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

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In collaboration with:
Broad Branch Associates | Development Alternatives Inc. (DAI) | Futures Institute | Johns Hopkins Bloomberg School of Public Health (JHSPH) | Results for Development Institute (R4D) | RTI International | Training Resources Group, Inc. (TRG)

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

Background

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

Source: https://jelford.files.wordpress.com/2013/05/where-is-ethiopia.jpg Source: World Bank Database accessed online on 4/8/2015.

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

Situation before health finance reform

- 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

The reform process

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

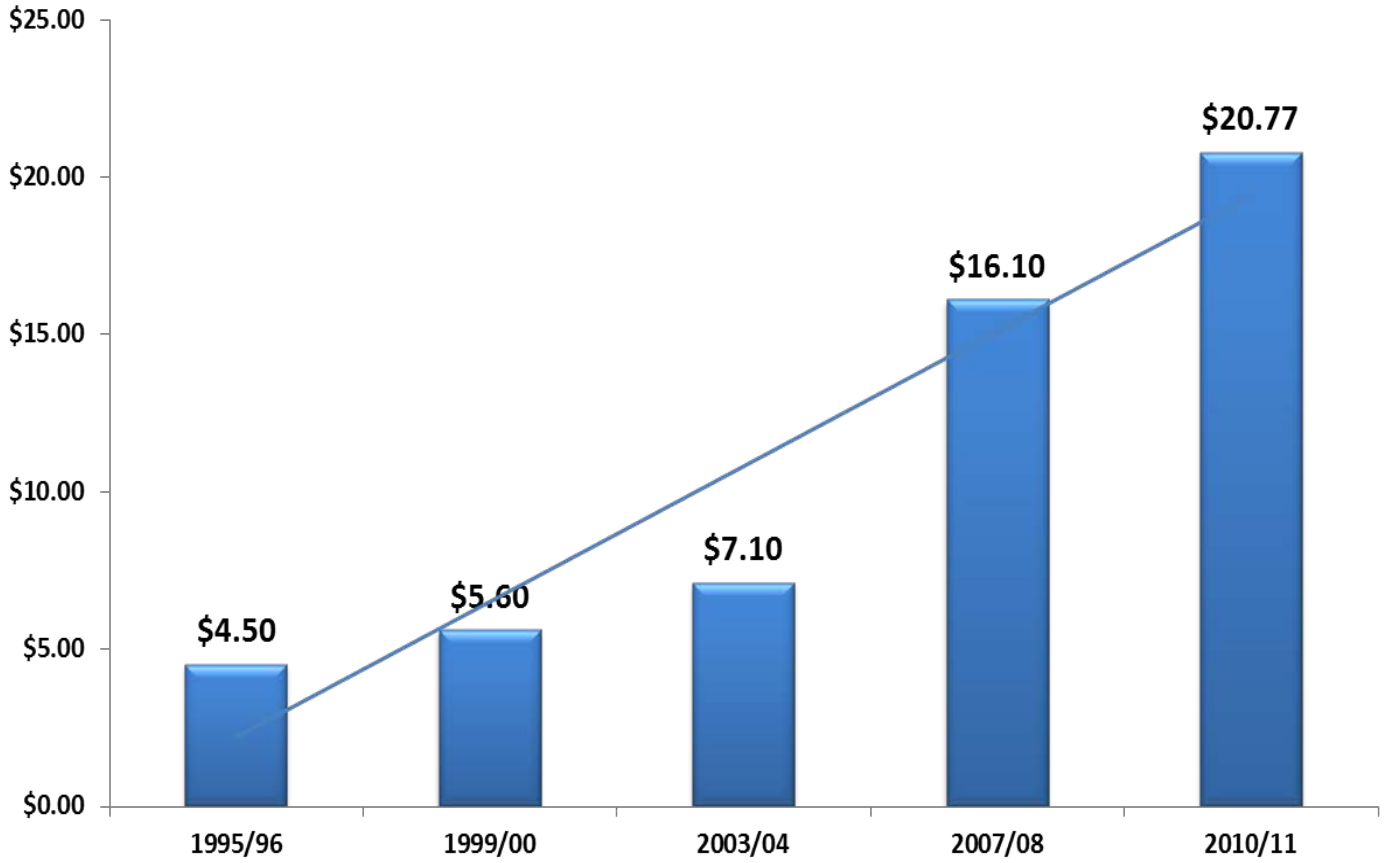
Second generation reforms (2008 – To-date)

