



TECHNICAL BRIEF

Community-Based Health Insurance: Achievements and Recommendations for Sustaining Gains in Ethiopia

The USAID-funded HSFR/HFG project provides technical assistance to the Government of Ethiopia to implement and scale-up health care financing reforms across the country. The goal is to increase access to and utilization of health services through improved quality of health care and reduced financial barriers.

Project objectives are to:

- Improve the quality of health services
- Improve access to health services
- Improve governance of health insurance and health services
- Improve program learning

June 2018

THE CHALLENGE

Low per capita health spending, high out-of-pocket expenditures, and low health care services utilization

Ethiopian health sector spending has risen steadily over the past two decades; annual per capita spending on health increased from US\$4.50 in 1995/96 to US\$28.65 in 2013/14.¹ Nevertheless, spending remains below the national target of US\$32 and the World Health Organization's recommended level of US\$60 by 2015 for low-income countries.² The total amount of spending for health in Ethiopia was estimated to be 49.6 billion birr in 2013/14, about one-third of which was out-of-pocket expenditure.³ High out-of-pocket costs can be catastrophic or impoverishing for those who do access health care services and they also have been identified as an important barrier to health service utilization, which currently is about 0.63 visits per year.⁴

The Ethiopian government, through the Federal Ministry of Health (FMOH), has been pursuing health care financing (HCF) strategies to increase the amount of domestic resources mobilized to the health sector, and to increase utilization of health services while also protecting the population from prohibitive user fees or catastrophic spending at time of sickness. Community-based health insurance (CBHI) has been the principal government effort to this end.

¹ Federal Democratic Republic of Ethiopia Ministry of Health. August 2017. *Ethiopia Health Accounts, 2013/14*. Addis Ababa.

² World Health Organization. 2014. *WHO African Region Expenditure Atlas November 2014*. WHO Regional Office for Africa. Brazzaville.

³ Federal Democratic Republic of Ethiopia Ministry of Health. August 2017. *Ethiopia Health Accounts, 2013/14*. Addis Ababa.

⁴ Federal Ministry of Health. 2016. *Health and Health Related Indicators*. Addis Ababa.

THE RESPONSE

Community-based health insurance

Health insurance was initiated in Ethiopia with the objective of mitigating financial barriers to health care. Its genesis can be traced back to 1998, when the FMOH issued its Health Care and Financing Strategy.⁵ The CBHI program is guided by this strategy, which states that the program aims to promote equitable access to health care, increase financial protection, promote cost sharing between the government and citizens, and enhance domestic resource mobilization for the health sector and social inclusion in health, mainly for rural households and for those who are engaged in the urban informal sector.

Led by the FMOH, regional health bureaus (RHBs), and local administrations, CBHI was piloted in 2010 in 13 woredas (districts) located in the country's four most populous regions: Amhara, Oromia, Southern Nations, Nationalities and Peoples (SNNP), and Tigray. Preparation for the pilot was thorough: Officials and staff from the Ethiopian parliament permanent social standing committee, ministries of Finance and Economic Development and of Labor and Social Affairs, and development partners visited African, Asian, and Latin American countries to learn from their experiences in implementing health insurance. A feasibility study was conducted to understand and define CBHI design parameters and consultations and policy workshops were held with stakeholders to decide on the basic design features of the program, including the unit of enrollment, benefit package, contribution level, subsidy requirement, and governance and staffing structure. A monitoring and evaluation modality was designed. Health facility and other actors were trained in aspects of CBHI implementation. Awareness creation and community mobilization activities were carried out, and four control woredas were selected to evaluate the pilot.

After two years, the pilot program was evaluated. Based on evaluation findings and recommendations, the Ethiopian government decided to scale up the CBHI program. A CBHI scale-up strategy to expand the CBHI program to new woredas within the "pioneer" regions as well as to additional regions was designed. A CBHI scale-up directive was endorsed in 2015, and was subsequently tailored to each regional context. Today, various FMOH policy and program documents, including the national Health Sector Transformation Plan (HSTP), have recognized CBHI as a

core government agenda and the preferred mechanism by which Ethiopia plans to achieve universal health coverage. The HSTP recognizes the government target of covering 80 percent of woredas and 80 percent of the country's population with CBHI by the end of the plan in 2020.

