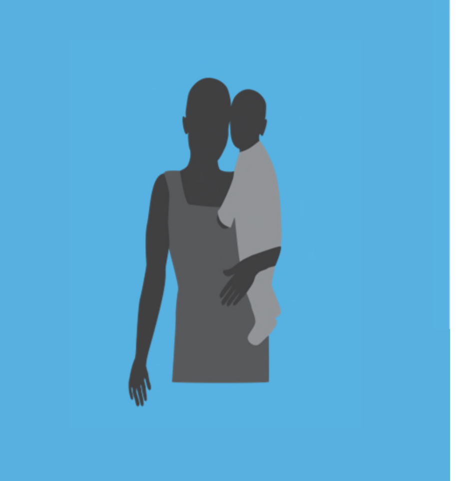

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Community Health Financing: Lessons from Ethiopia

Presented at the Institutionalizing Community Health Conference

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Johannesburg, South Africa

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)

Presentation Outline

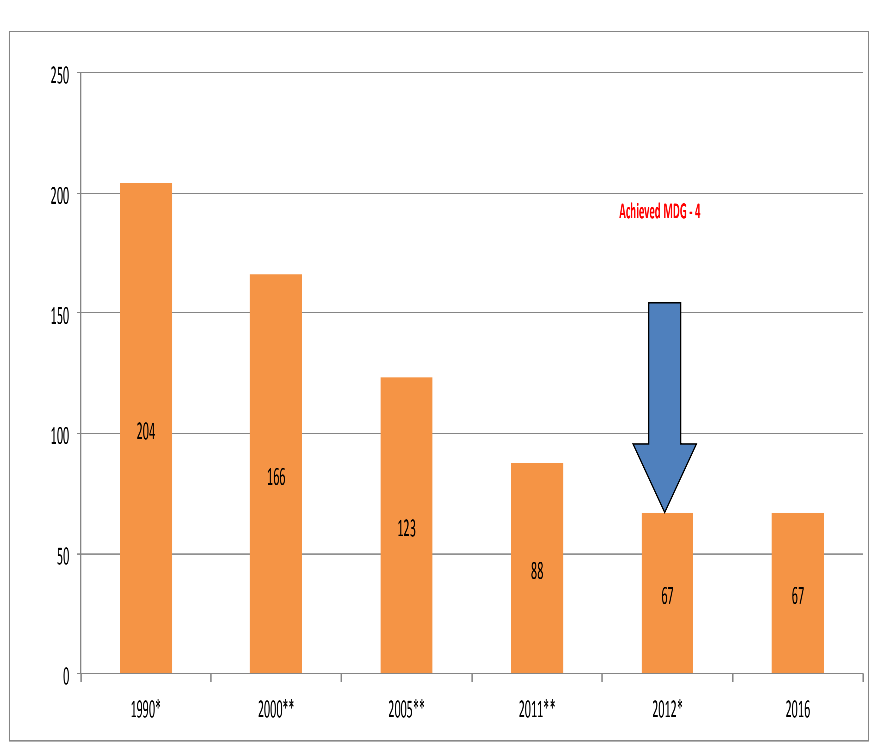
- Background
- Why CBHI in Ethiopia?
- Piloting: Scope, policy and technical processes
- CBHI pilot evaluation
- Methods
- Findings:
  - Funding and project management
  - Achievements
  - Challenges
- CBHI scale-up and status updates
- Conclusion
- Lessons from Ethiopia

