facilities and sets price benchmarks across the health system, with this function continuing to evolve and mature over time. Currently, EPSS is working on improving its market intelligence capacity to have a better grasp on pricing as well as working with local or regional wholesalers to procure low-volume medicines efficiently.

However, EPSS currently operates with limited visibility into total health facility revenues or essential medicines financing from sources like CBHI, donors, or user fees. This constrains its ability to plan effectively and undermines the alignment between procurement volumes and actual need.

Key Functions of EPSS

- Conducts bulk national tenders and framework contracts.
- Maintains a product costing manual and guidelines for price setting and shares an annual quantification template that includes estimated essential medicines prices with facilities. Prices are generally lower than private suppliers and act as a reference point for the public system, including CBHI payments.
- Distributes commodities to health facilities, typically via a pull system. Requires “certificate of non-availability” before facilities can procure from the open (private) market.

Challenges

- **Procurement delays and stockouts related to financing:** Frequent due to inflation and currency fluctuation eroding real purchasing power, limited and delayed government budget flows, and historically due to limited forex.
- **Price distortions:** During EPSS stockouts, facilities pay two to five times more through private suppliers.

- **Price Setting and market shaping:** Although EPSS is currently working on improving its market intelligence capacity to get better at setting prices in a dynamic market (inflation and currency fluctuations), it is not yet fully established in its ability to play a strong market shaping role such as price benchmarking, reconciling EPSS pricing with reimbursement tariffs under CBHI, demand aggregation across financing streams, or introducing price discipline across the private sector.
- **Lack of data integration:** EPSS has poor visibility across financing, supply chain and service delivery data.

EPSS is a well-respected institution — the cornerstone of the country’s public supply chain system and a central actor in ensuring access to essential medicines nationwide. The government is actively working to allay specific financing bottlenecks that undermine the effectiveness of EPSS. For example, Ethiopia has taken several positive steps to mitigate its forex challenges for essential imports, including medicines. The government’s Foreign Exchange Directive No. FXD/01/2024 liberalized the forex regime by eliminating mandatory surrender requirements, allowing banks to buy and sell foreign currency at market rates, and lifting import restrictions on multiple product categories. At the same time, the National Bank of Ethiopia has begun holding regular bi-weekly foreign exchange auctions to better allocate hard currency to private sector importers — ensuring suppliers of essential medicines receive preferential access to forex.

PRICING

Price Setting

Essential medicines pricing in Ethiopia is fragmented, with wide variation between public and private markets. In the public sector, EPSS sets prices through pooled national procurement and applies a standard 10% mark-up on locally manufactured products and 30% on imported products, averaging 27% nationally. Prices are reviewed periodically, but inflation and currency fluctuations make maintaining a stable price list difficult. EPSS is developing a price database to strengthen price intelligence and evaluate vendor quotations, part of broader efforts to institutionalize more systematic pricing practices.

In the private sector, wholesalers face forex volatility and minimal price regulation, with mark-ups typically ranging from 20–40%, while pharmacies apply unregulated mark-ups that can reach two to five times EPSS prices, particularly during stockouts. For example, a cefepime injection procured through EPSS costs ETB



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60, compared to ETB 160–170 from private wholesalers, and ETB 300 in private pharmacies. Medicines procured through EPSS remain the most affordable due to pooled purchasing and centralized price negotiation. Facilities must obtain a certificate of non-availability before buying from the open (private) market, yet delayed reimbursements and depleted RDFs often push them toward doing so. Geographic disparities further compound these challenges — in regions such as Gambela, retail mark-ups can reach 147% above national averages due to transport costs, limited suppliers, and weak regulatory oversight.

Drivers of Price Variation

Several underlying factors continue to drive significant variation in essential medicine prices across Ethiopia’s public and private markets, as summarized in Table 2 below.

Challenge	Description
Fragmented pricing and weak regulation	Absence of a national price registry or unified pricing authority allows large price variations across suppliers and facility types.
Inflation and forex volatility	Frequent currency depreciation and inflation make price lists quickly outdated and complicate cost recovery for EPSS.
Disconnect between EPSS and CBHI tariffs	Limited coordination between EPSS prices and CBHI reimbursement rates leads to underfunding and payment gaps.
Inequitable geographic access	Rural and remote facilities face higher procurement and transport costs, leading to inflated retail prices and reduced availability.
Limited cost transparency	Mark-ups at multiple levels (EPSS, wholesalers, pharmacies) are poorly tracked, and delivery costs are rarely reflected in final prices.