The Ethiopian Health Insurance Agency (EHIA) was established within the FMOH to lead the technical aspects of health insurance in the country. Since its establishment, the EHIA has overseen CBHI and issued numerous working documents (directives and manuals) that support CBHI implementation and operationalization.

Regionally, the process of implementing the CBHI program has been led by regional cabinets, regional steering committees, RHBs, zonal and district cabinets, and kebele cabinets.⁶ The primary role of local (regional, zonal, woreda, and kebele level) administrative structures is to: conduct community mobilization for registration and enrollment; target and identify households, and allocate budget to include the poorest (indigent) of them in CBHI through a local government subsidy; and provide political leadership and overall stewardship of the program. Routine work at the CBHI scheme level, such as registration, identification card preparation, data management, financial management, and reporting, is managed by full-time government employees who are paid with funds from the treasury.

CBHI INTERVENTIONS AND RESULTS

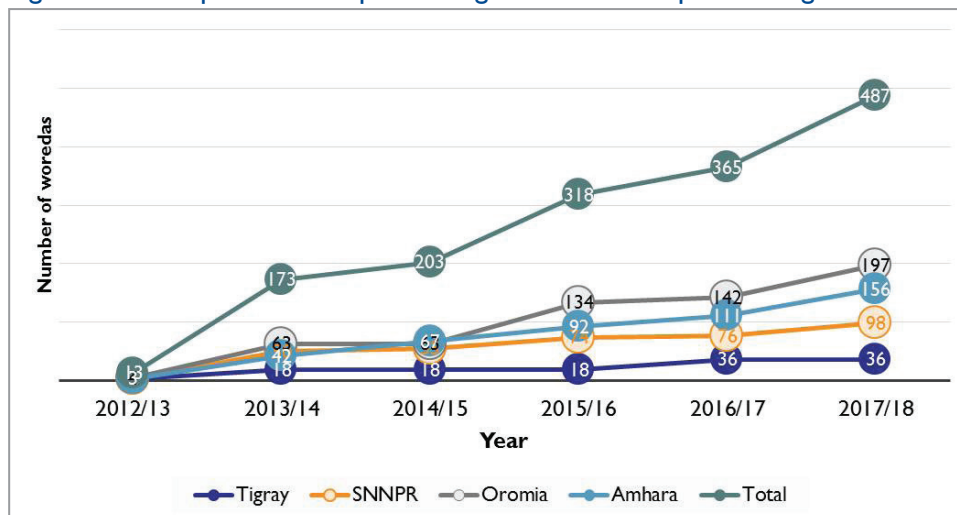
CBHI scale-up

The CBHI program has increased from the 13 pilot woredas established in 2010 to 512 as of March 2018. CBHI scale-up has been conducted using a phased approach – the program was first scaled up within the pilot woredas and then expanded to other woredas in the original four pioneer regions, where it still is most widespread (Figure 1). More recently, it was introduced in Benishangul-Gumuz and Harari regions and Addis Ababa and Dire Dawa city administrations. In Benishangul-Gumuz, three woredas were selected to implement the CBHI program, two of which have completed preparatory activities and have started covering the expenses of the beneficiaries through the CBHI schemes. Harari region and Dire Dawa city administration have put in place their legal frameworks to implement the program and have begun conducting preparatory activities including community mobilization.

⁵Federal Ministry of Health. 1998. *Health Care and Financing Strategy*. Addis Ababa.

⁶ Kebele is the lowest administrative unit in Ethiopia.

◆◆◆ Figure I. Scale-up of CBHI-implementing woredas in the pioneer regions



Addis Ababa launched CBHI in 2017/18 by selecting one woreda from each of the 10 sub-cities; the program will expand to cover other woredas in the city administration based on the experience of the current woredas.