Background (1): Country profile and health outcomes

Country profile

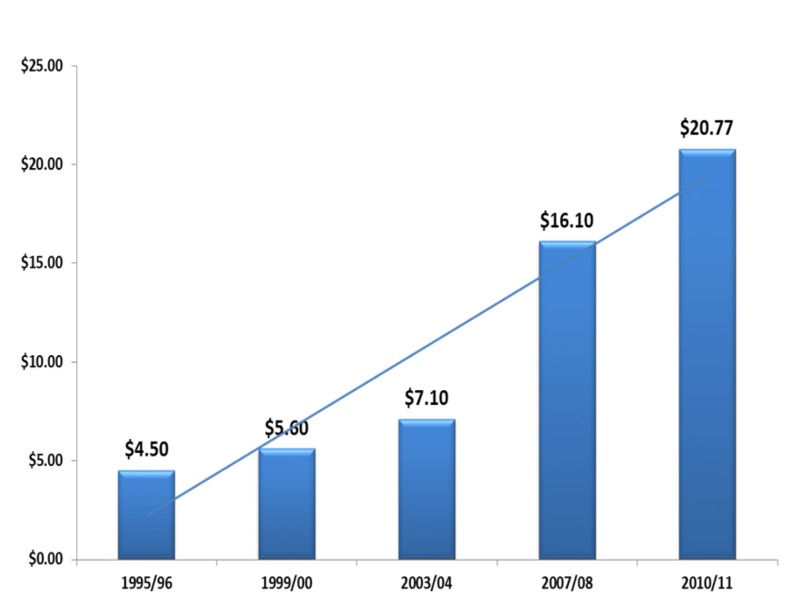
- Population: 103.53 million (2016)
- 43% under age 15
- Life expectancy (64 in 2012).
- 29.6% in poverty (2011)
- Annual per capita income: $590 (2015)
- Over 85% of the population in the informal sector

Health outcome: Under 5 Mortality Rate - Trend

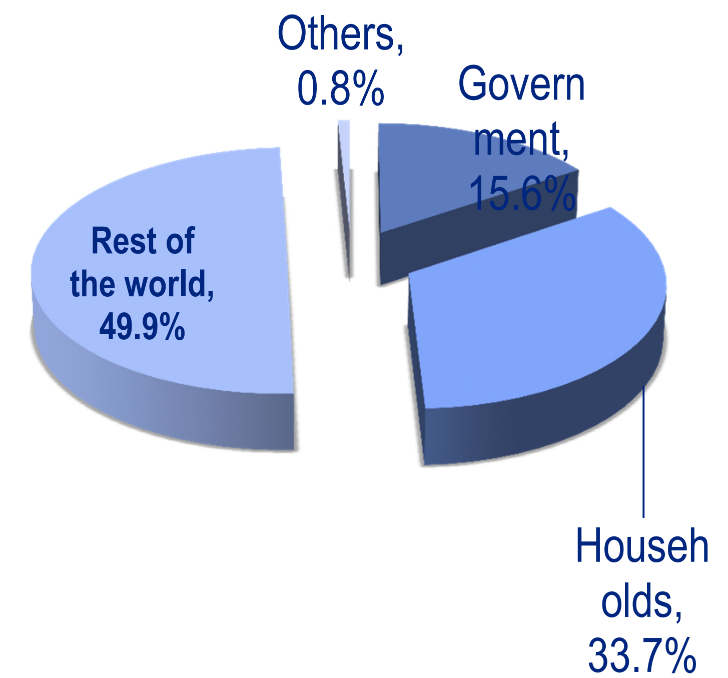


Background (2): Health financing

Per capita health spending trend



Who finances health, 2010/11?



Why CBHI in Ethiopia?

