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Community Consultations Held to Discuss Draft CBHI Proclamation

The draft community-based health insurance (CBHI) proclamation was the subject of 19 public consultation meetings held in July and August in Ethiopia's nine regions and two city administrations. Once passed, the proclamation will be the legal cornerstone for CBHI rollout. Over 3,500 people participated in the meetings. These public forums gave community members the opportunity to raise any questions or issues they had about the draft. Community representatives included cultural and religious leaders, as well as representatives of women's and youth groups.

The USAID Health Financing Improvement Program provided technical support to facilitate these meetings by providing resource persons who made presentations and led the discussions.

At the consultation meetings, attendees raised questions ranging from how CBHI identification cards would be issued, to why CBHI did not cover eye glasses, and whether it would cover housemaids living in a household. Some individuals expressed concern about possible future plans of moving to higher-level CBHI pools at the regional or federal levels, preferring the existing woreda-level pools which allow woredas (districts) to manage their own resources.

Participants also offered suggestions that included: Increasing government subsidies to enable coverage of all indigents/poor (poorest of the poor, unable to pay) with free enrolment in the CBHI schemes; allowing children older than 18 to be covered through their household membership; issuing identification cards for each household member to facilitate timely access to care; and reimbursing only 50% of expenses for hospital services accessed without following the referral system.

Some commented that urban lower-income people working in the informal sector are generally poorer than those in the rural areas, and suggested that CBHI enrolment fee/premium should not be higher in urban cities.

Some participants said that the regional-level public consultation meetings were good but should also be held at the 'got' or village level for fuller community feedback. They also recommended that the draft proclamation be translated into local languages so more people could read it.

The inputs gathered from all regions will be taken into consideration to help enrich the proclamation. The Ethiopian Health Insurance Agency will have separate discussions with regional health bureaus to improve the draft. There will be a final review by the Ministry of Health before its submission to the Council of Ministers.

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Committed Leadership Contributes to Successful CBHI Implementation in Jida Woreda

Jida and three other woredas in North Shewa zone were selected by the Oromia Regional Health Bureau (RHB) to start community-based health insurance (CBHI) in 2017/18. Of the four woredas, Jida was the only one that launched CBHI in the same year. It enrolled 72% of eligible households, which was way above the minimum requirement of 50% for initiating a CBHI scheme, and the highest enrollment rate in Oromia. By comparison, other woredas in Oromia selected for CBHI achieved less than 40%.

Currently in its second year, the CBHI renewal and new enrollment rate has reached 85% of Jida's nearly 14,000 eligible households, representing one of the highest percentage of enrolled households in the region. Nearby woreda representatives have already started visiting the woreda to learn about the success factors contributing to Jida's high level of performance.

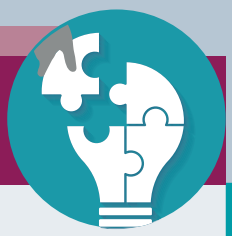
What are some of these success factors?

- Immediately after attending a two-day CBHI orientation workshop organized by the Zonal Health Department (ZHD), Jida leaders continued their planning efforts by holding similar meetings with kebele leaders and community representatives, followed by additional meetings in each kebele with even more community representatives and volunteers.
- Jida authorities acted quickly and immediately allocated funds from the woreda's available budget. The woreda administrator held a meeting with heads of various offices, including health and finance, and made a series of key decisions.
- The woreda allocated budget for CBHI operational expenses, including the printing of receipt vouchers for all 14 of its kebeles which otherwise should have been made available by the Bureau of Finance and Economic Development. Because CBHI schemes do not have the mandate to print receipt vouchers, they obtained approval from the regional finance bureau prior to doing so. According to Habtamu Geleta, CBHI Coordinator at North Shewa ZHD, this seemingly simple decision enabled the woreda to speed up the process and launch CBHI coverage a year ahead of the other woredas.
- When the CBHI registration and renewal period approaches, the CBHI board requests kebele officials, religious leaders, Aba Gedas (traditional leaders of Oromo communities), and other community representatives to start CBHI mobilization and registration work at the community level. They notify people about CBHI registration and membership fee collection dates at religious events and community meetings with enough advanced notice for them to organize their cash for registration. The advance work is so intense that cash collection in a kebele is usually completed within five days, with all eligible and paying households having made their contributions. By comparison, some kebeles elsewhere can take more than a month to finalize cash collection.
- The woreda obtained CBHI identification cards from the zone and sent a locally-hired crew of photographers to villages to take the group photo of household members for each household. This expedited photos required for identification cards which is often a bottleneck to CBHI members' ability to start accessing care.