When a woreda considers establishing a CBHI scheme, woreda authorities assess its feasibility in terms of implementation capacity of the woreda administration, readiness of health facilities to provide quality services to CBHI members, and community readiness to embrace the program. The decision to start CBHI is made by the local administration with subsequent approval from zonal and regional authorities. This process means that woredas can venture into CBHI only after assessing their readiness to effectively lead and implement the program.

Community mobilization, membership, and enrollment

Increasing knowledge and awareness of CBHI and mobilizing the community to make informed decisions to register and renew (re-enroll each year) has been the responsibility of woreda and kebele government. The approaches used include sensitization at public gatherings, meetings, and cultural and community events and festivals, and through tailored trainings on CBHI at schools so students can encourage their parents to join the schemes. Mass media such as radio and television have also been used as a method of communicating CBHI messages.

Membership in CBHI is voluntary. Members come from self-paying households and from non-paying households. Households that are relatively better off economically enroll as payee members and pay the contributions themselves, whereas very poor households that have been identified and included on an official list by woreda authorities are enrolled as indigent members. Indigents' contributions are paid for through a targeted subsidy funded by regional governments and woreda administrations, in a 70:30 percent split except in SNNP where districts pay 100 percent. The unit of membership in both cases is the household. With slight differences between regions, the number of indigents is to be 10 percent of a woreda/town administration's CBHI-eligible population.

With an ultimate aim of reaching 100 percent membership of eligible households (universal enrollment), regions have set a minimum membership level that must be achieved prior to establishing and running a CBHI scheme. These minimum thresholds are intended to keep schemes financially sustainable and socially inclusive with an appropriate risk mix.⁷ The minimum threshold used to be 30 percent of eligible households enrolled (20 percent in Oromia) but was revised to 60 percent in 2015.⁸

The average enrollment ratio in the pioneer regions in 2016/17 was 57 percent in Tigray, 56 percent in Amhara, 52 percent in SNNP, and 28 percent in Oromia.⁹

⁷Of the 60 percent threshold, 50 percent is self-paid by member contributions and 10 percent paid by government subsidy for the poor/indigent.

⁸ Federal Ministry of Health. 2016. CBHI Scale-up Prototype Directive.

⁹Registration and renewal activities for the current fiscal year are still under way and the final enrollment ratio for 2017/18 is not yet determined.

