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**Fiscal Space Analysis in the Health Sector: Evidence from Ethiopia**

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Background: In the past two decades, Ethiopia has invested huge amount of resource in the health sector resulting in significant gains in improving the health status of Ethiopians through under tremendous reform. One of the issues high on the agenda is health financing for universal coverage. Accordingly, the government has taken a number of measures to enhance health care financing which aims at increasing resource flows to health sector, improving the efficiency of resource utilization, and ensuring sustainability of financing to improve the overall coverage and quality of health service.

Objective: The objective of this paper is to examine and analyze the concept and various ways of increasing fiscal space for health to achieve universal health coverage in the context of Ethiopia.

Methods: The macroeconomic analyses are conducted from Ethiopian economic and social statistics data, government policy documents and other sources.

Results: In the past two decades, Health expenditure and resource have increased substantially in both absolute and per capita terms, but it still is not adequate to buy better health for all Ethiopians. So, from the result reveals that there is room to increase fiscal space for health using the options such as efficiency savings, increase government revenues and better prioritize budget expenditures, and implement innovative funding system.

The key findings and the Main Conclusion: Although Ethiopia health sector is highly depending on external flows of aid, There are the two top options to minimize the gap and increase the fiscal space for health by using domestic financing alone of which efficiency gains and innovating financing mechanisms will be needed to sustain the rate of improvement of health status and will achieve universal health coverage in Ethiopia.

Keywords: Expenditure, Ethiopia, Fiscal space, Health care financing, universal health coverage, efficiency gains, innovating financing

BTM3GK

**Challenges: in Implementing HTA In The Reimbursement Decisions In Algeria / A Compartive Analysis**

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To provide a comprehensive description of the current Drug Reimbursement Systems in Algeria and to compare it to two archetypes drug reimbursement systems in France and UK and to a system in a middle income country: Turkey where the HTA has been recently implemented.\
We collected and reviewed relevant information to describe the health care and drug reimbursement systems in these countries; we reviewed the legal framework and procedure documents. For Algeria, in addition to the data and information collected, we conducted informal interviews supplemented by a survey among key stakeholders.
Compared to the UK, no similarities were found. This is probably due to the cultural differences and the lack of expertise in the use of cost-effectiveness approaches. Compared to the France, we didn‚Äôt find similarities, except the final decision which is taken at the Ministry level. This is due to the administrative nature and the lack of transparency of the assessment in Algeria especially where the Methods as well as the Results of the assessment are not explicitly expressed. Compared to Turkey, we found some similarities in terms of process, but not in terms of Methods as this country is now more familiar with the HTA approach.
Our study shows that the implementation of HTA differs according to cultural and financial factors and to expertise capacity in data collection, analysis and use in the decision making process. The use of HTA in the drug evaluation and reimbursement system in Algeria is underestimated and underdeveloped. That‚Äôs why before adopting HTA approaches in the pharmaceutical sector, the Algerian authorities should consider these factors and improve the data quality and decision process transparency. This is becoming vital as cost of drugs is increasing and the fiscal space will be more constrained in the near future.

QJWR5A

**Costs of routine immunization and the introduction of new and underutilized vaccines in Ghana**

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Background: Limited knowledge exists on the full cost of routine immunization in Africa. Ghana was the first African country to simultaneously introduce rotavirus, pneumococcal and measles second-dose vaccines. Given their high price, it would be beneficial to Ghanaian health authorities to know the true cost of their introduction.

Material and Methods: The economic costs of routine immunization for 2011 and the incremental costs of new vaccines were assessed as part of a multi-country study on costing and financing of routine immunization known as the Expanded Program on Immunization Costing (EPIC). Immunization delivery costs were evaluated at the local facility, district, regional, and central levels. Stratified random sampling was used for district and facility selection. We calculated the allocation of nationwide costs to the four health-system levels.

Results: The total aggregated national costs for routine immunization ‚Äì including vaccine costs ‚Äì equaled US$ 53.5 million during 2011 (including central, regional, and district costs); this equated to US$ 60.3 per fully immunized child (FIC) when counting vaccine costs, or US$ 48.1 without. National immunization program delivery costs were allocated as follows: local facility level, 85% of total national cost; district, 11%; central, 2% and regional, 2%. Salaried labor represented 61% of total costs, and vaccines represented 17%. For new vaccine introduction, programmatic start-up costs amounted to US$ 3.9 million, primarily due to salaried labor (66%). The mean facility-level cost per vaccine dose administered in a routine immunization program was US$ 5.1 (with a range of US$ 2.4‚Äì7.8 depending on facility characteristics) and US$ 3.7 for delivery costs.

Conclusion: We identified a high cost per fully immunized child, mostly due to non vaccine costs at the facility level, which indicates that immunization program financing ‚Äì whether national or donor-driven ‚Äì must take a broad viewpoint. This substantial variation in overall costs emphasizes the additional effort associated with reaching children in various settings.

WYZTWC

**Aid Effectiveness and Assessment of Official Development Assistance for Health to Nigeria: 2000-2015**

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Background
Development Assistance for Health (DAH) in Nigeria has been on the increase since the advent of civilian democracy in 1999 after decades of military rule. Although Nigeria is not a donor-dependent country, donor agencies in the last decade have made significant investments in efforts to reform Nigerian health sector for improved service delivery and health outcomes. This paper attempts to track the trend of DAH over time, understand the aid instruments, the coordinating and accountability mechanisms among others. The information would help in improving aid alignment as Nigeria transits into the SDG era as a low-medium income country.
Methods
To understand the pattern of DAH in Nigeria, relevant data was extracted from the database of Organization for Economic Cooperation and Development (OECD)‚Äôs Development Assistance Committee (DAC). We also reviewed published literature and reports by Institute for Health Metrics and Evaluation (IHME) and International Health Partnership (IHP+), Nigeria‚Äôs Ministry of Budget and National Planning as well as the National Health Accounts. We also reviewed donor aid related policies and reports to further understand the coordination and accountability mechanisms for DAH in Nigeria.
Results
The results show that although donor funding constitute a small percentage of total health expenditure in Nigeria, DAH increased significantly over the past decade, running into millions of dollars. Funding and technical assistance from donor agencies were targeted at population health interventions especially disease programmes like HIV/AIDS, Tuberculosis and Malaria. Although we did not explore the political economy of DAH, it was observed that certain regions in Nigeria benefitted more from donor assistance. The geographic consideration may have been influenced by disease burden and socio-economic indices. Traditional bilateral donors like United States and Britain are major players in addition to multilateral donors, with Canada, Japan, France, South Korea, China, Norway active in the health sector as well. In recent times, international Foundations like Bill and Melinda Gates have become major players with the increasing roles of local philanthropies and foundations. Overall, donor coordination role by the government is weak, thus affecting aid alignment.
Conclusion
There is need to strengthen institutional mechanisms for coordinating DAH in Nigeria, as the country grapples with the realities of contracting fiscal space and reduced funding for the health sector. Pool funding mechanisms and strong accountability mechanisms might help to improve donor alignment and channeling of resources towards achieving UHC and health-related SDGs in Nigeria.