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Health Finance & Governance Project
Technical Briefing
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Health Finance & Governance
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The Role of Health Insurance in UHC: Learning from Ghana and Ethiopia

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

Experts

Presenters

Chris Lovelace, MPA
Principal Associate, Health Governance Specialist, Abt Associates Inc.
30+ years experience in public health
Former: British Columbia Min. of Health, New Zealand Min. of Health, World Bank

Hailu Zelelew, MA
Senior Associate/Health Economist, Abt Associates Inc.
25+ years experience in development and health
Former: Government of Ethiopia, several NGOs in Ethiopia including World Vision

Moderator

Jeanna Holtz, MBA
Principal Associate, Health Insurance Specialist, Abt Associates Inc.
25+ years experience in health insurance development and operations
Former: ILO (Microinsurance Innovation Facility), Allianz Group, Aetna

UHC is on the World Development Agenda

- Sustainable Development Goals (SDGs) adopted by UN (Sept 2015):

"Ensure healthy lives and promote well-being for all, at all ages" & "end poverty in all its forms everywhere"

- Goal 3 is for health
- Includes target to: "achieve UHC, *including financial risk protection, access to quality essential health care services and access to safe, effective quality and affordable essential medicines and vaccines for all."*

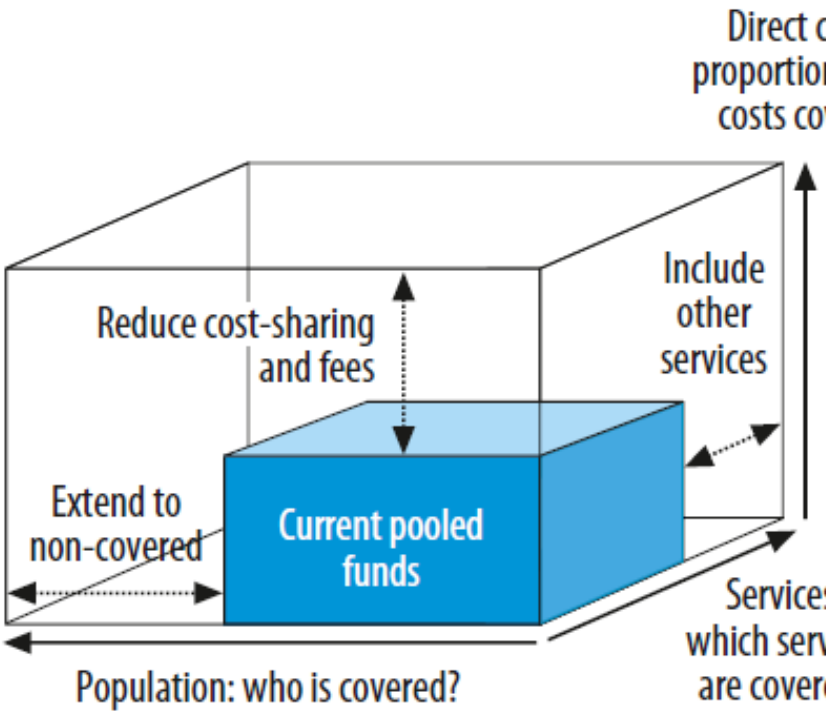
USAID's Vision

"USAID's own goals for international development, ending extreme poverty, and more specifically in global health to end preventable child and maternal deaths, achieve an AIDS free generation, and to protect communities from infectious diseases rely on the progressive realization of UHC"

Source: A. Pablos-Mendez, K. Cavanaugh, and C. Li. 2016. The New Era of Health Goals: Universal Health Coverage as a Pathway to the Sustainable Development Goals. Health Systems & Reform, 2(1):15-17.

