Ethiopia

The Commonwealth Fund

International Health Care System Profiles

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Overview

Ethiopia's decentralized health care system is governed at the federal, regional, and local levels. It is financed through government funding, international aid contributions, and out-of-pocket payments.[1] The launch of the Health Extension Program in 2003 deployed health extension workers to deliver essential services at the community level. The country's strong community health sector, supported by health extension workers and volunteer networks, such as the Health Development Army, has rapidly improved health care coverage, especially in maternal and child health.[2]

While Ethiopia has made promising strides toward universal health coverage, progress remains uneven. Community-Based Health Insurance, introduced in 2010, now covers about 45 percent of the population but is limited to the informal sector, with a program for formal employees still pending. Challenges include low government health spending, high out-of-pocket costs, rural–urban disparities, and damage to health infrastructure in Tigray related to ongoing military conflict.

HEALTH SYSTEM
BY THE NUMBERS

2.8%
Health care spending as a percent of GDP

67.8 years
Life expectancy at birth

46%
Public insurance coverage

Coverage and Access

Background and History

Ethiopia's health system began to take shape in the 1950s, when health policy focused on providing residents with basic services through networks of health centers.[3] The government had aimed to expand services after the 1974 Ethiopian revolution, but political and economic instability slowed progress. By the 1990s, health services were limited and skewed toward urban areas and curative services.[4] In response, the 1993 Health Policy established a decentralized health system that prioritized primary and community-based care.[5]

Ethiopia has a long history of community health care, with auxiliary health workers first introduced in the 1970s. This approach was strengthened in 2003 with the launch of the Health Extension Program (HEP), which established a network of community health workers — also known as health extension workers (HEWs) — to provide preventive care, health education, and basic treatment in rural areas.[6,7]

Ethiopia's Community-Based Health Insurance (CBHI), which covers the informal sector, was first launched in some administrative districts (*woredas*) in 2010. By 2017, CBHI was active in 384 woredas. The rollout of social health insurance (SHI) to cover civil servants and formal sector workers has been repeatedly delayed.[8]

Ethiopia's revised Health Care Financing Strategy (2022–31) focused on aligning health financing with the national push to become a middle-income country by 2025. Critical parts of the strategy include the deployment of innovative financing mechanisms, an increase in public-private partnerships, and the implementation of performance-based financing.[9]

The Role of Public Health Insurance

The primary public health insurance program, CBHI, was introduced in 2010 for people in informal employment, who make up about 85 percent of Ethiopians.[10] By 2024, 11.1 million households were enrolled in CBHI (73% of eligible households in CBHI-implementing woredas). Using the Ministry of Health's average household size of 4.6, this implies about 51 million people, about 46 percent of the population.[11]

Those who enroll in the program have access to government-provided primary, secondary, and tertiary care after paying a premium, which varies by region and household size. As of 2022, CBHI members paid ETB 500 (USD 10 per year, with a reduced fee of ETB 240 (USD 5) for dependents over age 18 living with their parents.[12] A 2022 study found that premiums were unaffordable for 38 percent of Ethiopians in the South Central region.[13]

In addition, the government has sought to introduce SHI for people engaged in formal employment.[14] The proposal requires those currently employed to contribute 3 percent of their monthly salary (employers would contribute a further 3%), while retired people would pay 1 percent of their monthly pension. The original plan was to fully implement SHI by 2014, but workers' resistance to paying premiums has led to delays.[15]

Services Covered by Public Health Insurance

Services that are covered under CBHI:[16]

- Preventive care, including routine immunizations and health education
- Inpatient care
- Outpatient care
- Maternity care
- Primary care
- Mental health care
- Pharmaceuticals (from an essential medicines list issued by the Ethiopian Food and Drug Authority [EFDA])
- Palliative care.

Services that are means-tested:[17]

- Dental care
- Eye care
- Long-term care
- Rehabilitation
- Assistive devices, including prosthetics and mobility aids.

Safety Nets

Ethiopia has put several safety nets in place to reduce financial barriers to health care access.