◆◆◆◆ Figure 2. Number of households enrolled in CBHI in the pioneer regions

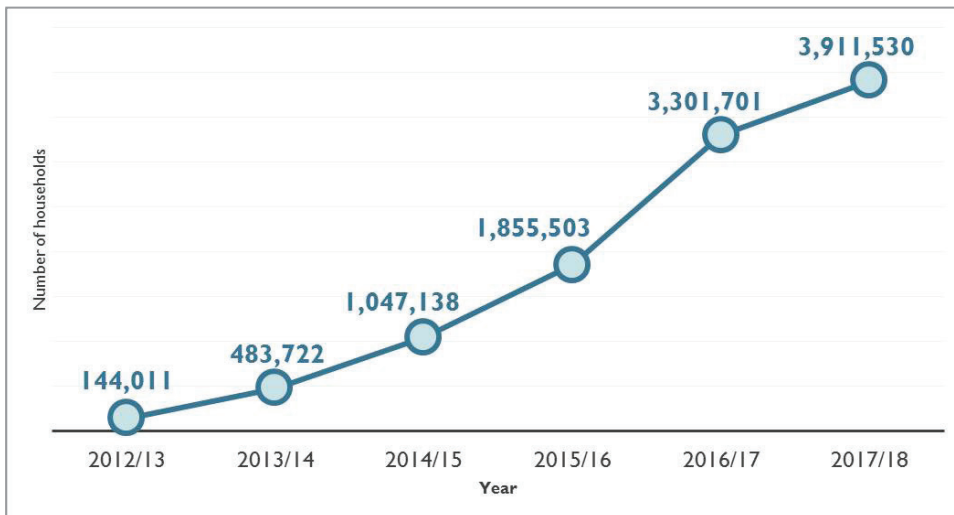


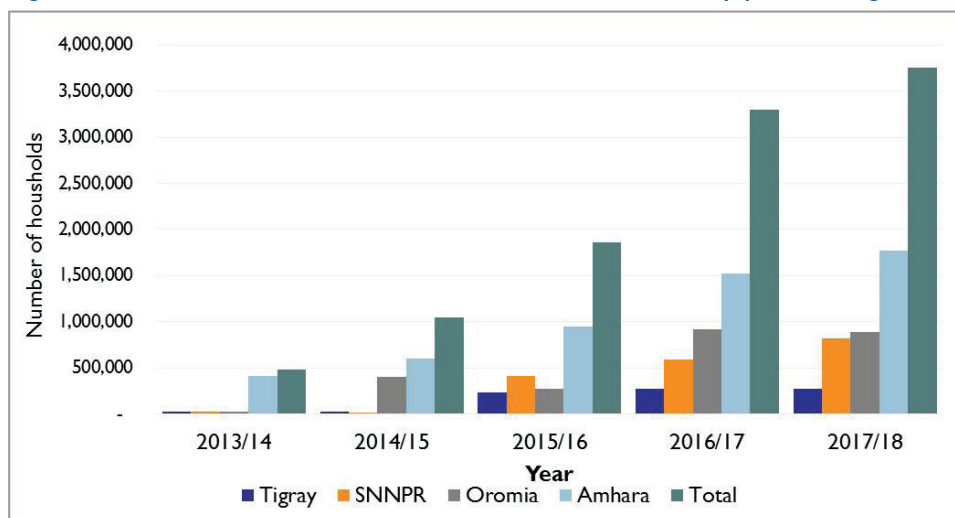
Figure 2 shows the steady growth of CBHI membership in the four regions over the last five years. Household enrollment, and therefore the number of individual beneficiaries, has increased from over 144,000 households (about 660,000 beneficiaries) in 2012/13 to over 3.9 million households (nearly 18 million beneficiaries) as of March 2018. This means that about 18 percent of the total population of Ethiopia has access to health services through CBHI schemes as of March 2018.

Membership enrollment and renewal is open once a year, from December through March; these are high harvesting months, a time when community members typically have money available to pay CBHI contributions. However, woredas have the option to set their registration period to a different time of year, depending on when their residents earn the most income. Fixing the registration/

renewal time to a clearly defined period has helped to lower woreda administrative costs (by focusing most of the CBHI administrative work) and to control adverse selection (people enroll during a specified period, not only when they are sick).

As shown in Figure 3, CBHI enrollment in the four pioneer regions has greatly increased each year since 2013/14. Growth seems to have slowed in the current fiscal year (2017/18), but final numbers are not in – registration and renewal activities were still underway when this brief was being written. During the past five years, all four regions worked to register as many households as possible. Amhara is in the lead with more than 1.7 million households enrolled; Oromia follows at nearly 1 million households, while SNNP and Tigray have enrolled about 864,000 and 272,000 households, respectively.

◆◆◆◆ Figure 3. Number of households enrolled in CBHI schemes by pioneer region, 2013/14–2017/18



Resource mobilization

The main sources of revenue for CBHI schemes are:

1) membership contribution payments from self-paying members; 2) a general subsidy from the federal government; and 3) a targeted subsidy for the indigent, from regional and woreda administrations.

Payments from members include a one-time registration fee and an annual enrollment/renewal contribution. Kebele cabinet and got¹⁰ leaders collect these monies. They document receipt of the contributions using cash collection vouchers and deposit the cash at banks or similar financial institutions. To improve collection efficiency, Amhara, Oromia, and Tigray regions recently introduced a provision to pay kebele cash collectors a small incentive payment (2 percent of the collected contribution).