UHC: Affordable, Equitable Access to Needed Care

The UHC Coverage Cube



FINANCIAL RISK PROTECTION

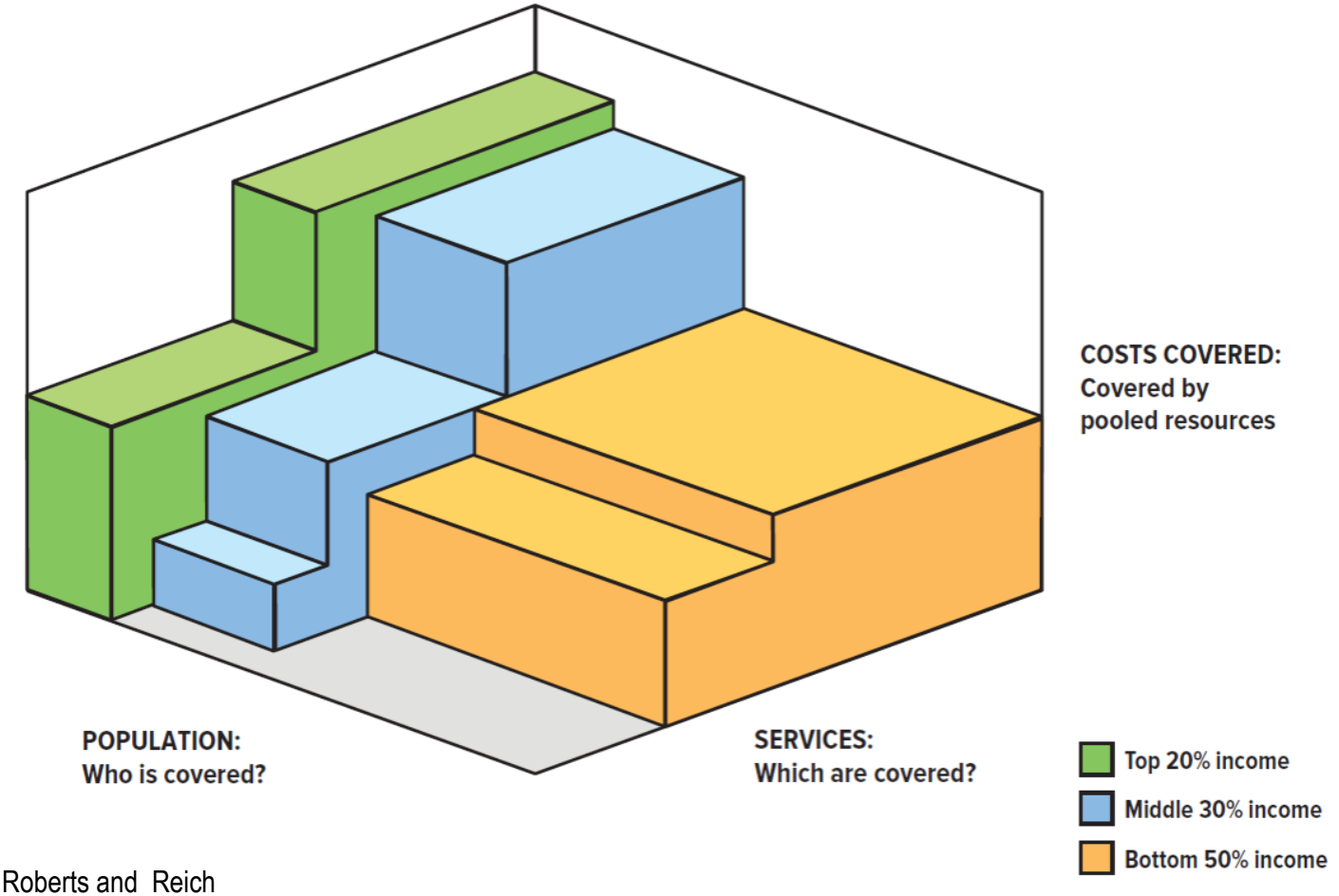
ACCESS

POPULATION COVERAGE

Source: World Health Organization and Busse, Schreyogg, & Gericke

What About Equity? Quality? Sustainability?

Hypothetical view of UHC by income group



Source: Hsiao, Roberts and Reich

No single pathway

GHANA

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National Health Insurance in Ghana:
Achievements, Challenges, and Opportunities

Chris Lovelace

March 2, 2016

Abt Associates Inc.
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Overview

- Introduction to Ghana and its National Health Insurance Scheme (NHIS)
- Achievements and Challenges
- Key Challenge of Financial Sustainability while Expanding Coverage
- Addressing the Challenge- Improved Expenditure Management
- National Technical Review of NHIS and the Way Forward

Ghana Country Profile

Total Population (2014)	26.7 million
Gross Domestic Product (2014)	$38.6billion
GNI per capita, Atlas method (current US$ 2014)	$1590
Life Expectancy at Birth (M/F) (2013)	61.1
Under 5 Mortality Rate (per 1,000) (2015)	61.6
Population Under Age 15 (2013)	38%
Population Over Age 60 (2013)	5%
Population Living in Urban Areas (2013)	53%

Source: World Bank Development Indicators, WHO GHO, CIA World Fact Book

Reforms in Ghana's Health System

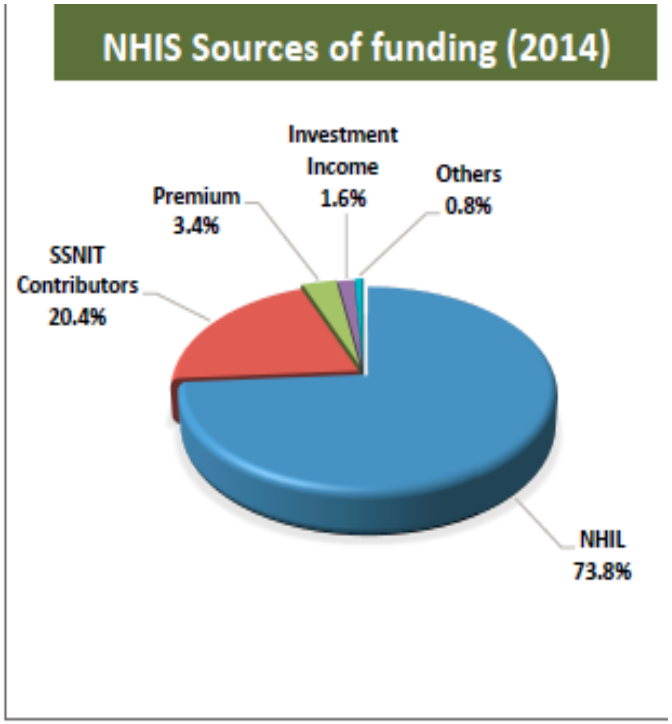
Source: NHIS GHANA-Overview of Reforms and Achievements, Presented by CEO Sylvester A. Mensah, November 2013

