Community based health insurance as pathway to universal health coverage: Lessons from Ethiopia

Hailu Zelelew
April 28, 2015
Port au Prince, Haiti
Presentation Outline

Background and overall health finance reform

- Background
- Why Ethiopia?
- Why health care financing?
- Situation before health finance reform
- The reform process
- HCF reform components, sequencing and financing trends
- Health finance synergy with other initiatives
- Health outcome trends

CBHI as a pathway to universal health coverage: Lessons

- UHC
- CBHI: definition and rationale in Ethiopia
- Piloting: Scope, policy and technical processes, funding and management
- CBHI pilot evaluation findings
  - Achievements
  - Challenges
- Current developments
- Lessons from piloting
Country profile

- Population: 94.1 million (2013)
- 43% under age 15
- Life expectancy (63 in 2012).
- 29.6% in poverty (2011)
- Annual per capita income: $470 (2013)
- Over 85% of the population in the informal sector

Why Ethiopia?

- Ethiopia went through manmade and natural disasters
- Successful progress in implementing health financing reforms
- Ethiopia implemented a wide range of reforms at the same time ➔ HCF complementary to other reforms/initiatives
- Registered recognizable improvement in health services and outcomes (at a very low level of per capita spending)
Why health financing? (Aims and Scope)

» Overall Aim:
  - Attain equitable, efficient, quality and sustainable health services

» Mainly incorporates
  - Revenue generation (tapping into additional resources for health)
  - Risk pooling (increasing access and financial protection), and
  - Purchasing (strategic spending to ensure efficient and effective service provision).

» HCF reform focus
  - An alternative arrangement for paying, allocating, organizing and managing health resources
Limited physical and financial access to health care
Shortage of operational budget in health facilities
Shortage of essential drugs
Misallocation of funds (higher spending on tertiary care, mismatch of resources ➔ inefficiency)
Centralization of decisions
Sustainability - prospects low
Inequity in health ➔ No systematic protection mechanisms for the poor
1. Developed a health care and financing strategy in 1998
2. Preparatory works: evidence generation, policy advocacy, consultations, training and study tours
3. Developed and adopted legal frameworks:
   • Proclamations
   • Regulations
   • Directives
4. Developed operational guidelines and manuals
5. Capacity building
6. Mentoring, supervision and monitoring
HCF reform: components, sequencing, financing trends and sources

First generation reforms (2000 – To-date)
- Revenue retention and utilization
- Fee waiver and exemption
- Establishing facility governing boards
- Outsourcing
- Introducing private wings

Second generation reforms (2008 – To-date)
- Introducing health insurance

Note: HI is part of the broader and continued HCF reform
Per capita spending trend (in US$)

- 1995/96: $4.50
- 1999/00: $5.60
- 2003/04: $7.10
- 2007/08: $16.10
- 2010/11: $20.77
HCF reform (3)

Sources of financing, 2010/11 NHA

- Rest of the world: 49.9%
- Households: 33.7%
- Government: 15.6%
- Regional and Local Government: 8%
- Federal Government: 5%
- Parastatals: 2%
- Others: 0.8%
Health finance synergy with other initiatives

Service coverage interventions

- Health Extension Worker Program: 2 HEWs per kebele (34,000 HEWs)
- Accelerated construction of health facilities:
  - Over 15,000 health posts
  - 300 health centers (1990s) to 2,185 (2013)
- Health sector development programs (4 b/n 1997-2015)
  - Prioritization of health services
  - Preventive and promotive care-focused

Health financing interventions

- Increased donor funding ➔ Harmonization and alignment (including MDG pooled fund)
- Fee waivers (to protect the poor) and exemptions (for provision of priority services)
- Decentralized planning and budgeting (Prevention focused district level budgeting)
- Facilities keep user fee revenues
- More recently HI introduced
Health outcome trends: Selected illustrations

Under 5 Mortality Rate - Trend

Sources:  * UN Inter-Agency Group for Child Mortality Estimation: 2013  
**Ethiopia DHS (2000, 2005 and 2011 Reports)
Health outcome trends (2)

Maternal Mortality Rate - Trend

- 1990: 990
- 1995: 920
- 2000: 750
- 2005: 560
- 2008: 470
CBHI as a pathway to UHC: Lessons
• UHC is gaining momentum – Ethiopia is a great example!