- Introducing health insurance

Note: HI is part of the broader and continued HCF reform

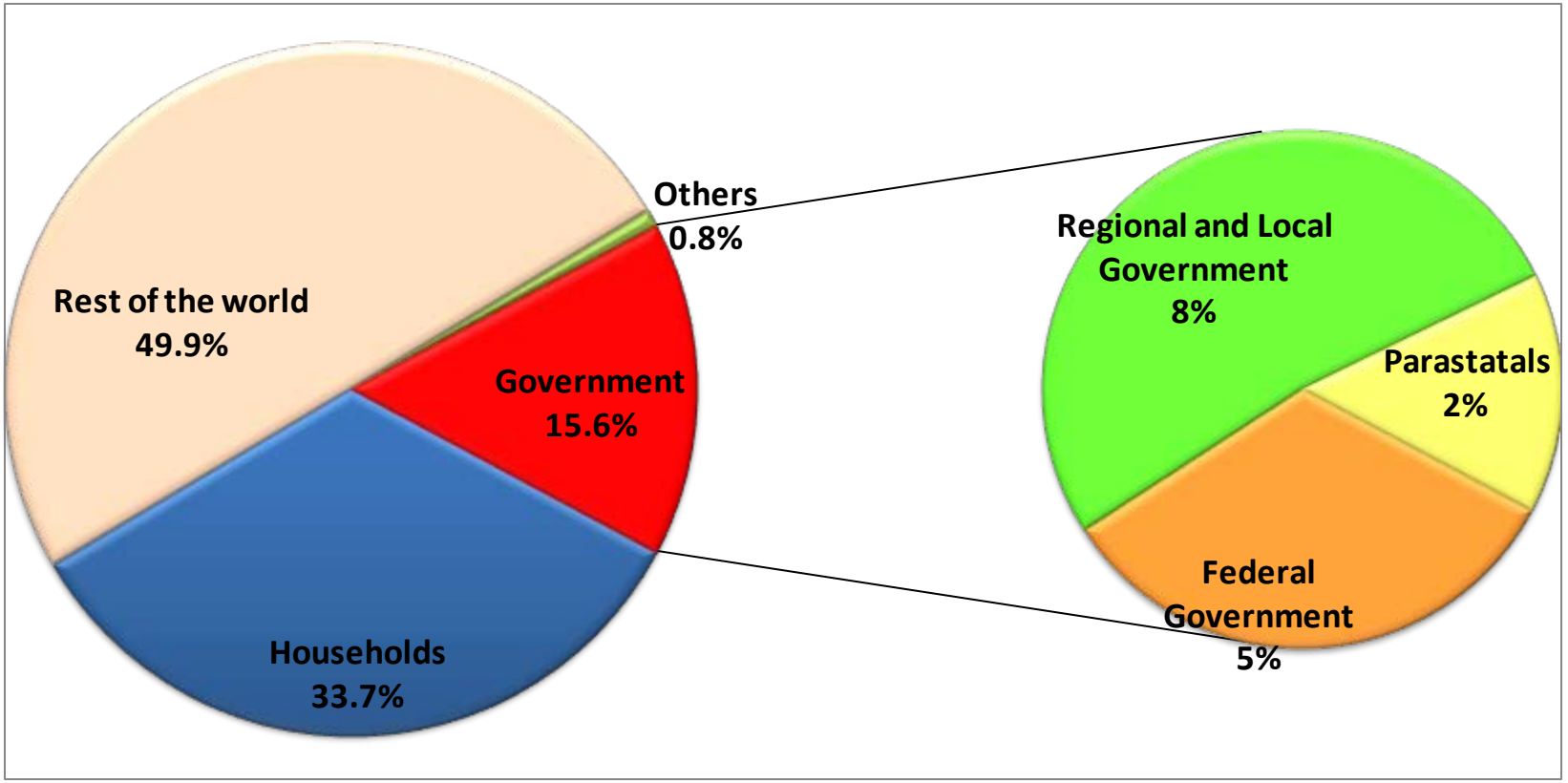
HCF reform (2)