Ghana's National Health Insurance Scheme

- NHIS was established in 2003 to secure financial risk protection against the cost of healthcare services
- NHIS Model and Funding:

Mainly comprises a combination of the following three models:

- **Bervridgian**: National Health Insurance levy (NHIL) representing 2.5% VAT
- **Bismarkian**: 2.5 percentage points of Social Security contributions
- **MHO**: Graduated informal sector premium based on ability to pay



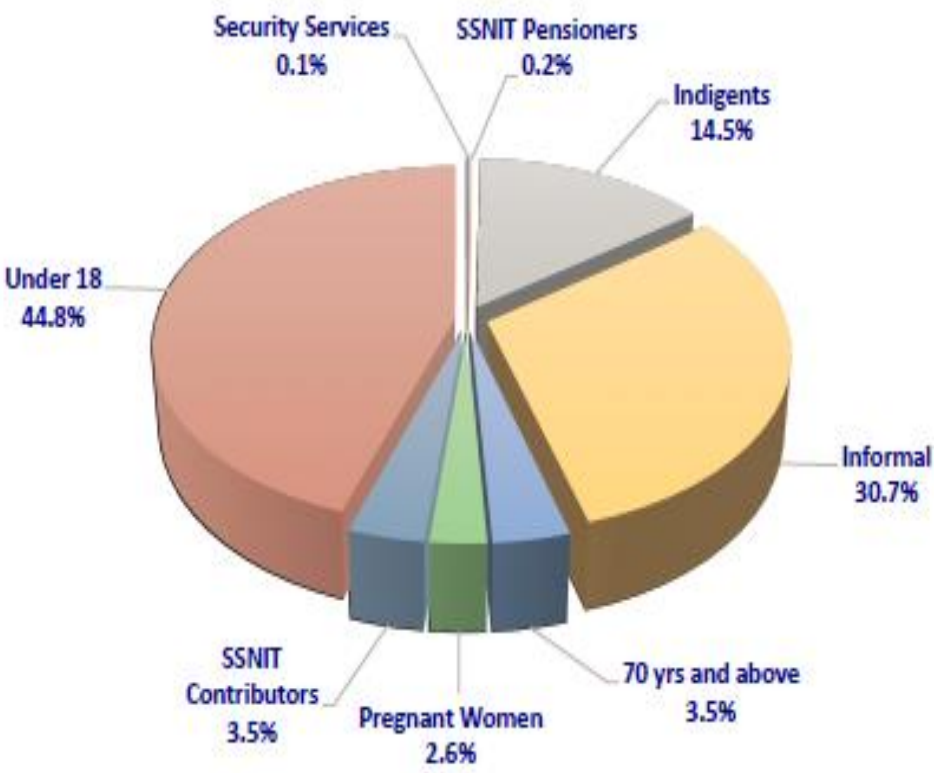
Earmarked funds (NHIL & SSNIT) constitute over 94% of total inflows

Source: NHIS GHANA-Overview of Reforms and Achievements, Presented by CEO Sylvester A. Mensah, November 2013

Achievements: Membership, Utilization & Claims

	2005	2014
Active Membership	1.3 million	10.2 million (38%)
Outpatient Utilization (visits)	597 thousand	29.6 million
Inpatient Utilization (visits)	29 thousand	1.6 million (2013)
Claims Payment (Amount GH¢)	7.6 million	968.4 million

Distribution of Active Membership (2014)