In earlier years, the annual contribution paid by households significantly differed among regions. Subsequently, the EHIA set a uniform, minimum contribution amount, to which regions are advised to adhere. The EHIA plans to introduce sliding scale contributions based on ability to pay. As a step in this direction, the EHIA has set different minimum contributions for rural and urban residents; they range from 200 to 350 birr, with some variation among regions. All large cities collect a 500 birr annual contribution per household. The household contribution covers only core family members (spouse and children under 18); extended family members pay additional contributions to be registered as beneficiaries under the head of household.¹¹

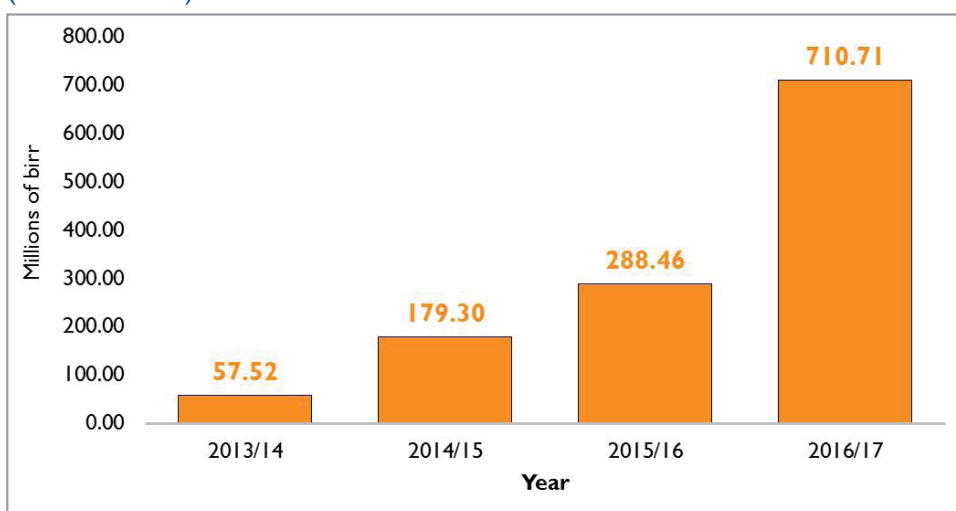
The amount of contributions collected by schemes from paying households alone has increased more than tenfold, from 41.42 million birr in 2013/14 to nearly 515.8 million birr in 2017/18.

Total resources mobilized (i.e., contributions plus general and targeted subsidies) for the current fiscal year is expected to increase as community mobilization activities continue to enroll and renew more households over the year.¹²

Figure 4 shows that the volume of resources mobilized by CBHI schemes is increasing significantly as more and more woredas launch the program and households enroll and renew. The total amount mobilized through CBHI in 2016/17 exceeded 710 million birr, which is more than double the amount of the previous year and more than a twelfold increase over the four years.¹³

The resources mobilized from self-paying household contributions provide the majority (84 percent) of CBHI scheme revenue (Figure 5). The general subsidy from the federal government accounts for 7 percent, and the targeted subsidy accounts for 9 percent. The general subsidy is released once a CBHI scheme has completed all of its preparatory work and starts providing coverage for health services rendered to beneficiaries. The CBHI program plays a vital role in increasing the commitment of the government to CBHI, as the legal provisions require the government to cover the full contributions of indigent households and make a matching contribution of 10 percent to each CBHI scheme based on the contributions mobilized from enrolled households.

◆◆◆ Figure 4. Total resources mobilized from CBHI contributions, general subsidy, and targeted subsidy (millions of birr)



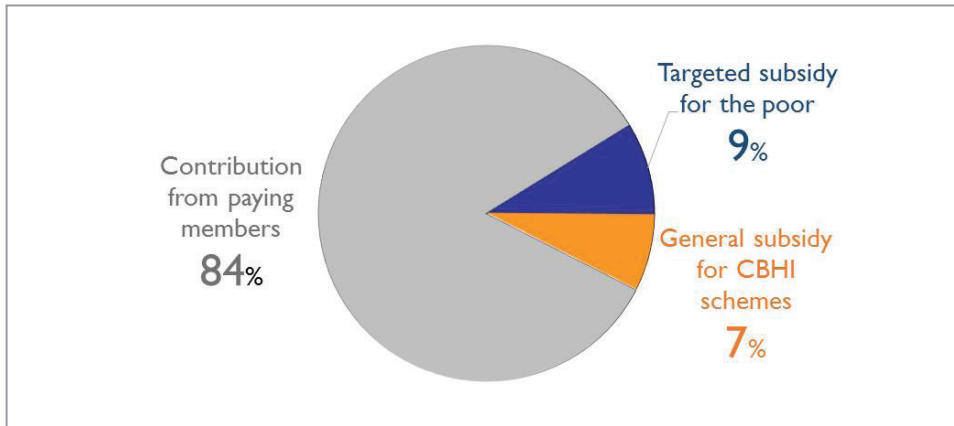
¹⁰A "got" is a sub-village within a kebele.