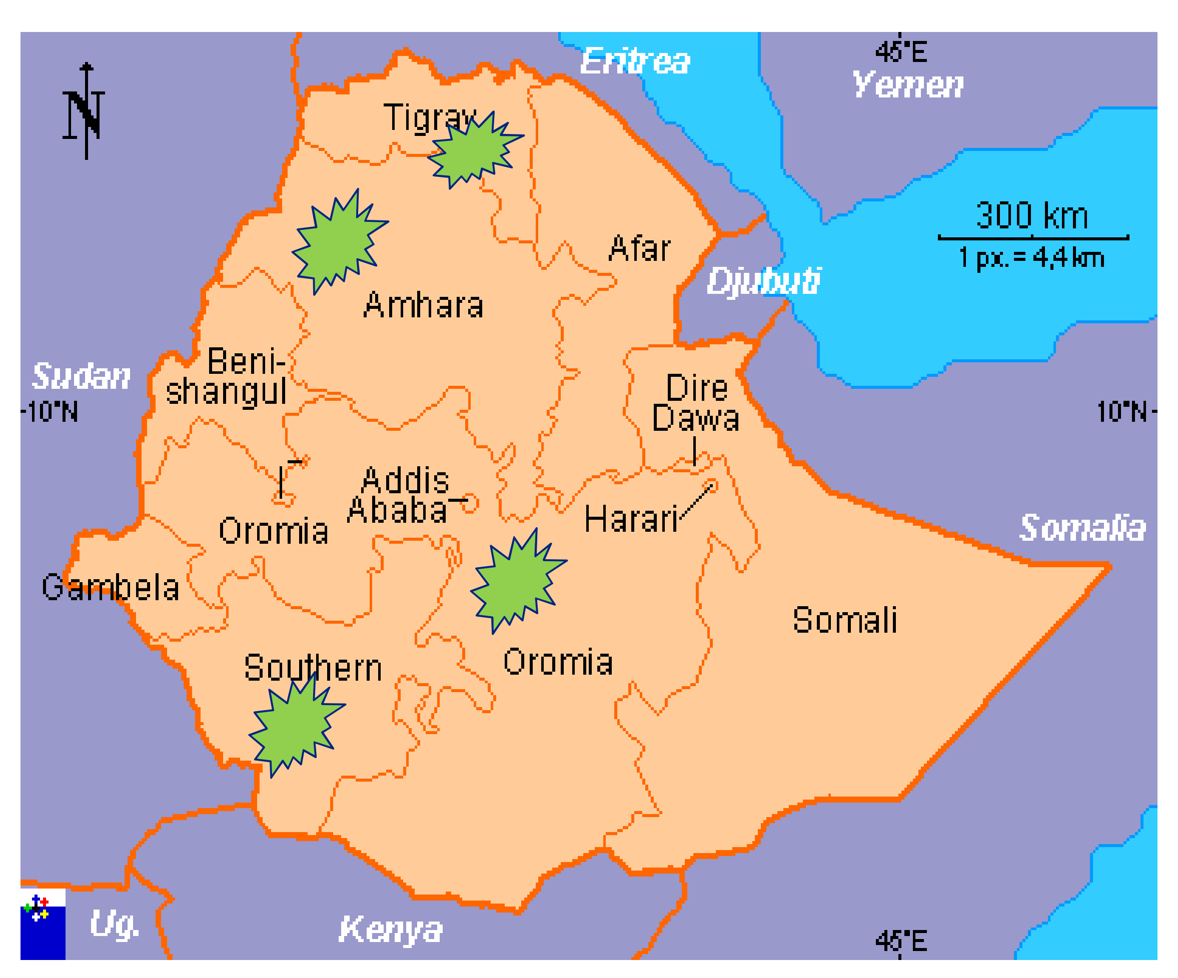
- > 85% of Ethiopians dependent on the informal sector
- Household OOP spending accounts 34% of THE
- Very low health service utilization (0.3 per capita visit per annum)
  ➔ This is despite increased availability of quality health services
- Build on existing community solidarity, trust, accountability and ownership in the informal sector

- 2008 Health Insurance Strategy:
  - CBHI for informal sector
  - SHI for formal sector
  - Long-term plan of creating a unified national health insurance

Pilot designing (1): Policy and technical processes

- Lessons from other countries (literature reviews and visits)
  - Ghana, Rwanda, Senegal, Mexico, Thailand and China
- Technical and policy documents produced, and discussions held
- Prototype pilot CBHI scheme designed
  - Membership, benefit packages, member contribution, subsidies, risk management, organizational arrangement, etc.
- Pilot districts selected and feasibility study conducted in each pilot district
- Financial Administration and Management System adopted
- Pilot implementation started in 2011