Table 2: Drivers of price variation

Ethiopia has made significant progress in strengthening EPSS’s market shaping and pricing capacity, though this remains an evolving area. Through the Ethiopia Market Shaping Capacity Improvement Program (EMSCIP), EPSS has established a Quantification and Market Shaping Directorate (QMSD) and developed a national market-shaping strategy to improve procurement efficiency, supplier management, and pricing intelligence. These reforms have already shortened procurement lead times, improved forecasting accuracy, and increased cost recovery. However, EPSS still requires stronger data linkages and policy coordination to play a fully strategic role — including benchmarking prices, aligning CBHI tariffs with procurement costs, and enforcing price discipline across markets. Continued integration of pricing, financing, and supply chain data will be essential to sustain affordability, efficiency, and equity in Ethiopia’s pharmaceutical system.

FUNDS FLOW AND PROVIDER PAYMENT

Health facilities receive revenue into their RDFs through different payment mechanisms — line-item budgets, fee-for-service, or capitation payment — depending on the funding source. The payment for medicines may be kept separate or bundled in with the service payment. The government budget is allocated to facilities using an input-based line-item budget, with a separate line for essential medicines. CBHI payments to providers are made either through fee-for-service, or through capitation in some pilot areas. In both cases CBHI payments for essential medicines are bundled in with service payments. At least 60% of health facility revenue coming from CBHI or out-of-pocket payments must be deposited into the DRF and used to procure essential medicines.

The tariffs paid by CBHI are set by the Ethiopia Health Insurance Service (referencing EPSS prices), however there is no systematic process between EPSS and CBHI to coordinate prices and tariffs. These tariffs are often not updated regularly or actively aligned with EPSS prices, leading to provider payment gaps and underfunding.

Funding Source	Payment Mechanism	Are payments for medicines bundled into service payments?	Notes
Government budget	Line-item budget	No	Strictly allocated to essential medicines line-item, minimal flexibility
CBHI	Fee-for-service	Yes	Retrospective payment based on claims according to a tariff schedule; at least 60% of revenue deposited into RDF and used to procure essential medicines.
	Capitation (pilot)	Yes	Prospective per-person payment based on the number of population served; at least 60% of revenue deposited into RDF and used to procure essential medicines
Out-of-pocket-payments	Fee-for-Service	No	Collected from patients at the time of service delivery; at least 60% of revenue deposited into RDF and used to procure essential medicines.
Donors	Donor Programs	No	Provided through co-financing with federal government domestic financing, or gap filling

Table 3: Provider payment mechanisms for essential medicines in Ethiopia

Government allocations are typically rigid and earmarked, while CBHI payments — bundled with service reimbursement — are often delayed or insufficient to cover the prices of essential medicines and health products, especially when facilities must procure from private suppliers during EPSS stockouts. A 2022 study of Shen Motta Hospital and Motta Health Center, both CBHI-associated facilities, found that medicines were stocked out for an average of 38.8 days in the hospital and 11.2 days in the health center over a six-month period. Situations like this have raised concerns about how essential medicines shortages undermine CBHI’s financial protection role.⁷ Although capitation pilots under CBHI have shown promise by improving predictability and reducing administrative burden — helping facilities maintain better drug availability⁸ — donor programs continue to operate parallel commodity flows that fragment the financing architecture. The absence of an integrated national framework to estimate total

financing needs, align CBHI tariffs with procurement realities, or streamline reimbursement across funding sources places heavy administrative burden on health facilities, exacerbating stockouts and weakening system efficiency.

These challenges are reinforced by findings from the 2024 study “An Assessment of Provider Payment Mechanisms in Ethiopia”⁹, which concludes that the country’s current mix of line-item budgeting, fee-for-service, and emerging capitation and performance-based mechanisms fails to reflect the cost of care—particularly for essential medicines and health products. Because CBHI and other purchasing arrangements bundle services and medicines, reimbursement rates are obscured and often fall short of actual procurement costs, forcing facilities to absorb financial losses or shift to more expensive private suppliers. The study further notes that tariffs and payment schedules are constrained by fiscal ceilings rather than updated cost data, resulting in underfunded claims payments and persistent inefficiencies in essential medicines financing. Together, these findings highlight the urgent need to align provider payment rates with real input and commodity prices and to strengthen financial integration between CBHI, EPSS, and public financing systems to ensure sustainability, affordability, and continuous availability of essential medicines.