• Yet 75% of world’s population lack adequate protection; 40% lack even the basics

• Definition of UHC:
  – where everyone can access quality services when needed without financial hardship
CBHI: definition and rationale for Ethiopia

**Definition:** CBHI is “any scheme managed and operated by an organization, other than a government or private for profit company, that provides risk pooling to cover all or part of the costs of health care services.”

**Rationale for Ethiopia:**

- > 85% of Ethiopians dependent on the informal sector
- Household OOP spending accounts 34% of THE
- Very low health service utilization (0.3 per capita visit)
- Build on existing community solidarity systems
- Build community trust, accountability and ownership
- 2008 Health Insurance Strategy:
  - CBHI for informal sector
  - SHI for formal sector
CBHI piloting: Scope

- Pilot schemes launched in January 2011:
  - 13 districts, in largest 4 regions
  - Average population about 140,000 per district
- 300,799 eligible households (1.8 million population)
Piloting: Policy and technical processes

- Lessons from other countries (literature reviews and visits)
  - Ghana, Rwanda, Senegal, Mexico, Thailand and China
- Technical documents and policy recommendations presented to government
- Health insurance strategy developed and endorsed in 2008
- Prototype pilot CBHI scheme designed
  - Membership, benefit packages, member contribution, subsidies, risk management, organizational arrangement, etc.
- Feasibility study conducted in each pilot district
- Financial Administration and Management System adopted
Piloting: Funding and management

- Contributions from paying members (amounts determined by individual schemes) ➞ 52% of total fund
- Government subsidy (two types) ➞ 48% of total fund
  - Targeted (for the poor)
  - General (for everybody)
- In addition, local governments hired 3 staff per scheme and cover scheme’s operational costs
- Each scheme linked to local government structure
- TA from partners
CBHI evaluation findings: Achievements and challenges
Achievements (1)

- Enrollment: 52% (157,553 households/over 700,000 beneficiaries)
  - Voluntary at household level
  - Enrollment variable by district (25-100% penetration)
  - Indigents average 15% of all members (variation across districts)

- Increase in health services utilization (0.7 visit per capita for insured vs 0.3 for national average)
  - Effect on health-seeking and treatment-giving behavior
  - Availability of medicine an issue
  - Urban use high (Yirgalem)

- Poverty reduction effect:
  - 7% for insured vs 19% for non-insured (out of pocket expenditure >15% non-food expenditure)
Achievements (2)

- Financial viability with risk pooling at district level:
  - On average 72% of schemes’ revenue paid to health facilities
  - 3 schemes had a financial deficit
  - Yirgalem city, with worst financial performance, had highest utilization (and is most urban)
Major challenges

- Membership declined after initial stage
- Financial difficulty among some schemes
- Variation in commitment of local officials
- Providers differ in their readiness to deliver quality care (staffing, medicines, laboratory facilities, reception, outpatient services, etc.)
- Inadequate mechanisms to address complaints
Current developments:

- Government satisfied by pilot results and decided to scale up
- CBHI is being expanded to 185 districts in the four regions
- Government is aware of the resource implication of scale up
- National CBHI scale-up strategy being prepared
Lessons from the pilot schemes

- CBHI is promising pathway to UHC (high coverage rate → 52%)
- It provides financial risk protection
- It enhances health services utilization
- Creates pressure on providers for quality care
- It requires strong government commitment
- Partners’ support is critical
- It has significant budgetary and organizational implication
Thank you

www.hfgproject.org