In addition to CBHI, a fee waiver system defrays health care costs for people with low incomes, people with disabilities, and other groups.[18] Beneficiaries are given an identification card that allows them to receive services in public health care facilities without a user fee.[19] Services provided free of charge include:

- Maternal and child health care, including prenatal, delivery, and postnatal care
- Vaccinations for children and adults as part of the national immunization program
- Tuberculosis treatment, antiretroviral therapy, and malaria treatment
- Basic health care services, which are provided through the HEP.[20]

"The health care system is supportive of vulnerable groups. For example, care for children under five and for pregnant mothers — including antenatal care, delivery, and postnatal care — is free, whether or not the mother has insurance. That's a real strength of the system," said Genanew Kassie Getahun.

Ethiopia also aims to reduce food poverty through the Productive Safety Net Program. The program, which is not formally part of the health care system, provides food and cash transfers to food-insecure households and attempts to build climate resilience in marginalized communities.[21]

The Role of Private Health Insurance

Private health insurance coverage in Ethiopia is minimal: only about 1 percent of the population is enrolled in such plans.[22] Policies are primarily held by people in formal employment. Employers pay the premiums for 75 percent of these workers.[23]

The Role of Government

The different levels of government have distinct roles in the health care system. The Federal Ministry of Health is the government body responsible for formulating health policies, strategies, and programs. The ministry oversees the implementation of health services across the country and ensures that health initiatives align with national development goals.[24]

Thirteen Regional Health Bureaus operate within the federal structure.[25] Regional Health Bureaus are responsible for planning, implementing, and monitoring health services within their regions and adapting national policies to meet local needs.[26] Bigger regions may also have Zonal Health Departments to help organize the implementation of health activities.[27]

Woreda Health Offices manage local primary health care services and aim to address community-level health needs.[28]

Amid increasing demand for services, the private sector has grown in Ethiopia, and in 2019, one in four outpatient visits and one in five inpatient visits took place in private facilities.[29] To encourage public-private partnerships, the Ministry of Health has created a Public–Private Partnerships in Health Unit within the Partnership and Collaboration Directorate.[30]

Integration and Care Coordination

Ethiopia's health system has suffered from fragmented, uncoordinated care and issues with referral systems.[31] Since 2022, JSI and Amref Health Africa have collaborated on the Improve Primary Health Care Services Delivery project, which intends to strengthen links across primary health care.[32] The project, which connects public and private primary health care facilities at the district level through administrative and clinical support, has notably improved maternal and child health outcomes.[33]

Under the government's multisectoral approach, health care initiatives are integrated with nutrition, water, sanitation, and education policies — an acknowledgment that improving health goes beyond medical care. For example, Ethiopia's nutrition policy links agriculture and health to improve nutritional outcomes. Water, sanitation, and hygiene initiatives are integrated with health programs to address sanitation-related diseases.[34]

Operations and Resources

Overview of the Delivery System

Ethiopia's three-tier health care system encompasses:[35]

- **Primary care:** The first point of contact for patients, typically provided through health posts (*see Primary Care*) and health centers. These facilities provide routine health care, immunizations, maternal and child care, and health education. Primary care also includes community-led care through the HEP, including HEWs and volunteer health workers, such as members of the Health Development Army (HDA).
- **Secondary care:** Includes general hospitals that provide planned and emergency inpatient and outpatient care. These hospitals handle more advanced cases referred from primary care facilities and offer emergency care and basic surgical procedures.
- **Tertiary care:** Specialized hospitals that offer advanced treatments in areas such as neurosurgery, oncology care, and cardiac surgery. These facilities also serve as training and research institutions.

Primary and specialist care, particularly CBHI-covered services, are most commonly paid for on a fee-for-service basis. Some regions are piloting a capitated payment system at the health center level, where payments are based on the number of households assigned to each health center, utilization patterns, historical data, and other factors.[36]

Primary Care

Primary care is provided in two types of facilities:[37]

- **Health posts:** Located in rural villages (*kebeles*) and staffed by HEWs, these facilities provide preventive care, immunizations, and health education.
- **Health centers:** Overseeing multiple health posts, health centers provide outpatient consultations, maternal and child health care, and treatment for common illnesses. Primary care physicians, nurses, midwives, and other health care professionals collaborate to provide comprehensive care.