DATA SYSTEMS

Multiple Data Systems for Financing, Supply Chain and Service Delivery

Ethiopia has multiple data systems supporting financing, supply chain and service delivery. The table below lists a few and is not comprehensive. These systems operate in silos and are fragmented, resulting in information gaps across the supply chain.

System	Purpose	Managing Entity
Integrated Financial Management Information System (IFMIS)	Public financial management system for budget execution	Ministry of Finance
Auditable Pharmaceutical Transactions and Services (APTS)	Tracks facility-level transactions and revenue from medicines	Regional Health Bureaus
Forlab+	Electronic forecasting and supply planning tool	EPSS
Health Commodity Management Information System (HCMIS)	Electronic logistics management system for end-to-end visibility	EPSS
Electronic Logistics Management Information System (e-LMIS)	Tracks stock levels, inventory, and consumption at health facilities	EPSS (limited rollout)
Quantimed/ForLAB	Used for quantification and forecasting of commodity needs	MOH & partners (manual updates)
Model 19	Physical logistics transaction document used by health facilities to receive pharmaceuticals from designated suppliers	Health facilities and EPSS (paper based)
District Health Information System (DHIS2)	Aggregates service delivery data	MOH
Claims information system for CBHI	Currently manual, a digital process and platform is being designed including — enrollment, claims management, and disbursements	Ethiopian Health Insurance Service

Table 4: Illustrative list of health sector information systems in Ethiopia — spanning financing, supply chain and service delivery.

Gaps

- **Fragmentation and poor interoperability** between systems such as IFMIS, HCMIS, and DHIS2 hinder comprehensive visibility of essential medicines and health products and hamper planning, gap estimation and real-time decision-making.
- **Limited data use in budgeting**, as forecasting outputs from quantification exercises are not systematically applied in budget development or allocation.
- **Manual processes persist in critical areas** such as CBHI claims and budget reconciliation, increasing delays and administrative burden.
- **Data quality and timeliness** are inconsistent across facilities, with many lower-tier facilities facing gaps in reporting and digital infrastructure.
- **Limited access and feedback loops**, as facility-level staff often lack actionable data and insights to improve ordering and stock management.

EPSS is currently working on several system improvements, including piloting interoperability between HCMIS and APTS, aiming to align consumption, revenue, and procurement data; the rollout of e-LMIS aims to improve visibility across the supply chain (coverage remains limited); and under the CDSS program there is growing interest in aligning forecasting tools with budgeting cycles to close the planning–execution gap.

RECOMMENDATIONS



Establish an integrated essential medicines and health products financing framework:

Consolidate government line-item budget, CBHI, donor, and user fee resources under a unified pharmaceutical planning and budgeting process, with aligned provider payment rules and digital tracking across all sources.



Institutionalize forecast–budget linkages: Formalize the link between forecasting and budgeting, requiring reconciliation between quantification outputs and essential medicines and health products budget allocations, actively identifying financing gaps.

Ethiopia has recently introduced CDSS, a government-led approach that directly links demand forecasting, financing, and procurement to ensure supplies match committed budgets. The full implementation of CDSS should alleviate the mismatch between forecasting and budgeting and provide the needed data to inform gap estimation and advocacy for continued domestic resource allocation for essential medicines.



Fully integrate donor supported program commodities forecasting and budgeting processes into government systems:

With shifts in the global health financing landscape, donor support for program commodities (HIV, TB, malaria, family planning, vaccines, and nutrition) is likely to vary. This creates an opportunity to harmonize donor-funded support with national forecasting and budgeting for essential medicines and health products, ensuring full integration into country systems.



Establish a national price governance mechanism: Create a coordinated essential medicines and health products pricing and market intelligence platform to manage a national price registry, conduct regular cost and market analysis, and publish benchmark pricing and markup guidelines. This would reduce price variability and support more equitable, cost-effective procurement practices. A market-shaping strategy implemented through demand aggregation, supply planning, transparent pricing, and coordination with key financing and procurement actors can unlock system-wide savings and improve access.



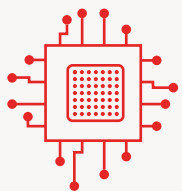
Advocate for timely budget and provider payment disbursements: Use evidence on stockouts, price volatility, and service delivery gaps to raise awareness of the financial and health costs of delayed insurance reimbursements and MOF/MOH budget releases. Develop tools to systematically monitor disbursement timelines and associated opportunity costs.