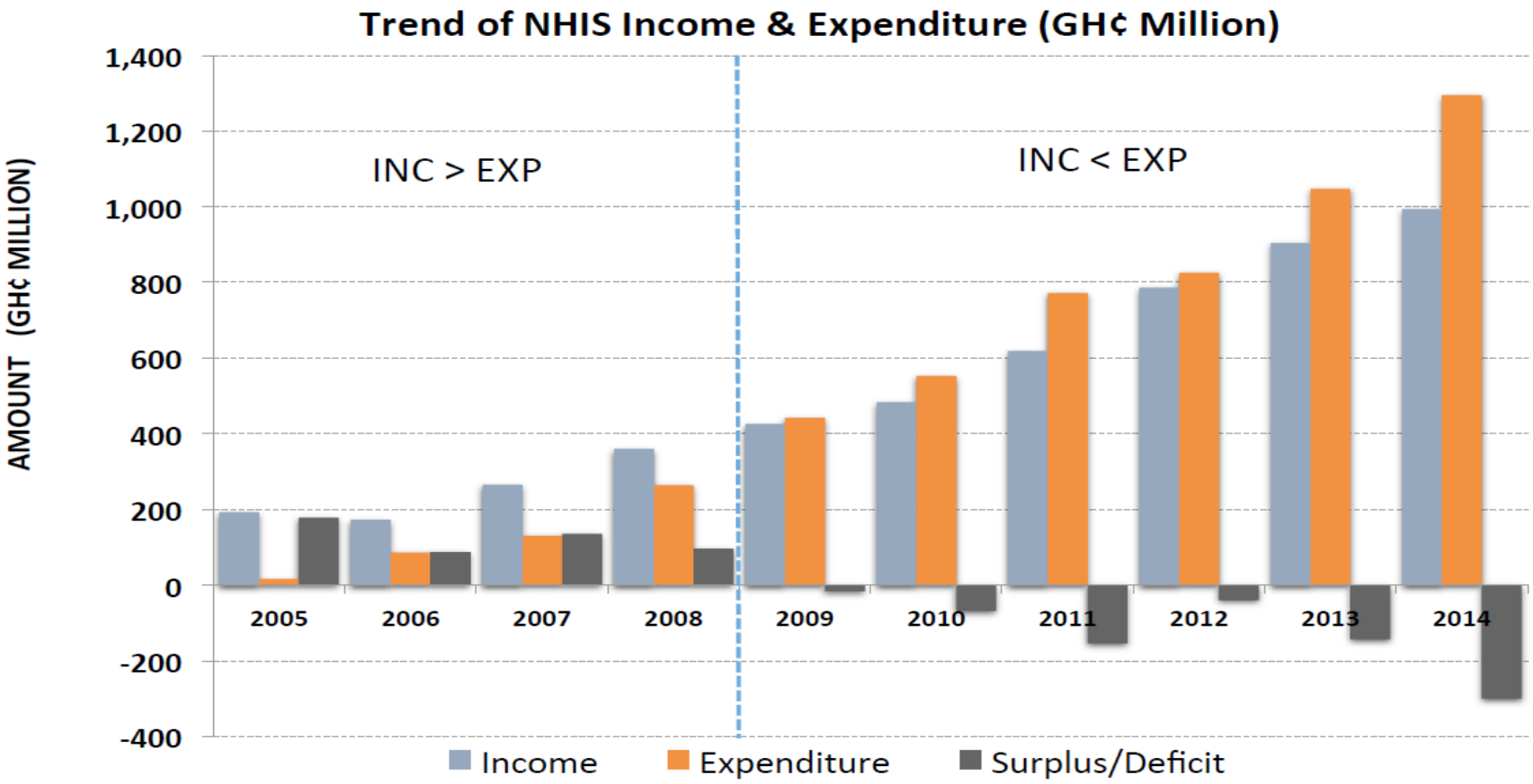
Source: Ghana NHIA Annual Reports

Ghana NHIS: Achievements and Challenges

- Clear improvements in health-seeking behavior: membership and utilization
- Positive results on financial risk protection-
- Challenges: financial sustainability, lack of cost containment, slow growth, equity in membership coverage, quality of care
- Lessons to be learned and shared

Key Challenge of Financial Sustainability

Spending has exceeded revenues since 2009 and claims liabilities continue to increase