As of 2023, there were 17,569 operational health posts and 3,826 health centers. While this is a slight decrease since 2020, these numbers are still recovering following significant destruction of health care infrastructure in conflict zones, particularly in Tigray.[38]

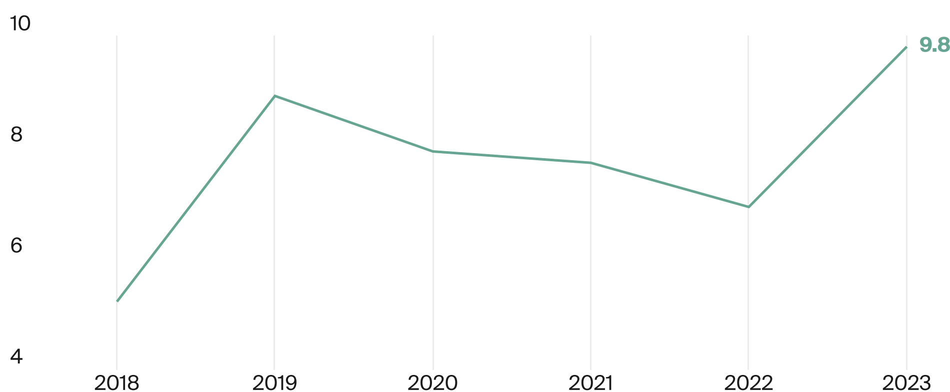
The HEP forms an important part of the primary care system. HEWs work out of health posts and provide services in facilities and in the community; they also make home visits.[39] HEWs, who are paid a salary by the government, are recruited from the local area and given 12 months of vocational training on basic curative services, health promotion, and disease prevention.[40]

HEWs are supported by the HDA and Women's Development Army (WDA), cadres of volunteer health workers who together number nearly a million.[41] HEWs and HDA/WDA members typically work closely together. HEWs train HDA/WDA volunteers in health matters, such as disease prevention, family planning, or nutrition, and rely on them to spread these messages at the grassroots level. HEWs and HDA/WDA volunteers also work together on vaccination programs, screenings, and awareness campaigns.[42]

There is no formal requirement for people to register with a general practitioner (GP) or a physician practice. GPs are not required to provide out-of-hours care.

There were 9.8 GPs for every 100,000 people in 2023, up from 5.2 in 2018.[43] There are no data available for the percentage of primary care physicians employed privately versus publicly.

Number of GPs per 100,000 People, 2018–23



Source: The Global Health Observatory, Medical doctor: generalist medical practitioners (number), distributed by World Health Organization, accessed October 22, 2025. Numbers calculated using population data from the World Bank. Source: World Bank Open Data, Population, total, distributed by World Bank Group, accessed October 22, 2025.

Outpatient/Specialist Care

Specialist care is provided through secondary and tertiary facilities, including general and specialized hospitals, primarily in urban areas.[44]

Patients mostly access specialist care through referrals from health centers or primary hospitals, but there are no formal referral requirements.[45]

Access to specialist care is limited by a shortage of trained professionals: There were only 4.5 specialists for every 100,000 people as of 2022.[46] In 2022, the salaries for specialist physicians in hospitals were one-third of the recommended salary for a general practitioner.[47] There are no data available for the percentage of specialists employed privately versus publicly.

"Vulnerable populations are often served at primary health facilities by non-specialized manpower, while specialists are concentrated at higher levels, creating a major obstacle for those who need specialized services," said Genanew Kassie Getahun.