Harmonize public procurement costs with provider payment rates: Ensure CBHI reimbursement rates reflect actual health facility procurement costs, especially from EPSS, to avoid provider losses and maintain supply chain sustainability.



Assess CBHI capitation pilot to optimize essential medicines and health product allocation within bundled payments: As Ethiopia pilots' capitation under the CBHI scheme, it offers an opportunity to reduce administrative burden and provide greater financial autonomy. To maximize the effectiveness of this payment model, it would be prudent to determine the optimal share of the per-capita bundled payment that should be allocated to essential medicines and health products. This assessment should consider Ethiopia's specific pricing dynamics and supply chain and operational costs to ensure capitation amounts sufficiently cover needs without compromising service quality or financial sustainability.



Integrate data systems across the supply chain: Link siloed information systems to enable end-to-end visibility of financing, supply chain and service delivery data. A unified dashboard should enable real-time monitoring of commodity needs, financing flows, stock levels and service delivery gaps — improving transparency, accountability, and timely decision-making.



Leverage peer learning platforms: While each recommendation will require country-specific dialogue and stakeholder engagement, there is also a unique opportunity for countries such as Ethiopia to share experiences, assess effective practices, and co-create solutions through forums like the Joint Learning Network, fostering evidence-based learning and best practice development.

Theme	Key Finding	Recommendation	Intended Outcome
Essential Medicines Financing Framework	Financing fragmented across line-item budgets, CBHI, donors, and user fees	Establish an integrated framework consolidating all funding streams with harmonized planning, payment rules, and digital tracking	Improve efficiency, reduce duplication, and enable unified, transparent pharmaceutical financing
Forecast-to-Budget Linkages	Forecasting not consistently reconciled with MOF/MOH budget allocations	Formalize structured forecast–budget reconciliation and explicitly identify financing gaps	Ensure budget allocations reflect quantified needs, highlight shortfalls, and strengthen advocacy with government and stakeholders
Donor Integration	Program commodities (HIV, TB, malaria, FP, vaccines, nutrition) managed in parallel donor-driven processes	Fully integrate donor-supported forecasting and budgeting into government systems	Harmonize donor and domestic financing, improve sustainability, and align with national priorities
Pricing & Market Governance	Significant price variation and weak market intelligence	Establish a national price governance mechanism with a benchmark registry and market intelligence platform	Reduce price variability, improve equity, and enable market-shaping strategies for efficiency and access
Budget Execution	Delayed treasury releases and reimbursements disrupt procurement and service delivery	Use evidence on stockouts and costs of delays to advocate for timely disbursements; systematically track timelines	Enhance predictability, accountability, and timeliness of financing flows
Insurance Tariffs & Provider Payments	CBHI reimbursement rates not aligned with actual procurement costs from EPSS and private suppliers	Harmonize CBHI tariffs with real procurement costs	Reduce provider financial losses, strengthen RDFs, and sustain supply chain viability
CBHI Capitation Pilot	Current pilot lacks clarity on allocation for essential medicines	Assess optimal share of capitation payments for medicines and health products	Ensure adequate financing, promote rational use, and enhance facility-level financial autonomy
Digital Systems	Fragmented data across financing, supply chain, and service delivery platforms	Develop a unified dashboard linking all data sources for real-time monitoring	Improve transparency, accountability, and responsiveness across the system
Peer Learning Platforms	Limited structured opportunities for cross-country exchange	Leverage platforms such as the Joint Learning Network for peer exchange and co-creation	Foster evidence-based reform, accelerate adoption of best practices

Table 5: Recommendations summary

ENDNOTES

- ¹ The Lancet Global Health Commission on financing primary health care: putting people at the center. Hanson, Kara et al. The Lancet Global Health, Volume 10, Issue 5, e715 - e772
- ² Bayked E. The need to update Ethiopia's national health and medicine policies: essential tools for informed decision-making in healthcare and the pharmaceutical sectors . Frontiers in Public Health, 24 April 2025 Volume 13 <https://doi.org/10.3389/fpubh.2025.1533710>
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- ⁸ [Woldeyohannes, F. H. \(2023\). "Towards strategic health purchasing in Ethiopia: Piloting capitation to reform the provider payment modality \(PPM\)"\[PowerPoint presentation\].](#)
- ⁹ Koricho et al., 2024, An Assessment of Provider Payment Mechanisms in Ethiopia, Health Systems & Reform, DOI: 10.1080/23288604.2024.2377620

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