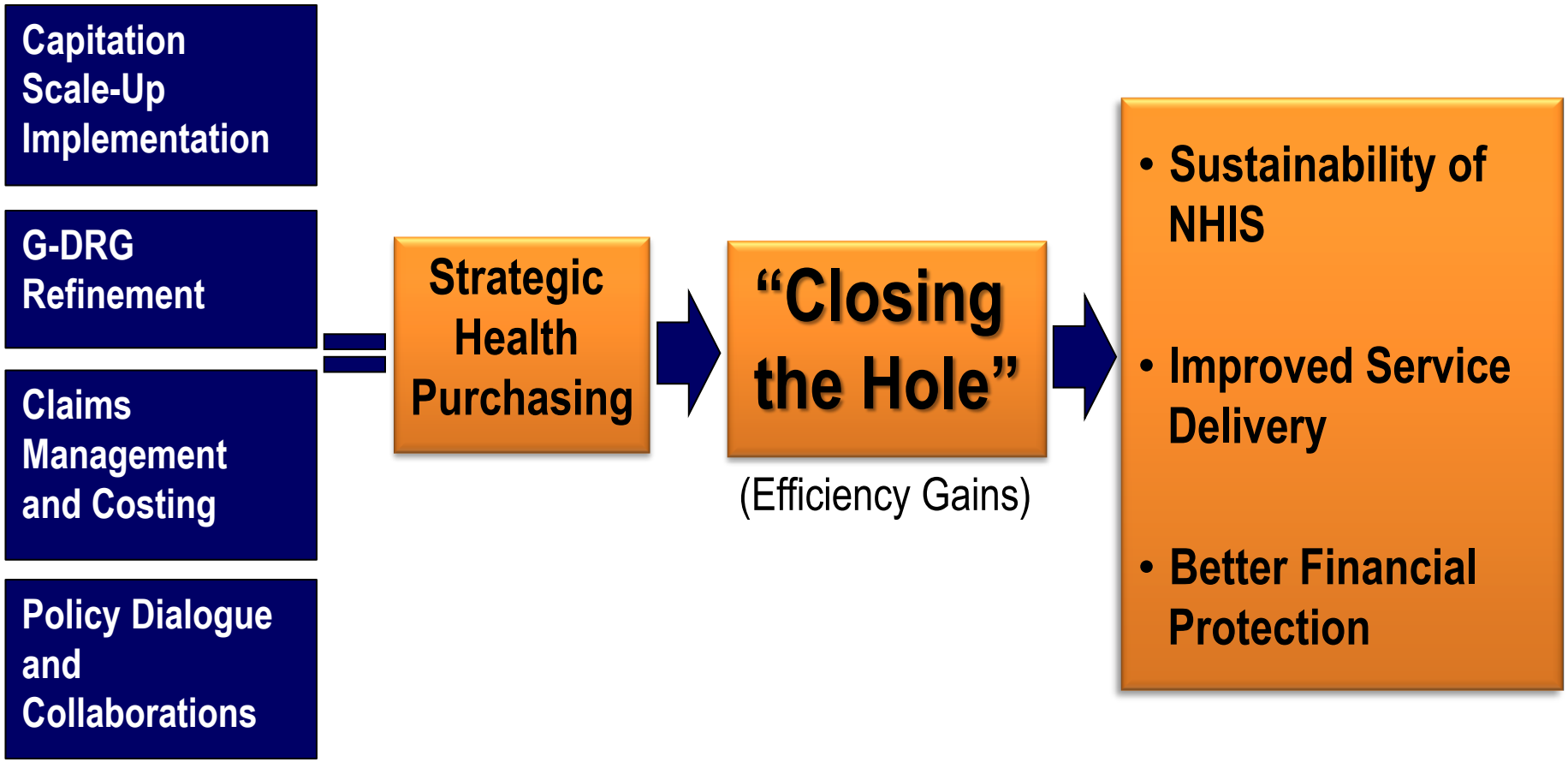
Source: Presentation by Caroline Jehu-Appiah, Experiences of Ghana's National Health Insurance Scheme, African Development Bank, June 11, 2015

Addressing NHIS Financial Sustainability

Turning NHIS from a passive bill-payer to an evidence-based strategic purchaser

- **Improve expenditure management and contain costs**
- **Strategic health purchaser**
- **Enhanced ability to generate and use evidence for decision-making**
- **NHIS Technical Review**
- **Financial sustainability and expanded coverage**

Improving Strategic Health Purchasing



Improving the Use of Evidence in Decision-Making

Goal: **Strengthened generation and use of evidence in NHIS operations**

Objective #1: **New tools developed for data visualization and interpretation**

Objective #2: **Advanced knowledge & skills among NHIA staff in using data for management decisions**

Objective #3: **Improved strategies for generation, management, and sharing of data**

Activity #1: **Dashboard Development and Use**

Activity #2: **Operations Research**

Activity #3: **M&E Policy**

Activity #4**: Learning and Knowledge Exchange**

National NHIS Technical Review & The Way Forward

National technical review of NHIS underway to determine viable reform options

- Technical Committee- will prepare draft report
- Advisory Committee- will make recommendations based on draft report
- Final report expected completion in mid-2016

ETHIOPIA

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Health Finance & Governance
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Community Based Health Insurance as a Pathway to Universal Health Coverage:

Lessons from Ethiopia

Hailu Zelelew

March 2, 2016

Abt Associates Inc.
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Outline

- Background (Country profile, health system in 1990s, and health finance)
- Health sector initiatives and synergy with financing reforms
- Health outcome trends
- Rationale for CBHI in Ethiopia
- Piloting: Scope, policy and technical processes
- CBHI pilot evaluation findings
  - Funding and management
  - Achievements
  - Challenges
- Current developments
- Lessons from Ethiopia

Ethiopia Country Profile

Source:
https://jelford.files.wordpress.com/2013/05/where-is-ethiopia.jpg

- Population: 96.96 million (2014)
- 43% under age 15
- Life expectancy (63 in 2013)
- 29.6% in poverty (2011)
- GNI per capita: $550 (2014)
- Over 85% of the population in the informal sector

Source: World Bank Database accessed online on 2/26/2016.