Physician Workforce and Education

Ethiopia has 28 public medical schools.[48] The cost of a medical degree varies by institution and student nationality. For example, Addis Ababa University, which uses the European Credit Transfer System (ECTS), charges ETB 2,307 (USD 18) per ECTS credit for Ethiopian students, compared with USD 100 per credit for students from Intergovernmental Authority on Development member states and East African countries. Other international students pay USD 150 per ECTS credit.[49]

Shortages of doctors caused the government to drastically increase the number of medical students over the past two decades. This policy has raised concerns about overloading infrastructure and the quality of training.[50]

Low government spending on health has also impacted the workforce. Spending is insufficient to finance more staff, leading to high unemployment among the health care workforce, even amid a shortage of health workers.[51]

The government has sought to implement programs to improve health workers' skills. "Catchment area mentoring" matches high-performing, experienced health workers with newer employees to teach them skills and improve the quality of care. Since its implementation, the program has focused on maternal and child health, with mentees reporting greater knowledge and skills and higher confidence levels after mentoring.[52]

Hospitals

There are three main types of hospitals:[53]

- **Primary hospitals:** These are the first level of referral hospitals in rural areas, offering basic health care services.
- **General hospitals:** These provide a broader range of services and handle more complex cases.
- **Specialized hospitals:** These teaching and tertiary care hospitals offer advanced services in specific medical fields.

As of 2024, Ethiopia had 404 hospitals and 27.4 hospital beds for every 100,000 people.[54]

Nurses play a critical role in the health care system, especially given the shortage of doctors. The country had 100 nurses for every 100,000 people in 2022, the same as the low-income-country average of 100.[55] Nurses manage outpatient and inpatient care, treat chronic disease, and provide health education.[56]

Mental Health Care

In Ethiopia, mental health care is integrated with primary health care to improve accessibility and address treatment gaps.

The Ministry of Health provides mental health services at multiple levels. Health posts, health centers, and primary hospitals form the first line of mental health care provision, offering basic services, such as identification and treatment management. Community health workers receive training to provide mental health awareness and support and refer complex cases to higher-level facilities.[58] Mental health services are covered for those who have public health insurance.[59]

General hospitals provide inpatient and outpatient mental health services for moderate conditions. There's only one specialist mental health hospital: Amanuel Mental Specialized Hospital in Addis Ababa, which treats severe conditions and serves as a hub for research and workforce training.[60]

Ethiopia has fewer mental health professionals than the average for low-income countries.[61]

MENTAL HEALTH CARE **BY THE NUMBERS**

In 2020, there were **0.1 psychiatrists per 100,000 people**, equal to the average for low-income countries.

There were **0.7 mental health professionals per 100,000 people** in 2020, lower than the average of 1.4 in low-income countries.[57]

Long-Term Care and Social Support

Long-term care for the elderly is largely informal and provided by family members. Urbanization, migration, and economic pressures, however, are weakening these support systems. Ethiopia does not provide financial support to family caregivers, and as younger family members increasingly migrate to urban areas or abroad, traditional family care arrangements are deteriorating.[62]

Formal long-term care services are scarce.[63] Ethiopia has both government-owned and private care homes, but many caregivers lack formal training.[64]

Cost and Affordability

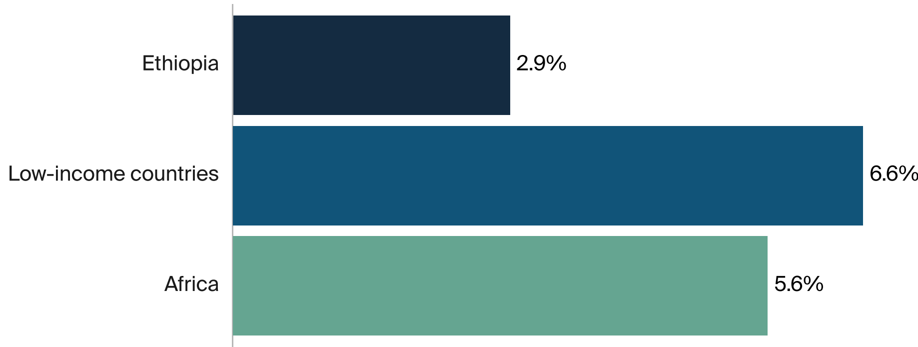
Health Care Spending Overview

In 2023, Ethiopia spent 2.8 percent of its gross domestic product (GDP) on health, compared with an average of 6.6 percent across low-income countries.[65] The government's budget allocation has risen but hasn't matched inflation. In 2023–24, the real value of the health budget was 3 percent lower than in the previous financial year.[66]