Credit: Ayenew Haileselassie

Jida woreda

Achievements made during the first two years of CBHI operations testify to the high level of institutional commitment and community involvement in Jida. The USAID Health Sector Financing Reform/Health Financing and Governance project (2013-2018), implemented by Abt Associates, also played a part in the woreda's success. In its first year of CBHI implementation, the project helped the woreda in encoding and entering CBHI application form data on a computer, and developed databases for CBHI members, contributions, and service utilization. Support continues under the USAID Health Financing Improvement Program (2018-2023) with technical assistance for review meetings and supportive supervision at the regional and zonal levels in Oromia. Findings from these interventions are used in guiding CBHI practices in woredas across the region.



Domestic Resource Mobilization for Health in Ethiopia

Domestic Resource Mobilization (DRM) is the process through which countries raise, allocate and spend their own funds to finance public services, including health.[1] DRM for health is key to ensure health services and products are available on a sustained basis. Mobilizing resources for health domestically is a country's path toward universal health coverage (UHC) – enabling people and communities to use the health services they need, at a level of quality, ensuring that the use of these services does not cause financial hardships.

To reach UHC, projections of resource needs show that low income countries, such as Ethiopia, will have to spend on average at least US$ 112 per capita on health by 2030 (Stenberg, et al., 2017). For many countries the combination of stagnant and declining donor funding and increasing demand for health highlight the need to mobilize more resources. According to the latest National Health Accounts accomplished this year (2019), in Ethiopia, per capita health spending was $33.21 in 2016/17, with 35% of it accounting for donor contributions. Thus, the Government of Ethiopia (GOE) is challenged to rapidly accelerate and increase domestic financing for health.

Currently the GOE is revising its 1998 health financing strategy. The draft strategy aims to mobilize more resources for the health sector from domestic public sources such as general and earmarked taxes. It also emphasizes mobilizing revenues from households and governments at different levels of the country (national/sub-national) by expanding prepayment/risk pooling mechanisms, Community-Based Health Insurance (CBHI) for informal sector households and Social Health Insurance (SHI) for formal sector households. In 2011, CBHI was pilot tested in 13 districts. Currently CBHI coverage has reached over 500 districts (about half of the districts in the country) providing financial protection for over 20 million Ethiopians. Together, with contributions from the households and general and targeted subsidy from the government, sizable amount of funds are being mobilized through the CBHI program.

The share of domestic financing (government and households) in total health expenditure (THE) is showing improvement - from 49% in 2010/11 to 65% in 2016/17. However, donor financing of health remains substantial – still accounting for more than a third of the THE. Given the risk of declining donor funding in future, Ethiopia's ambition to reach lower middle income country status by 2025 and its commitment to achieve UHC through primary health care, the country needs to rapidly and significantly increase its domestic financing of health. This includes an increased share of health spending as percentage of gross domestic product and an increased share of government spending on health as a proportion of general government expenditures. In combination with other DRM strategies, increased domestic financing will facilitate overcoming the shortfalls resulting from possible decline in donor funding, and ensure more resources to address the increasing demands for health care.