Per capita spending trend (in US$)



HCF reform (3)

Sources of financing, 2010/11 NHA



Health finance synergy with other initiatives

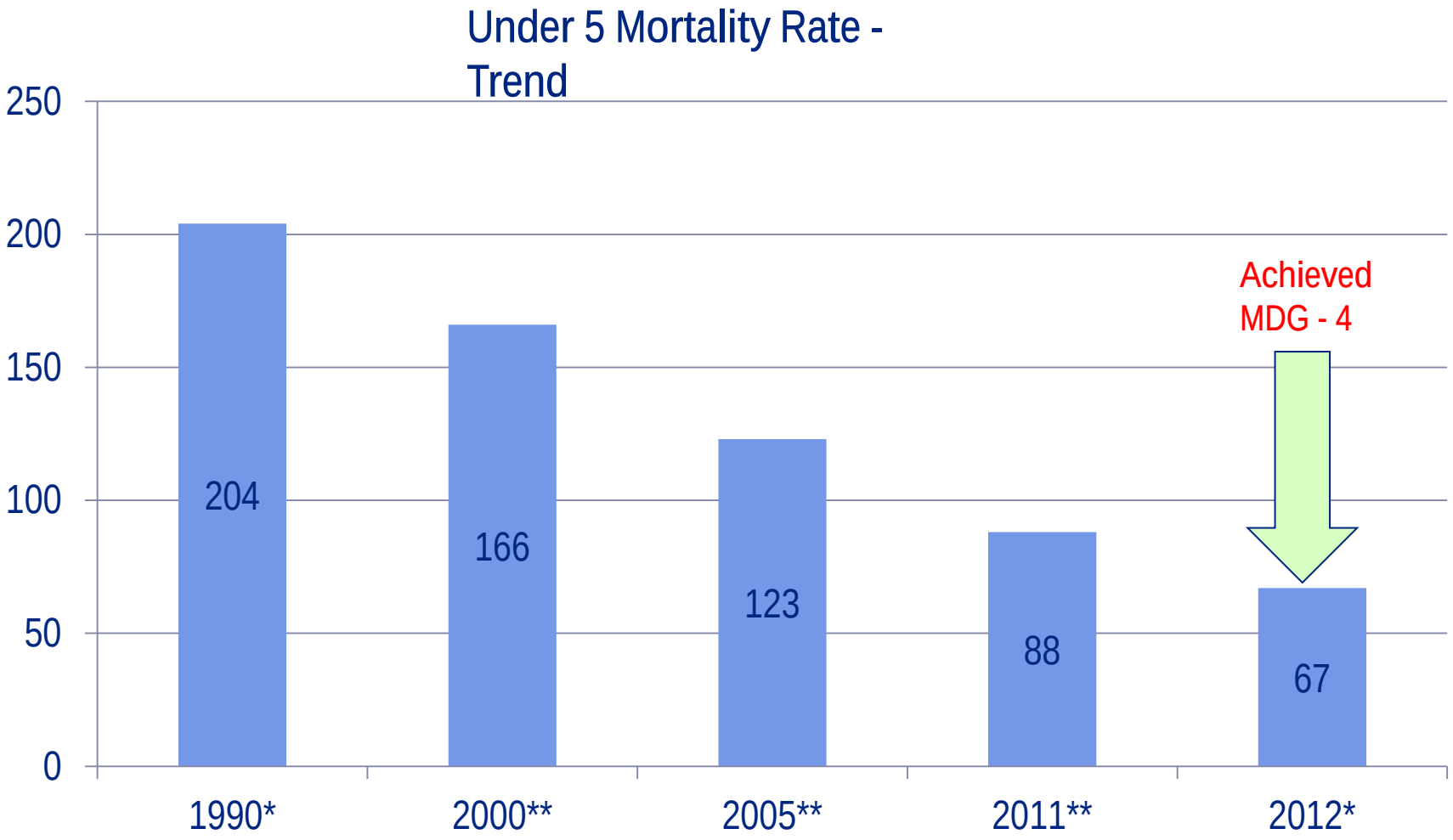