¹¹Extended family members are family members other than the spouse and children who live in and depend on the income of the CBHI member household head.

¹²Security issues this fiscal year led all regions to extend the period of community mobilization activities.

¹³Final data for all of 2017/18 will be available in July 2018.

◆◆◆ Figure 5. CBHI scheme revenue by source



Health facilities are using the significant resources mobilized through CBHI to improve health service quality. The health sector, and particularly woreda health offices and health facilities, are now better positioned to plan ahead for quality improvement initiatives because they can reasonably forecast the amount of resources they will get from the community and government through CBHI schemes.

Benefit package and health service utilization

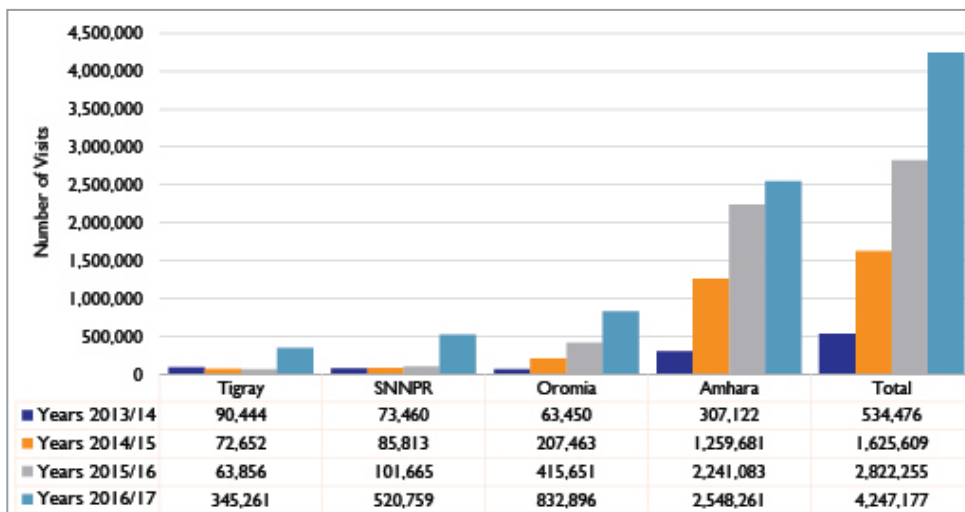
The main purpose of CBHI is to improve access to health care by reducing the financial burden of obtaining it. CBHI beneficiaries are entitled to access a package of basic curative health services free of charge (no co-payment) at the time of service at public facilities. In some instances, CBHI schemes also contract with private and community facilities, particularly pharmacies, to provide services when public facilities cannot; in most cases, this is providing medications when there are drug stock-outs in public facilities. There is no set limit to the amount of services a beneficiary can obtain but the services must be on the list covered under the benefit package.

Beneficiaries must first enter the health care system by accessing services at health centers. They can obtain hospital-level services when referred by the health center (except emergency care, which can be accessed without referral).

Schemes enter into contract agreements with health facilities to provide services to and be reimbursed for health services provided to CBHI members. Facilities are selected by schemes and the community based on their proximity to members, so they may be located in or adjacent to the woreda where beneficiaries reside. Beneficiaries included in a household membership are issued and are required to bring CBHI identification cards to access services. There is nothing on the card that indicates the type of membership a household has (i.e., self-paying or subsidized indigent), which reduces bias and stigma among providers or others in the community.

