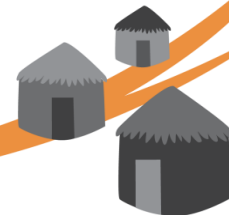




Institutionalizing Community Health Conference



27-30 March 2017 | Johannesburg, South Africa



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Federal Democratic
Republic of Ethiopia
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Community Health Financing: Lessons from Ethiopia

Presented at the Institutionalizing Community Health Conference

March 28, 2017
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)

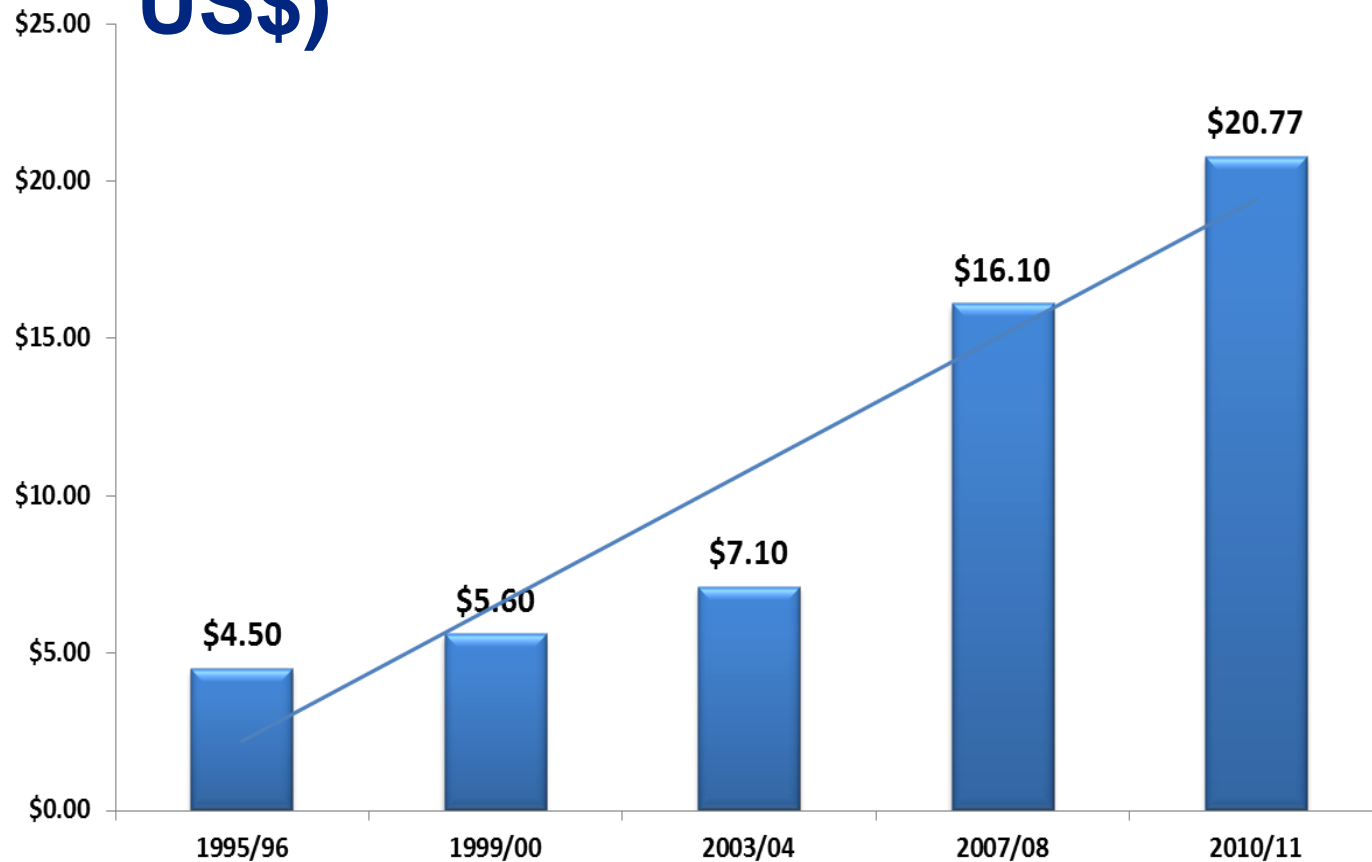
Country profile



- 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

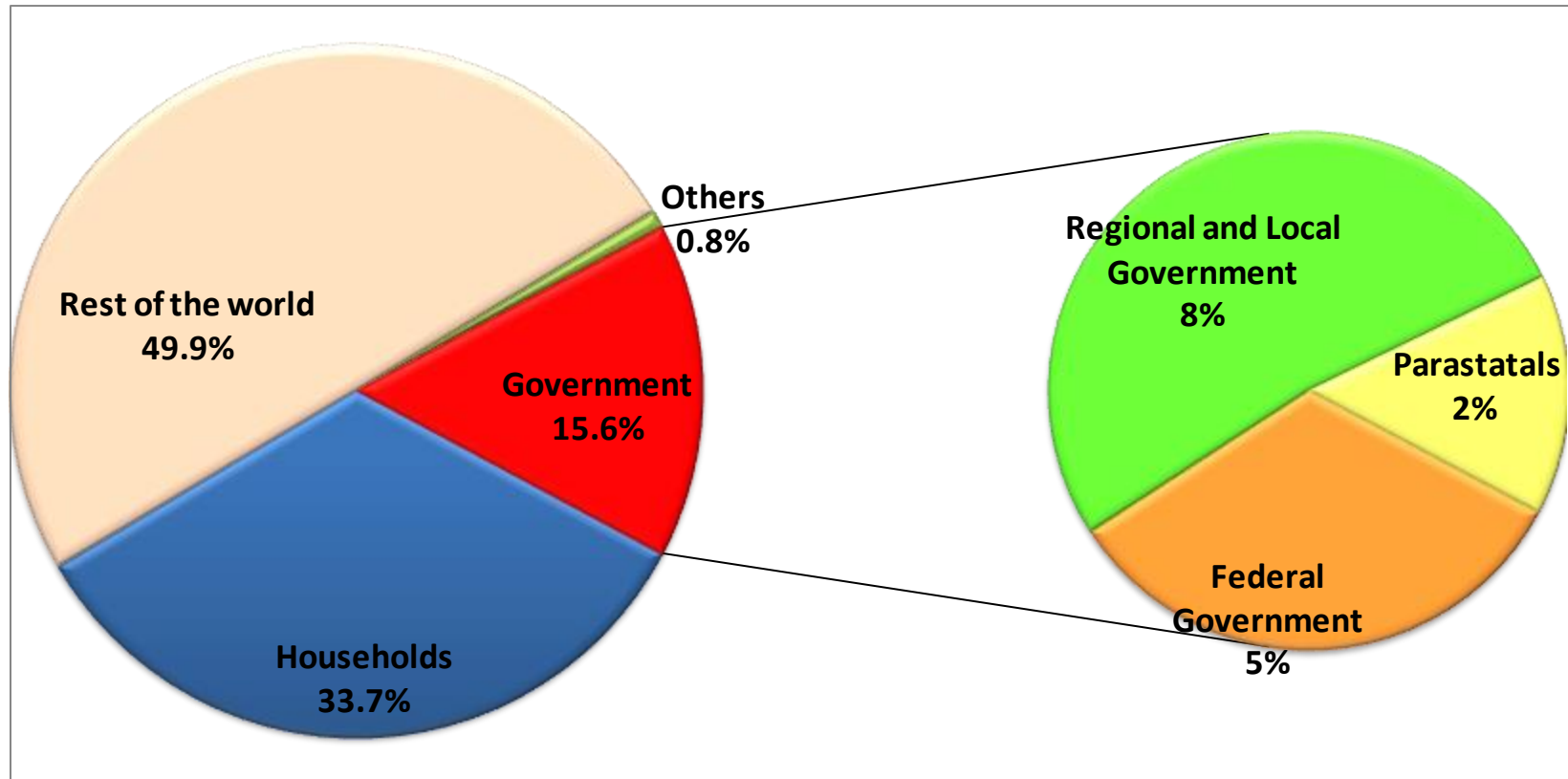
Background (2): Health spending trends

Per capita spending trend (in US\$)