Government spending accounted for 22.4 percent of total health expenditure in 2022, while prepaid private health spending was just 4.7 percent. The two largest sources were out-of-pocket spending (39.2% of total expenditure) and international development assistance (33.6%).[67]

The low level of government spending has led to inadequate staffing levels and has negatively affected the quality of care.[68] High out-of-pocket spending has also stymied development, as households are obliged to prioritize health spending over subsistence needs, decreasing productivity.[69]

Health Care Spending as a Percentage of GDP, 2022



Source: The Global Health Observatory, Current health expenditure (CHE) as percentage of gross domestic product (GDP), distributed by World Health Organization, accessed October 22, 2025.

Pharmaceutical Spending

Pharmaceutical spending makes up a significant portion of the health care budget. In 2019, the country allocated about USD 860 million to pharmaceuticals, which represented 1 percent of its GDP and 32 percent of total health expenditure.[70] There are no data available for the average per capita spend on pharmaceuticals.

The EFDA is responsible for regulating, registering, and ensuring the quality of drugs. It also regulates importers and exporters of pharmaceuticals.[71] Health care providers adhere to an essential medicines list issued by the EFDA.[72] However, there is no price regulation of pharmaceuticals, and prices are solely determined by market forces.[73]

The Ethiopian Pharmaceuticals Supply Service is responsible for procuring and supplying medical supplies to public and private institutions across the country. The agency has incentives programs and advance payment support for the local pharmaceutical market, including paying 30 percent of the tender value to local suppliers in advance.[74]

Medicines are the most expensive component of health care for patients. Limitations around public health insurance, including low enrollment rates and the failure to implement SHI for people in formal employment, are pushing people who rely on prescription drugs into poverty.[75]

Cost Sharing and Out-of-Pocket Spending

Out-of-pocket spending accounts for the highest proportion of total health expenditure, at 46.3 percent, slightly higher than the 42.7 percent average across other low-income countries.[76]

The financial burden of out-of-pocket spending is substantial: In 2022, 10.4 percent of the population was pushed below the poverty line because of medical costs.[77] Medicines, which represent the largest share of out-of-pocket expenses, account for over 65 percent of total health expenditure, including both prescription and over-the-counter drugs. Households seeking inpatient care, those with lower economic status, and people living in urban areas were among the most affected by high out-of-pocket payments for medicines.[78]

There are no explicit caps on out-of-pocket spending for beneficiaries. Although a wide range of services is ostensibly free for vulnerable people, a lack of resources means this is often not the case in practice.[79]

Percentage of Health Care Spending That Is Out of Pocket, 2022

Source: The Global Health Observatory, Out-of-pocket expenditure as percentage of current health expenditure (CHE) (%), accessed November 4, 2025.

How Are Costs Contained?

Ethiopia has implemented several measures to contain health care costs. The Health Sector Transformation Plan II (2020 to mid-2025) aims to reduce out-of-pocket expenses — from 31 to 25 percent of total health spending — and reduce the incidence of catastrophic health spending to 1.8 percent.[80]

The 2022–31 Health Care Financing Strategy sets out strategic objectives to reduce out-of-pocket spending, including negotiating with service providers to reduce costs, strengthening supply chain management, and widening health insurance coverage. The strategy also sets out plans to boost efficiency and cost effectiveness, such as by increasing resource pooling and strengthening the financial tracking system.[81]