CBHI piloting (2): Scope



- Pilot schemes launched in January 2011:
  - 13 districts, in the largest 4 regions
  - Average population about 140,000 per district
- 300,799 eligible households (1.8 million beneficiaries)
- Community ownership elements:
  - Decision about establishment
  - Decision about enrollment
  - Determining membership and contribution amounts
  - General assembly of schemes
  - Board membership

CBHI PILOT SCHEMES EVALUATION IN 2014

Evaluation Methods

- **Literature Review:** Reviewed relevant documents on the design, status of CBHI schemes as well as lessons from other countries
- Primary Data Collection from HHs and individuals:
  - A household survey of randomly selected 2987 sample HHs (200 in each pilot woreda and 100 in each control woreda);
  - Exit interviews of 462 patients
- **KIIs:**144 KIIs with CBHI stakeholders
- **Focus group discussion:** 52 Focus group discussions conducted with CBHI members, non-CBHI members and health professional
- **Reviewed CBHI routine monitoring** data from the health sector reform (HSFR) project and FMOH

Findings (1): 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

Findings (2): Achievements

- Enrollment: 52% (157,553 households/over 700,000 beneficiaries)
  - Voluntary at household level
  - Enrollment variable by district (25 – close to 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
  - The likelihoods of CBHI members visiting a health facility when feeling sick is higher by 26.3 percentage points relative to non-members.
- Effect in reducing impoverishment:
  - Impoverishment rates: 7% for insured vs 19% for non-insured (out of pocket expenditure >15% non-food expenditure)

Finding (3): Major challenges

- Membership declined after initial stage
- Financial difficulty in 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

CBHI Scale up – Status Updates

Scale-Up (1): Status updates

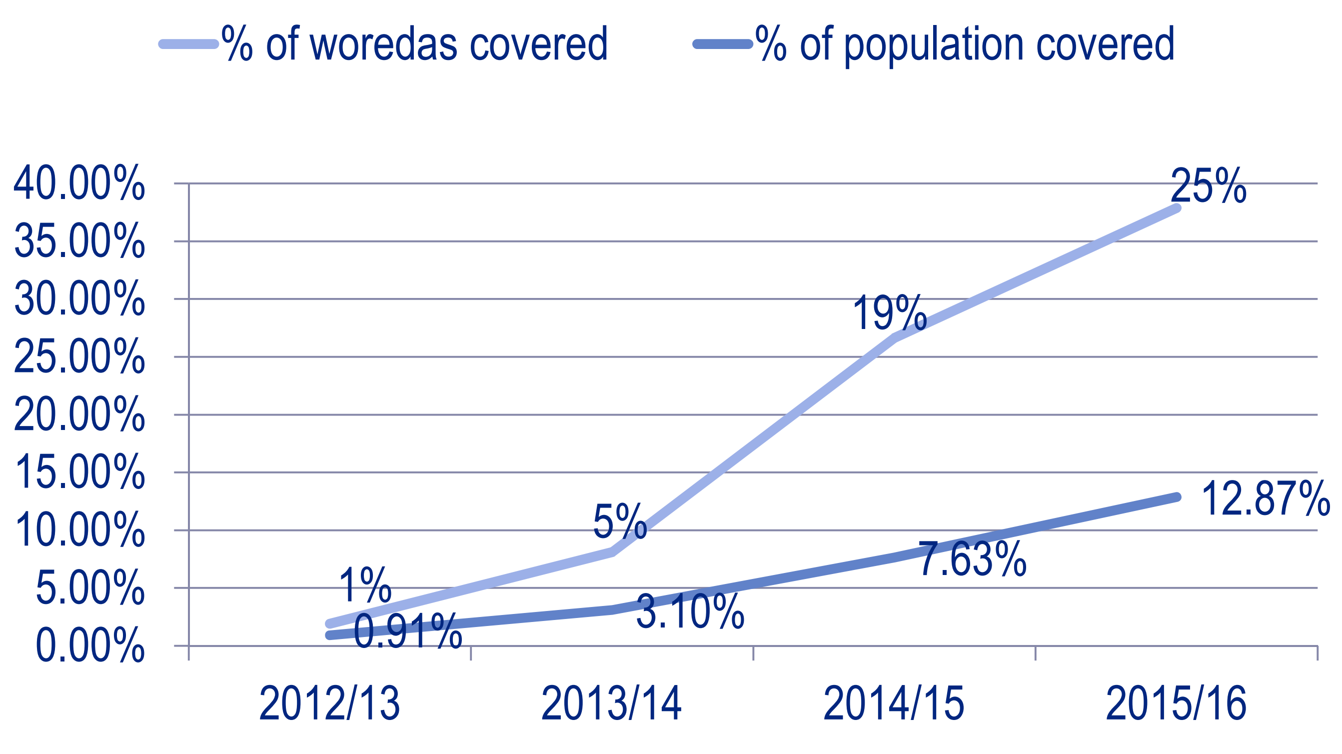
- Government satisfied by pilot results and decided to scale-up
- CBHI scale-up strategy developed and ready for endorsement
- CBHI promotion and expansion well in progress