Evidence shows that CBHI has contributed to an increase in the utilization of modern health care services. As can be seen in Figure 6, the number of visits made by CBHI beneficiaries in the four pioneer regions has increased from about half a million in 2013/14 to more than 4.2 million

◆◆◆ Figure 6. Number of health service visits made by CBHI beneficiaries by region and year



in 2016/17.¹⁴ A recent study conducted by the Health Sector Finance Reform/Health Finance and Governance (HSFR/HFG) project, which examined utilization at 28 health centers, found that the utilization rate for CBHI beneficiaries has reached 0.67 visits per year while the rate for non-members is 0.39.¹⁵ This means that the CBHI-insured population is 1.7 times more likely to visit health facilities than the non-insured. Anecdotal evidence indicates that many people who have lived with untreated illness or conditions for years have visited facilities and benefited from health care after enrolling in CBHI.

The provider payment mechanism used under CBHI is fee for service. Each facility submits its request to the CBHI scheme either monthly or quarterly; payment is quarterly. Before payment is made, the CBHI scheme and EHIA does a clinical audit of the claim, to evaluate the quality and appropriateness of care and identify and address issues like fraudulent requests and inadvertent errors.

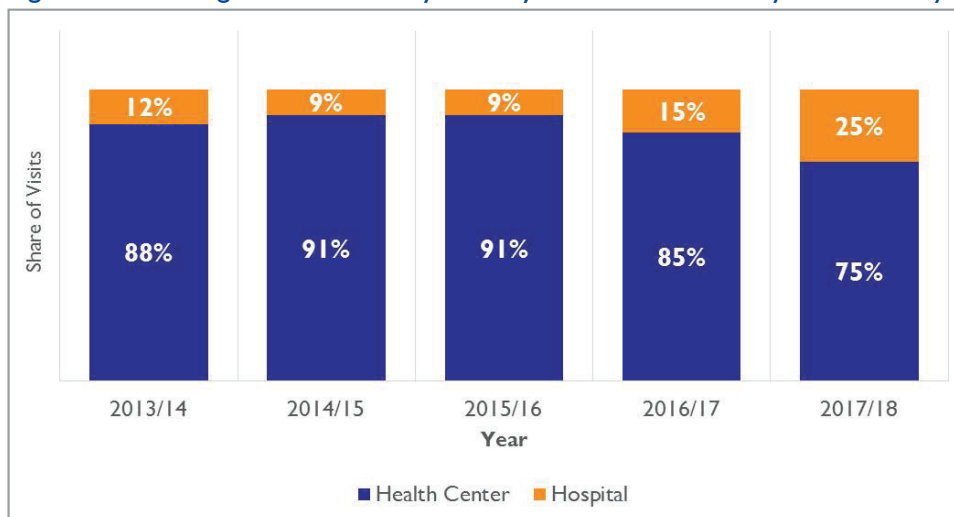
CBHI schemes' routine reports indicate that the proportion of visits between health centers and hospitals is in line with general health policy, with most services and utilization occurring at the primary care level. Over the last four years, about 75–91 percent of total CBHI beneficiary visits were at health centers and the remaining visits were at hospitals (Figure 7). This is in line with the expectation that insured patients are advised/obliged to first visit health centers before accessing hospital services.

Regarding resource flow, health centers have received the majority of reimbursements made by CBHI schemes (out of the total reimbursements made to all facility types). In 2016/17, for example, out of the total reimbursements made by CBHI schemes, 67 percent went to health centers, 33 percent to hospitals.

Governance of CBHI schemes

CBHI schemes have their own governing structures that comprise a general assembly and a woreda-level CBHI board. The general assembly is made up of CBHI members who represent the community, and of representatives from relevant woreda government offices such as the woreda administration, health office, finance and economic development office, and women and children's affairs office. The general assembly is the highest decision-making body of a CBHI scheme's governance structure. It is responsible for reviewing and evaluating the scheme's annual report, nominating its board members, and approving its audit report. When local CBHI issues arise, such as setting the dates of the registration and renewal season and deciding whether to include households with two or more spouses, it is the general assembly that determines how the issue will be addressed. CBHI boards are selected from members of the general assembly. While the generally assembly meets once per year, the board is expected to meet quarterly to deliberate agenda items including reviewing scheme performance.