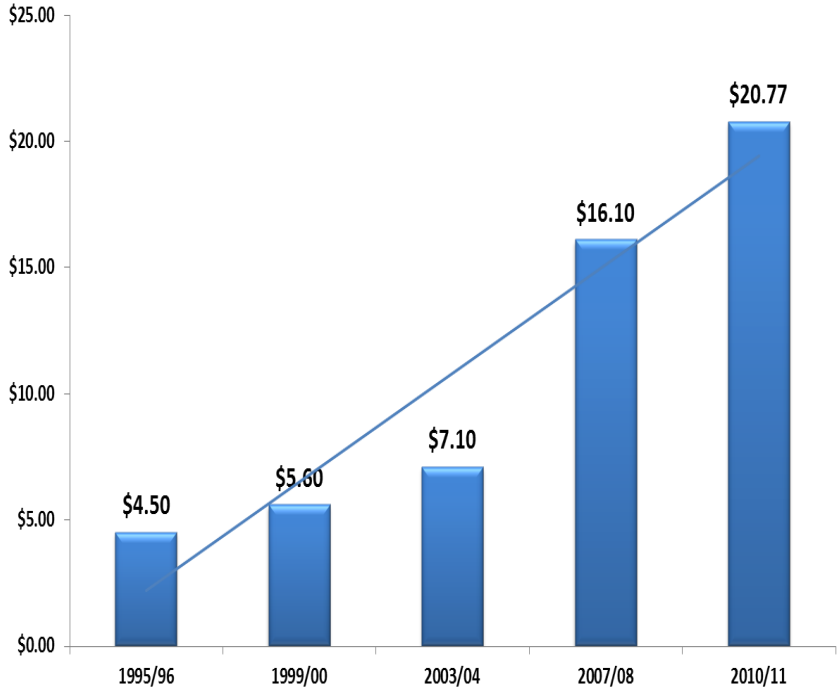
Background: Ethiopian Health Sector in the1990s

- 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

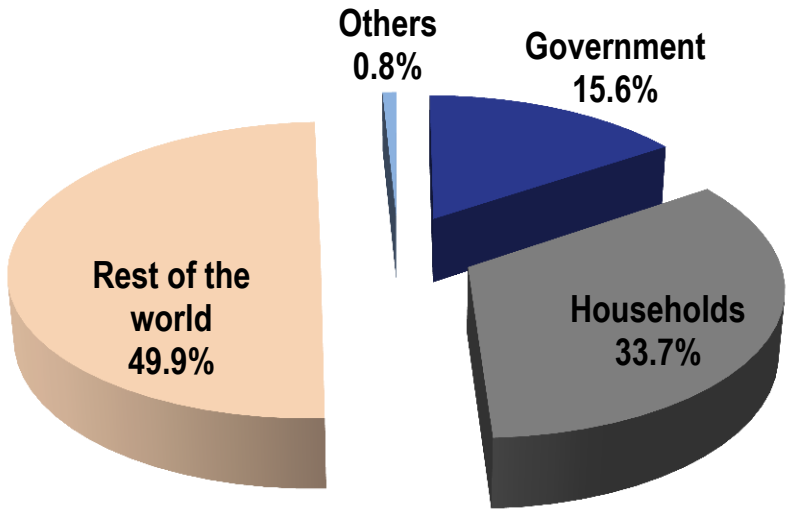
Late 1990s and early 2000, Ethiopia introduced a wide range of reforms.

Background: Health Financing

Per capita spending trend



Sources of health finance



Health Finance Synergy with Other Initiatives

Service coverage interventions

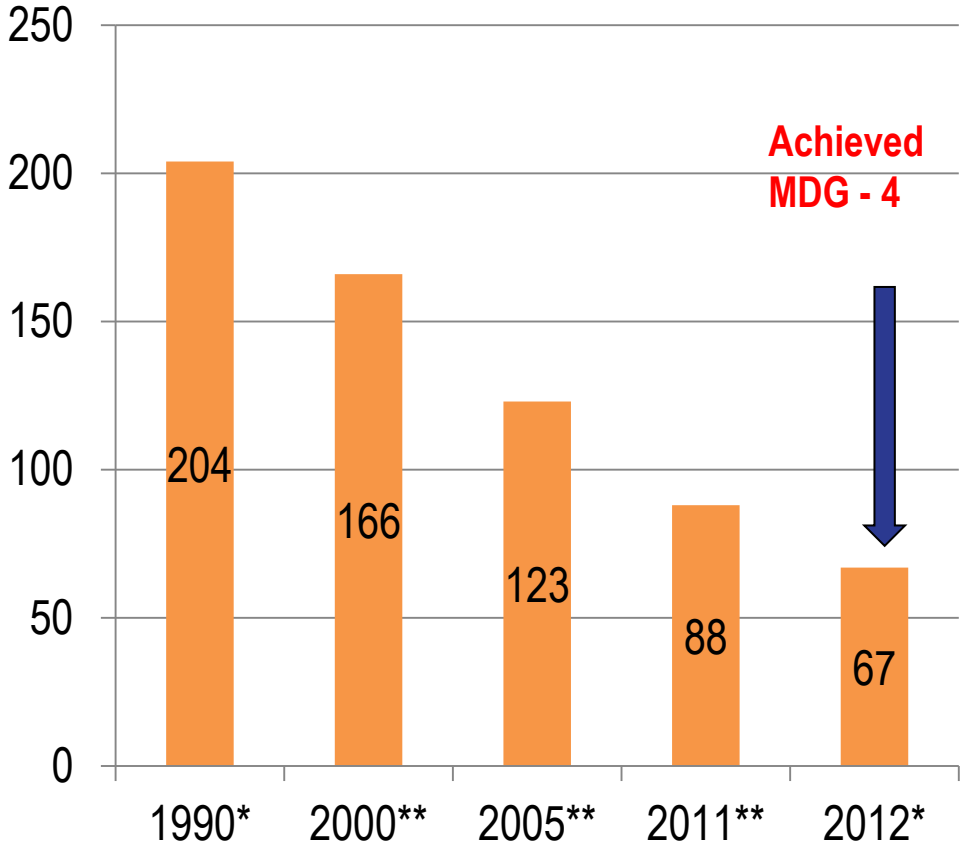
- Accelerated training of HWs
  - Health Extension Program: 2 HEWs per kebele (42,336 HEWs, 2014/15)
  - Training of mid-level HWs, and more recently physicians
- Accelerated construction of health facilities:
  - Over 15,000 health posts
  - 300 health centers (1990s) to 3,586 (2015)
- HSDPs (4 b/n 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 planning and budgeting)
- Facilities retain and use revenues
- More recently HI introduced