Health spending has steadily increased over the last two decades – $4.5 per capita spending in 1995/96 to $33.21 in 2016/17. However, per capita health spending is still low, compared to the needs for reaching the SDG goal of UHC by 20130. The USAID Health Financing Improvement Program provides technical assistance to the GOE in achieving the increase in the share of domestic resources from 64% in 2013/14 to at least 70% by the end of the program period in 2023.

[1] USAID. 2017. Domestic Resource Mobilization. Washington, DC. https://www.usaid.gov/what-we-do/economic-growth-and-trade/domestic-resource-mobilization

Oromia Regional Health Bureau Conducts Consultative Meeting on Health Care Financing Reform Implementation

Oromia is the biggest region in Ethiopia. It has been implementing health care financing (HCF) reforms for more than a decade with technical support from USAID projects, including the current USAID Health Financing Improvement Program. In an effort to further improve the performance of the HCF interventions, a regional consultative meeting was held in Adama on July 10. The meeting focused on HCF reform implementation by government authorities and was attended by133 participants, including Regional Health Bureau (RHB) heads and deputy heads, zone and town administration health office heads, hospital CEOs, and development partner representatives that support HCF reform implementation in the region.

Dr. Dereje Duguma, Head of the Oromia RHB, opened the meeting. He noted that HCF reform had led to quality improvements and other positive changes in the health services thanks largely to health facility leadership. He urged hospital and health center heads to deliver even more.

Following the opening speech, Mr. Deresu Tsegaye, the USAID Health Financing Improvement Program's Senior Health Care Financing Advisor for the Oromia Region, presented findings from integrated supportive supervision that was conducted in 2019 at 44 health facilities (38 health centers and 6 hospitals). Supportive supervision is conducted jointly by government officials from relevant departments, agencies and technical support groups to review the progress in reform implementation and identify the shortcomings and challenges that the government needs to address going forward. Data and findings/observations presented by Mr. Deresu served to guide the meeting discussions.

Mr. Deresu's presentation was followed by a discussion chaired by Dr. Dereje Duguma and his two deputies, Dr. Abdulkadir Gelgelo and Mr. Dereje Abdena. During the discussion, participants raised a number of challenges encountered in the HCF reforms implementation, including:

- Starting reforms in new health facilities without adequate training for personnel.
- Poor audit practices at some health facilities.
- Lack of clarity in the region with respect to the provision of some exempted health services. For instance, the boundary between pregnancy and non-pregnancy related illnesses.
- Inadequate budget allocation for the exempted health services.
- Outsourcing practices that were causing health facilities to lose revenue because of high costs related to the outsourced services.
- Private wing being poorly implemented, with lack of clarity in the directive as a possible cause.

Dr. Abdulkadir, Deputy Head of the Bureau, said that the Oromia RHB would establish a committee to address the issues raised during the meeting. He also stated that the RHB would develop a format for health facilities to report expenses incurred for exempted services.

Meeting participants expressed appreciation that the consultative meeting was organized and they could raise, discuss and address the issues relevant to the furtherance of the HCF reforms implementation.

At the meeting's close, the RHB urged facilities to start implementing the recently revised, region-wide user-fee schedule that was to be take effect in July 2019. The RHB also reaffirmed to participants that it will provide technical support in implementing the HCF reforms and their further strengthening in collaboration with development partners like the USAID Health Financing Improvement Program. Zone and woreda level Planning, Budgeting, Monitoring and Evaluation offices have started to assign focal persons to work with the regional Resource Mobilization Directorate based on decisions made by the RHB following the meeting.

Health Financing is a quarterly newsletter produced by the USAID Health Financing Improvement Program that supports the Ethiopian government in its efforts to further strengthen health financing functions and systems to support universal health coverage of quality primary health care services for Ethiopian citizens with reduced financial barriers. Abt Associates implements the Program in collaboration with core partners Breakthrough International Consultancy, Dimagi, the Institute for Healthcare Improvement, and Results for Development, and resource partner Harvard School of Public Health. Cooperative Agreement No.: 72066319CA00001.

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