◆◆◆◆ Figure 7. Percentage of health facility visits by CBHI beneficiaries by health facility type and year



¹⁴ Visits for 2017/18 are not shown as data from all regions is not yet available this year.

¹⁵ Seyoum Akililu. May 2018. *Community-Based Health Insurance Performance and Implementation Challenges: A Study of Data from Sample Schemes, Kebeles, and Health Facilities*. Rockville, MD: Health Finance and Governance Project, Abt Associates Inc.

Because CBHI is community based, involves annual contributions, and currently lacks automated data management, it requires strong and regular monitoring and review. This is provided by zonal, woreda, and kebele administrations and health departments. Middle- and higher-level government structures like the FMOH, the EHIA, and RHBs have also played an important role in overseeing CBHI implementation process, in making effective working environments for scheme staff, and in providing monitoring and follow-up.

RECOMMENDATIONS FOR STRENGTHENING CBHI

Higher-level risk pooling: Given the voluntary nature of CBHI membership, the size of the CBHI risk pool (currently limited to the woreda level) is not large enough to provide access to a broad benefit package. Even the current CBHI schemes have gaps in their efficiency and capacity to manage contracts with higher-level (higher than woreda-level) health facilities such as referral and tertiary-level hospitals. Larger and higher-level pools may provide the leverage to facilitate contracting with these health facilities. There is discussion in Ethiopia about developing a higher-level pooling mechanism. If the nation wishes to accelerate its move toward universal health coverage in the near future, it will need to increase CBHI enrollment and create higher-level pools that foster cross-subsidization among different socio-economic groups in the country and that promote access to a more comprehensive benefit package while striving for a national health insurance system.

Modern information management system: CBHI implementation generates a significant volume of data on members (profiles, contributions, and health service utilization) that must be stored, protected, processed, and analyzed. This is becoming increasingly difficult to do using a manual system. A modern, automated health insurance information management system is needed.

Capacity building and technical support: CBHI is relatively new to the health financing system in Ethiopia, and Ethiopia is a large country. The prime stakeholders involved in its implementation need to be oriented to the benefits and features of the program and trained on their duties and responsibilities. Continuous capacity building and technical assistance are needed for successful expansion and consolidation of the program.

Building membership: CBHI membership currently is voluntary. It might be challenging to institute a mandatory CBHI program – enforcement would be difficult given the target population, which is engaged in the informal economy and is largely dispersed across vast rural areas. Continuous community sensitization and mobilization efforts are therefore critical to retain existing members and attract new ones.

Sliding scale for CBHI contributions: The current contribution amount should be re-examined to establish a sliding scale that takes into account the ability of people in different income groups to pay the required contributions. If the CBHI program aims to increase equity in access to health care, it would further improve equity by setting contribution levels based on the ability of different income groups to pay.

Sustainability hinges on quality service delivery: The sustainability of the CBHI program is directly related to the growth in program uptake. The quality of health services, particularly the availability of most needed drugs in public facilities, affects households' decisions whether to enroll or renew. Government at all levels should work to improve health service quality in general and the availability of drugs in particular.

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A flagship project of USAID's Office of Health Systems, the Health Finance and Governance (HFG) Project supports its partners in low- and middle-income countries to strengthen the health finance and governance functions of their health systems, expanding access to life-saving health services. The HFG project is a six-year (2012-2018), \$209 million global health project. The project builds on the achievements of the Health Systems 20/20 project. To learn more, please visit www.hfgproject.org. The HFG project is led by Abt Associates in collaboration with Avenir Health, Broad Branch Associates, Development Alternatives Inc., Johns Hopkins Bloomberg School of Public Health, Results for Development Institute, RTI International, and Training Resources Group, Inc.

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