In 2021, the CBHI program was expanded to cover more rural areas in an effort to lower out-of-pocket expenses and improve financial protection for households.[82] The government has also implemented electronic health records (EHRs) and telemedicine to streamline health care delivery, enhance efficiency, and potentially reduce administrative costs (*see Health Care Technology*).[83]

Quality and Outcomes

Health Outcomes

In 2021, overall life expectancy was 67.8 years — 66 for men and 69.7 for women.[92] This is close to the average of 63.7 years overall across all low-income countries in that year.[93]

Infant mortality has substantially declined over the past two decades and is now lower than both the average for low-income countries and the average for Africa.[94] Maternal mortality has also declined significantly, dropping by 72 percent between 2000 and 2020.[95] Both developments have been attributed to the rollout of the HEP and the impact of HEWs, as well as the impact of volunteer community health workers, such as the HDA.[96]

Disparities in health care outcomes, particularly between urban and rural areas, still exist, however, despite the HEP and other government efforts. For example, in 2023, 37 percent of rural children ages 12 to 23 months received full immunization, compared with 65 percent in urban areas.[97] In 2022, 70 percent of urban women had skilled birth attendants, compared with 40 percent of rural women.[98]

"In principle, people have access to care — but access to what?" asks Vassar College's Elizabeth Bradley. "The issue is not necessarily financial exclusion but the absence of services. For example, if you develop a kidney stone in rural Ethiopia, there is simply no treatment available."

Ongoing war has destroyed the health care system in Tigray, Ethiopia's fifth-largest region, with severe shortages of food and health care supplies and power outages stymying the efforts of health workers.[99] The conflict has set Ethiopia back significantly, says Bradley. "Tigray used to be the height of Ethiopian health care. Other than Addis Ababa, that's where the best-quality care was given, but today it's decimated."

There has been a near doubling of the rate of mortality in children age 5 and under in Tigray since the pre-war period. Many children have died from preventable causes.[100]

Addressing Health Inequities

As discussed above, the Tigray conflict has severely disrupted progress in health care delivery. By 2022, 85 percent of health centers and 70 percent of hospitals were nonfunctioning. The HEP network, which had been one of the best-performing in Ethiopia before the war, was nearly completely destroyed.[101]

The government has implemented several initiatives to address health care workforce shortages and improve service availability in underserved regions. The Health Workforce Improvement Program (2020–25) focuses on strengthening the health workforce by building capacity and ensuring that health workers are equitably distributed.[102]

HEALTH OUTCOMES **BY THE NUMBERS**

Life expectancy at birth was **67.8 years** in 2021 (compared with 63.7 across low-income countries).

- Life expectancy for **women was 69.7 years** in 2021 (compared with 65.8 across low-income countries).
- Life expectancy for **men was 66 years** in 2021 (compared with 61.6 across low-income countries).[84]

The top three causes of death in 2021 were:

- Lower respiratory infections: **48 deaths per 100,000 people**
- Preterm birth complications: **35 deaths per 100,000 people**
- Diarrheal diseases: **34 deaths per 100,000 people**.[85]

The maternal mortality rate was **195 deaths per 100,000 live births** in 2023 (compared with 442 on average across Africa).[86]

The infant mortality rate was **36 deaths per 1,000 live births** in 2022 (compared with 43 on average across Africa).[87]

There are currently no data available for the avoidable mortality rate in Ethiopia.

In 2021, the share of Ethiopia's population with mental health disorders was **12 percent** (compared with 13% on average across low-income countries).[88]

The suicide rate was **9 per 100,000** in 2023, compared to 6.4 on average in low-income countries.[89]

There are currently no data available for the homeless population in Ethiopia.

Guns are responsible for **2.8 deaths out of every 100,000 deaths** in Ethiopia.[90]

In 2022, **2.8 percent** of adults were affected by obesity.[91]

In 2022, Ethiopia launched the Five-Year National Health Equity Strategic Plan (2022–26), which was aligned with the Health Sector Transformation Plan II.[103] The plan has nine strategic directions, including improving the accessibility of health centers, community engagement, and empowerment; ensuring the integration of health equity into all health policies; and improving the management of the health supply chain.