CBHI role play in the market

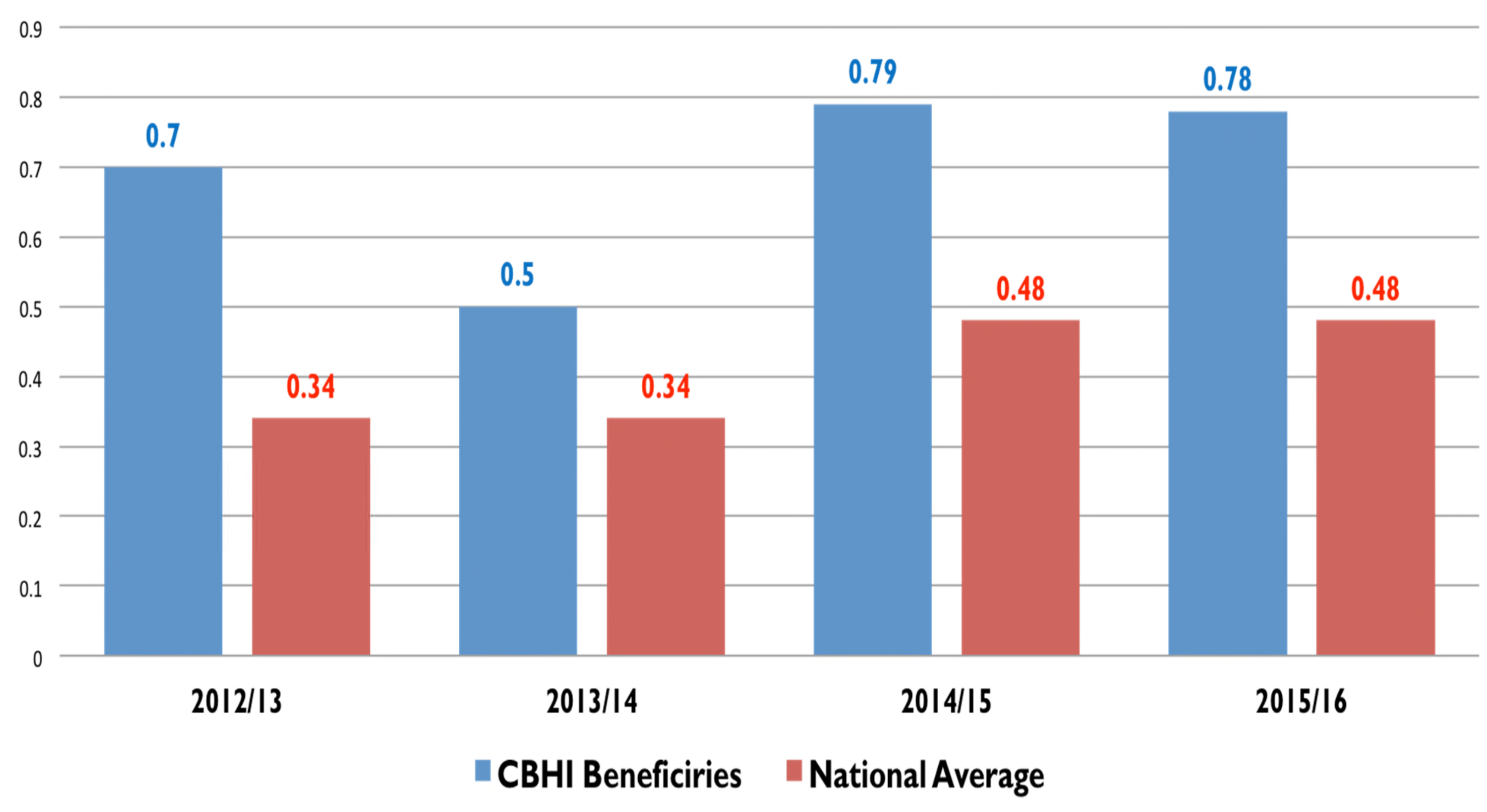
Scale-up (2): Status updates

- CBHI is being expanded in the four regions + Benshangul-Gumuz and Addis Ababa
  - CBHI being scaled-up to 350 additional districts (227 launched)
  - About 6.6 million households (37.9% of eligible HHs) covered (19.1% of them poor HHs)
  - Together with the pilot 11.3 million beneficiaries protected through these schemes
- Birr 388,902,114 ($18 million) collected through premium and Birr 186,469,026 ($8.1 million) through government targeted subsidy)
- 80% of districts and 80% of households target under HSTP, by 2020
- CBHI one of the three woreda transformation priorities