Service coverage interventions

- 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

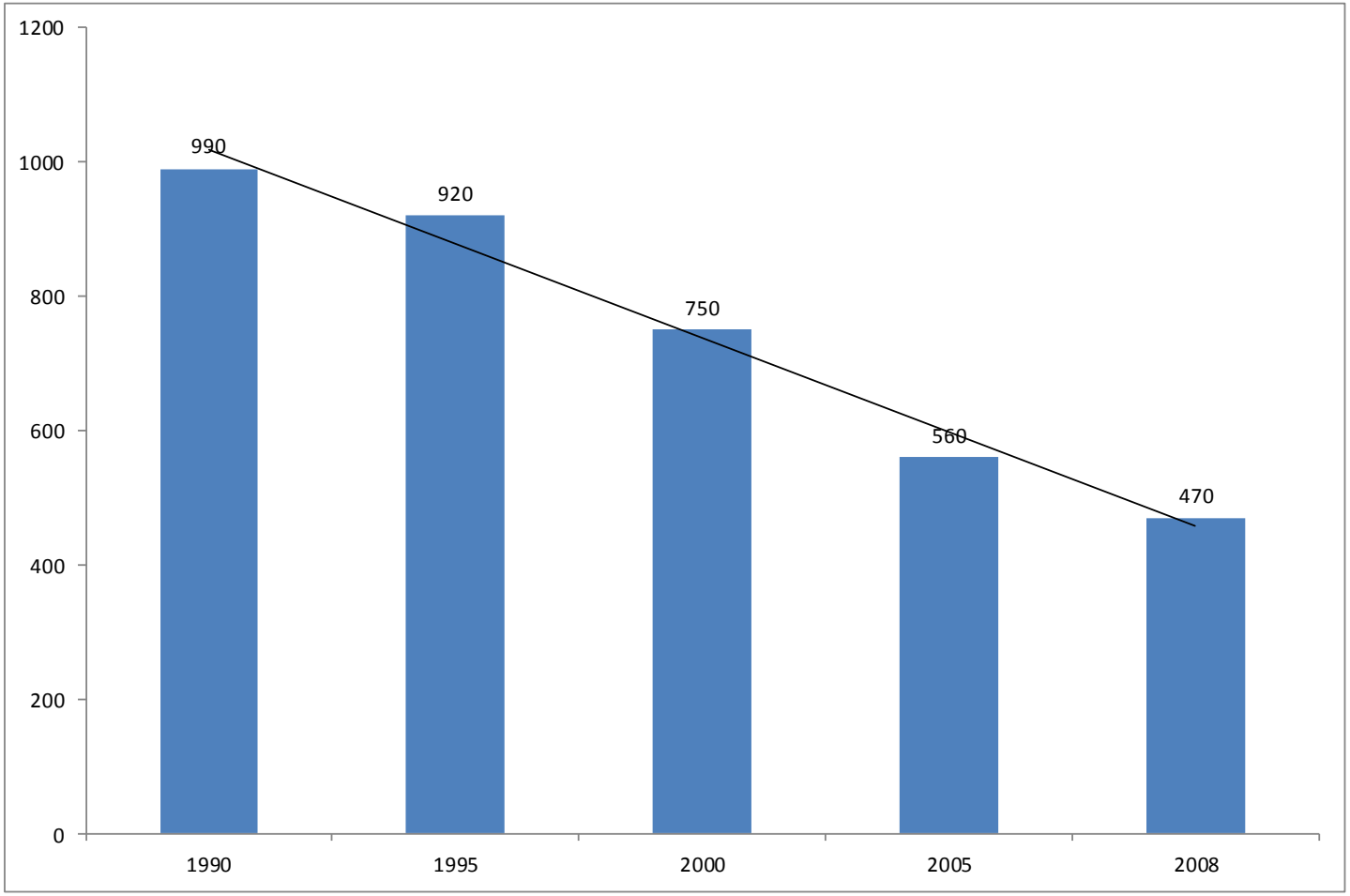
Health outcome trends: Selected illustrations