Innovation and Reform

Health Care Innovation

The Health Sector Transformation Plan II, which was in effect until June 2025, set targets for maternal and child health care, disease prevention and control, the HEP, public health emergency management, and financing. The government planned to achieve these targets by improving:[104]

- The provision of equitable and comprehensive health services
- Health emergency and disaster risk management
- Engagement with communities
- Local ownership of health services
- Pharmaceutical and medical device access and use
- The development of regulatory systems
- Human resource management and training
- Decision-making and innovation
- Health financing
- Digital health adoption
- The integration of health policies and strategies
- Collaboration with the private sector.

The National Healthcare Quality and Safety Strategy 2021–25, meanwhile, focused on improving health care outcomes and confidence in the system. It had five core objectives:[105]

1. **Improving evidence-based health care,** including methodical patient assessments, accurate diagnoses, appropriate treatment, and effective communication with patients about their conditions
2. **Making care more patient-centered** by meeting people's needs and preferences throughout their lives and including communities in the design and assessment of health care services
3. **Reducing preventable harm during care delivery,** especially when providing treatment for high-risk conditions, and establishing transparent error reporting systems to inform future clinical decision-making
4. **Improving health care delivery efficiency** by avoiding waste and the overuse of ineffective approaches to care
5. **Prioritizing investment in continuous learning and improvement** by committing to adapting to new technologies, treatment options, and approaches.

In 2024, the Ministry of Health, in collaboration with nonprofit Last Mile Health, launched Ethiopia's first integrated in-service training program for HEWs on noncommunicable diseases. The aim is to equip health workers with the knowledge and skills to address conditions such as diabetes and hypertension at the community level, thereby improving early detection and management.[106]

In the same year, the government partnered with NEST360 on the Saving Little Lives initiative, which aims to improve neonatal care for sick newborns. A global health alliance dedicated to reducing newborn mortality in African hospitals, NEST360 is training health care providers and implementing evidence-based practices to improve infant survival rates.[107]

Health Care Technology

There is strong potential for using digital technology to improve health care in Ethiopia.[108] "A key advantage is that Ethiopia did not have to overhaul an outdated electronic system," says Vassar College's Elizabeth Bradley. "Instead, it bypassed older infrastructure entirely, moving straight to cloud-based solutions."

Electronic Health Records

Ethiopia began implementing EHRs in 2013, but progress has been relatively slow, and studies show that only half of Ethiopian health professionals feel ready to use EHRs.[109] Barriers to their adoption include a lack of technical literacy and reliable power supply, as well as privacy concerns.[110]

However, Bradley identifies EHRs as an area where the Ethiopian health system can make significant progress. "EHRs could be a moment of optimism for Ethiopia," she says. "They didn't start with a mess of an electronic system they had to redo, and they are learning from high-income countries and what they have done."

Telemedicine

Ethiopia is advancing health care integration through the Digital Health Blueprint, which sets out 10 priority areas for digital health, including remote health care delivery.[111] The Ethiopian Telemedicine Project is helping facilitate collaboration between rural health centers and urban hospitals and enabling patients living in rural locations to access specialist advice. The Ministry of Health's Digital Health Strategy 2020–25 also names telehealth as a priority area for improving access to care.[112]

Private initiatives have also sought to improve health services through digital technology. One example is Medanit, which has partnered with the Ministry of Health to integrate various health care services and enable patients to manage many aspects of care remotely.[113] Patients can book in-person and virtual physician consultations, search for suitable doctors, order diagnostic tests, and arrange prescription deliveries. The platform also links to EHRs, consolidating all information in one place for patients and physicians to access.[114]

But adoption of telemedicine has been limited, and only 53 percent of health professionals feel positive about it. Many of those who held positive attitudes toward telemedicine had already received digital training and have access to reliable internet and electronic devices. To capitalize on the potential of telemedicine, it will be vital to expand education and access to technology.[115]

This profile reflects data as of January 2026. New or updated information may have become available since its release.

Notes

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