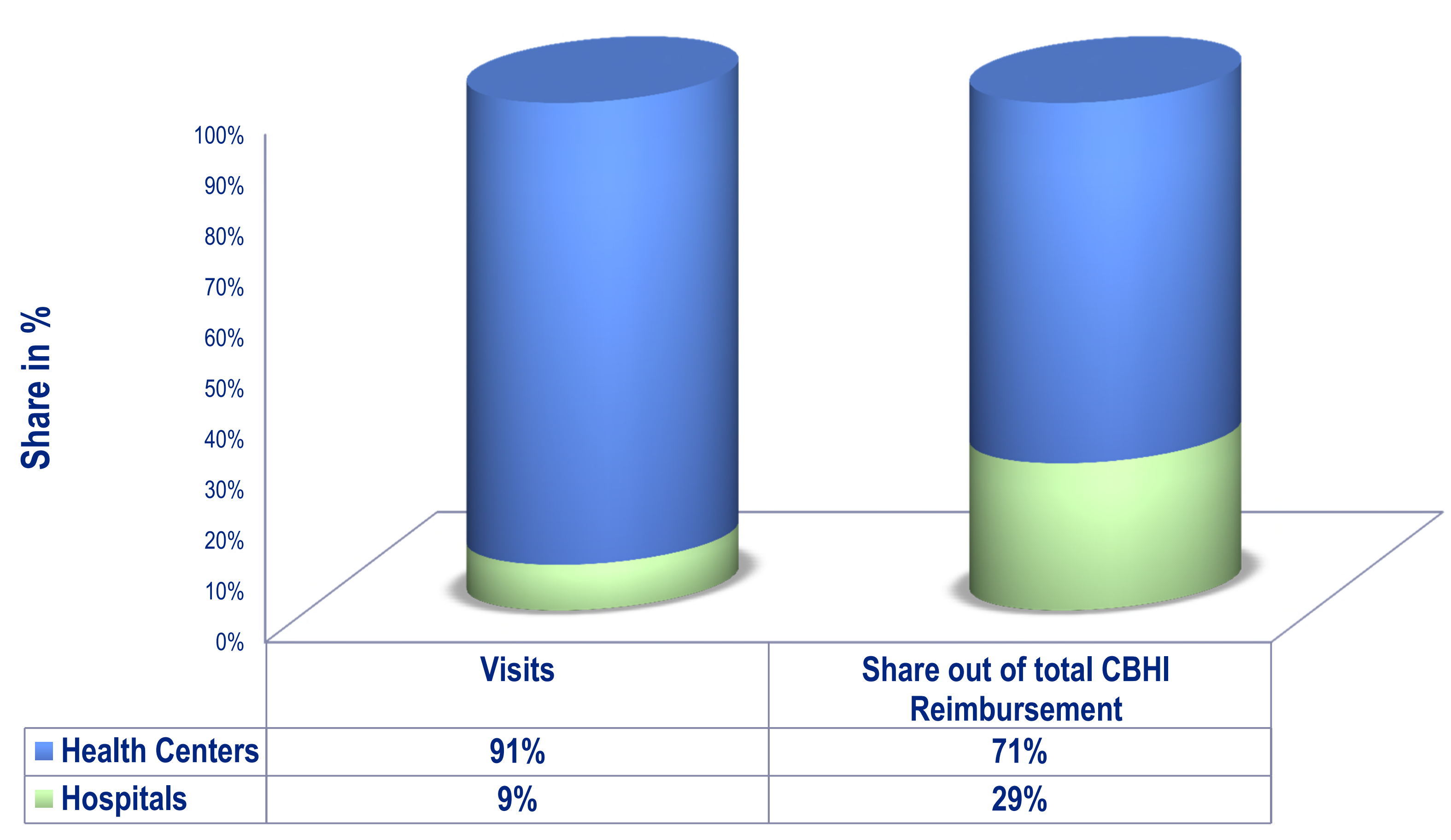
Scale-up (3): Status up-dates



Scale-up (4): Improved health facility visits
(CBHI beneficiaries vs national average comparison)



CBHI beneficiaries health services utilization and reimbursement by type of health facilities



	Visits	Share out of total CBHI Reimbursement
Health Centers	91%	71%
Hospitals	9%	29%

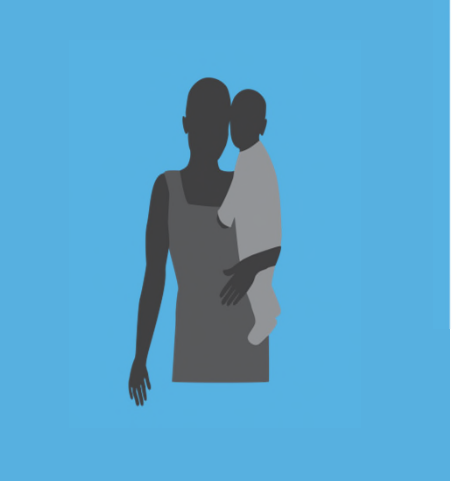
Conclusion

- CBHI is promising pathway to UHC (high coverage rate, pilot → 52%, and over all about 38% of eligible HHs)
- Inclusiveness: Almost one-fifth (19.1%) of CBHI members are poor HHs covered through targeted subsidy
- Women and children empowered
- It provides financial risk protection
- It increases health services utilization
- Increases availability of finance in health facilities

Lessons from the pilot schemes

- Access to quality care is critical for enrollment and renewal
- It requires strong government commitment
- It has significant budgetary and organizational implication
- Partners' support is critical

Proud CBHI members in Tigray



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