Selected Health Outcome Trends

Under 5 Mortality Rate - Trend

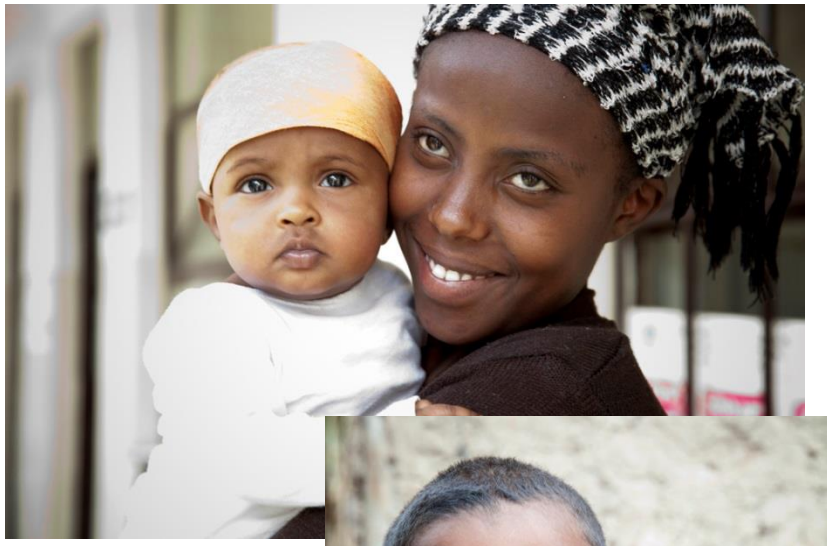


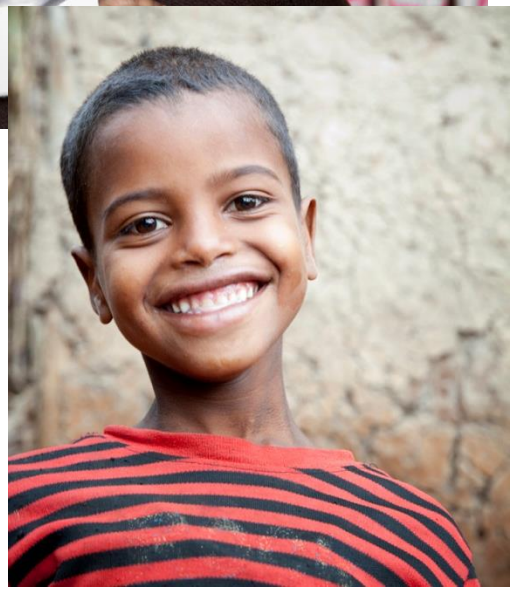
- Ethiopia achieved MDG – 4 in 2012
- Encouraging progresses recorded in other health related MDGs
- Overall health outcome has improved

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

CBHI: Rationale for Ethiopia

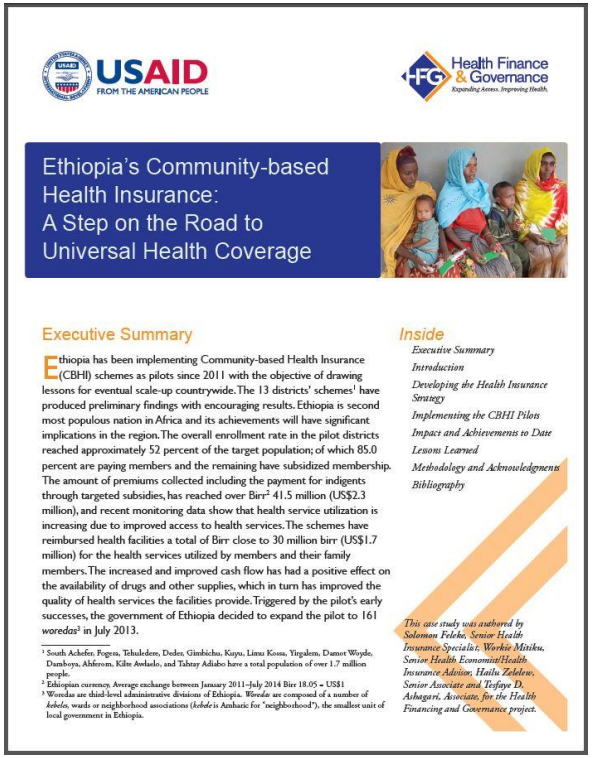
- > 85% of Ethiopians dependent on the informal sector
- Household OOP spending accounts 34% of THE
- Very low health service utilization (0.3 per capita visit)
- Build on existing community solidarity systems