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



CBHI as a pathway to UHC: Lessons

Universal health coverage

- 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

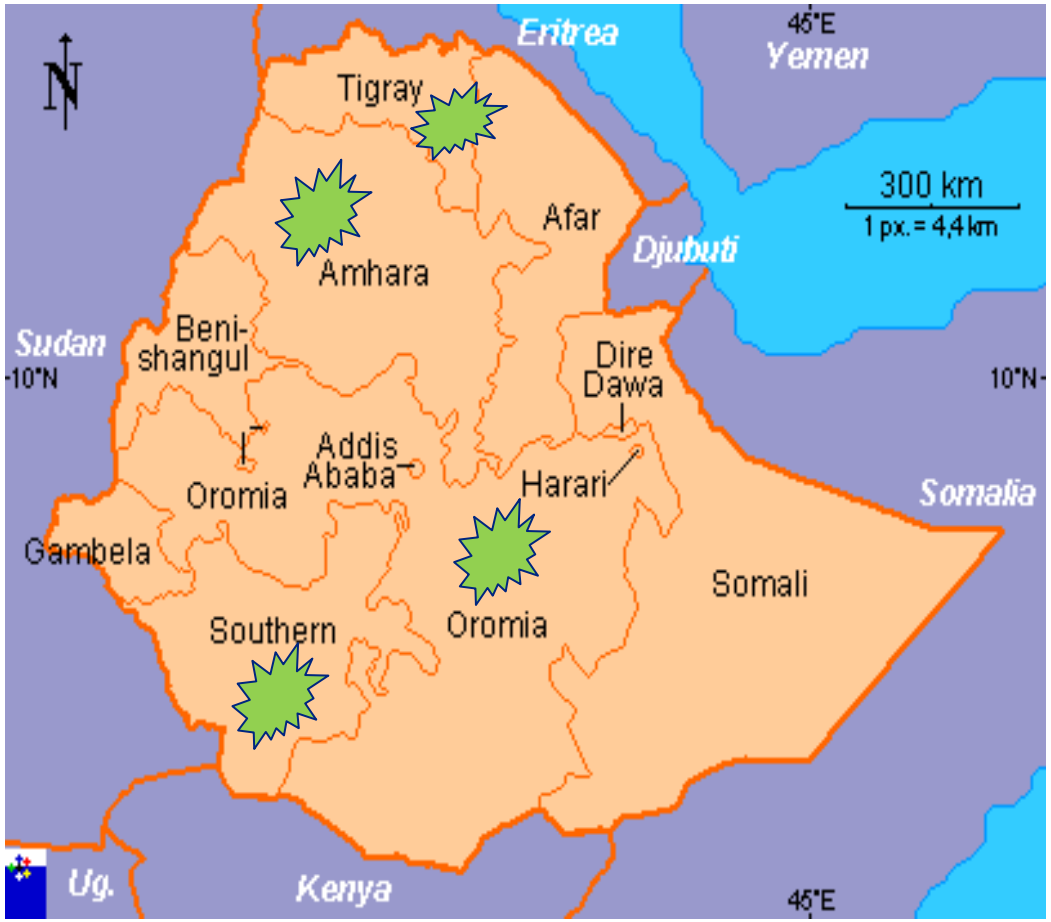
CBHI: definition and rationale for Ethiopia

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

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