Piloting: Policy Process and Implementation

- 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
  - SHI for the formal sector
  - CBHI for informal sector (over 85% of population)
- CBHI Piloting
  - Pilot design: Membership, benefit packages, member contribution, subsidies, risk management, organizational arrangement, etc.
  - Piloting launched in January 2011: 13 districts in largest 4 regions



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Ethiopia's Community-based Health Insurance: A Step on the Road to Universal Health Coverage

Executive Summary

Ethiopia has been implementing Community-based Health Insurance (CBHI) schemes as pilots since 2011 with the objective of drawing lessons for eventual scale-up countrywide. The 13 districts' schemes[1] have produced preliminary findings with encouraging results. Ethiopia is second most populous nation in Africa and its achievements will have significant implications in the region. The overall enrollment rate in the pilot districts reached approximately 52 percent of the target population; of which 85.0 percent are paying members and the remaining have subsidized membership. The amount of premiums collected including the payment for indigents through targeted subsidies, has reached over Birr[2] 41.5 million (US$2.3 million), and recent monitoring data show that health service utilization is increasing due to improved access to health services. The schemes have reimbursed health facilities a total of Birr close to 30 million birr (US$1.7 million) for the health services utilized by members and their family members. The increased and improved cash flow has had a positive effect on the availability of drugs and other supplies, which in turn has improved the quality of health services the facilities provide. Triggered by the pilot's early successes, the government of Ethiopia decided to expand the pilot to 161 *woredas*[3] in July 2013.

[1] South Achefer, Fogera, Tehuledere, Dedes, Gimbichu, Kuyu, Lima Kosa, Yirgalem, Damot Woyde, Damboya, Abfirom, Kilte Awdaelo, and Tahtay Adiabo have a total population of over 1.7 million people.
[2] Ethiopian currency. Average exchange between January 2011–July 2014 Birr 18.05 = US$1
[3] Woredas are third-level administrative divisions of Ethiopia. *Woredas* are composed of a number of *kebeles*, wards or neighborhood associations (*kebele* is Amharic for "neighborhood"), the smallest unit of local government in Ethiopia.

Inside

This case study was authored by Solomon Feleke, Senior Health Insurance Specialist, Workie Mitiku, Senior Health Economist/Health Insurance Advisor, Hailu Zeleke, Senior Associate and Tesfaye D. Ashagari, Associate, for the Health Financing and Governance project.

2014 CBHI EVALUATION: FINDINGS, ACHIEVEMENTS, AND CHALLENGES

Piloting: Funding and Management

- 13 districts, with an average population about 140,000 each
- 300,799 eligible households (1.8 million population)
- 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

CBHI Achievements

- 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 service utilization (0.7 visit per capita for insured vs 0.3 for national average)
  - Effect on health-seeking and treatment-giving behavior
- Poverty reduction effect:
  - 7% for insured vs 19% for non-insured (out of pocket expenditure >15% non-food expenditure)

Major Challenges

- Low membership renewal and new enrollment
- Financial difficulty among some schemes
- Variation in commitment of local officials
- Facilities 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 + over 131 in process
  - About 1.6 million HHs (over 22% poor HHs) joined CBHI schemes, and over 7.3 million people are covered (Dec. 2015)
- Piloting in urban settings and pastoral areas about to start
- Government is aware of the resource implication of scale up
- National CBHI scale-up strategy and directive developed
- Government plan to cover 80% of the districts and 80% of the population by 2020

Lessons from Ethiopia

- CBHI is promising pathway to UHC
  - High coverage rate ➔ 52%
  - Provides financial risk protection including the poor
  - Enhances health service utilization
  - Creates pressure on providers for quality care
  - Requires strong government commitment
    - Organizational, staffing, and budgetary implications
  - Partners' support is critical

Q&A

Chris Lovelace

Hailu Zelelew

Jeanna Holtz

Resources: www.hfgproject.org

- **Ghana**
  - Video: Tackling the Challenge of Financial Sustainability: Ghana's National Health Insurance Authority
  - Brief: Building on Community-based Health Insurance to Expand National Coverage: The Case of Ghana
- **Ethiopia**
  - Brief: Ethiopia's Community-based Health Insurance: A Step on the Road to Universal Health Coverage
  - Report: Universal Health Care in a Low-Income Context: An Ethiopian Case Study

Questions? Email us at: hfgproject@abtassoc.com.

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