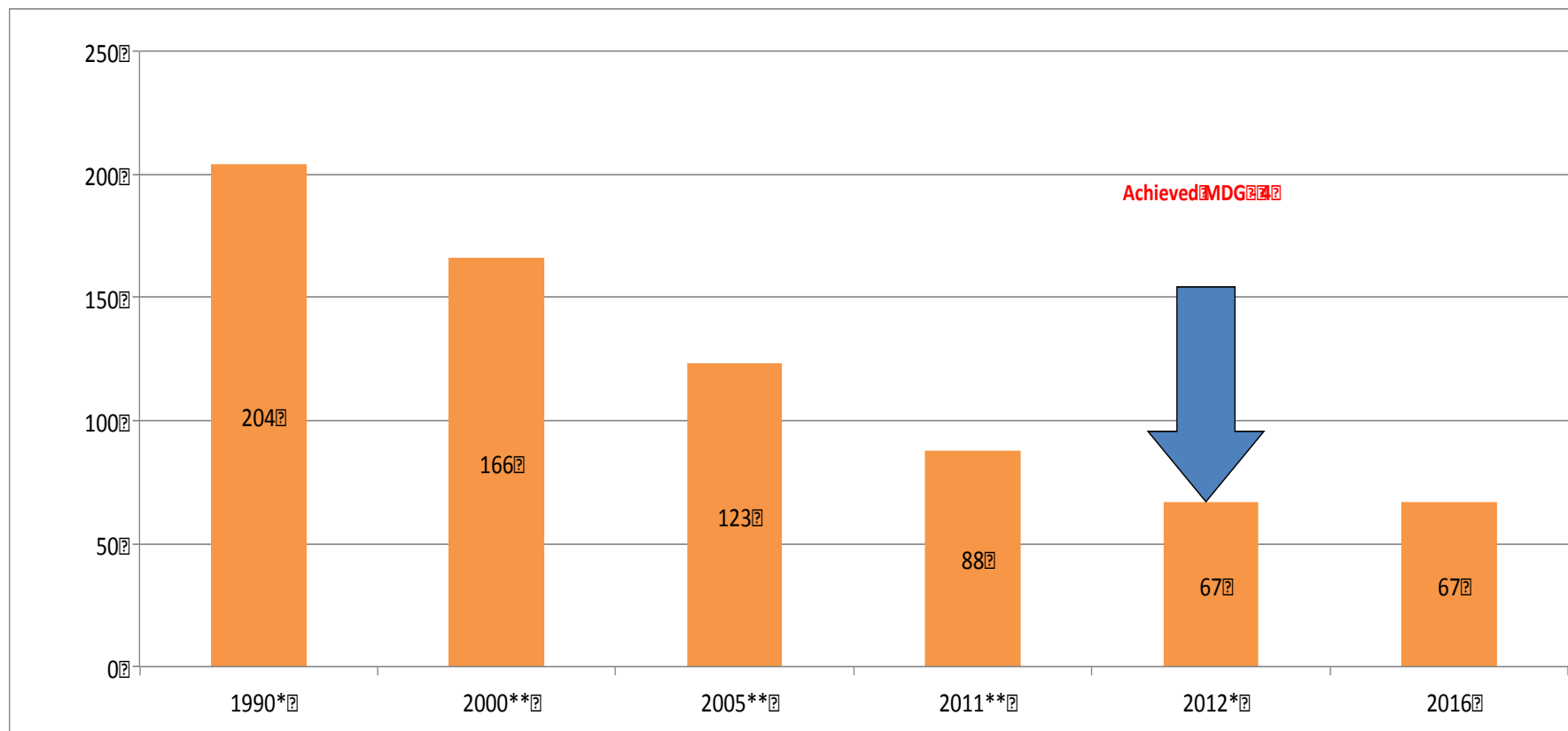
Background (3): Sources of health finance

Sources of financing, 2010/11 NHA



Background (4): Health outcome trends

Under 5 Mortality Rate - Trend



Sources: * UN Inter-Agency Group for Child Mortality Estimation: 2013
** Ethiopia DHS (2000, 2005, 2011 and 2016 Reports)



Why CBHI in Ethiopia?

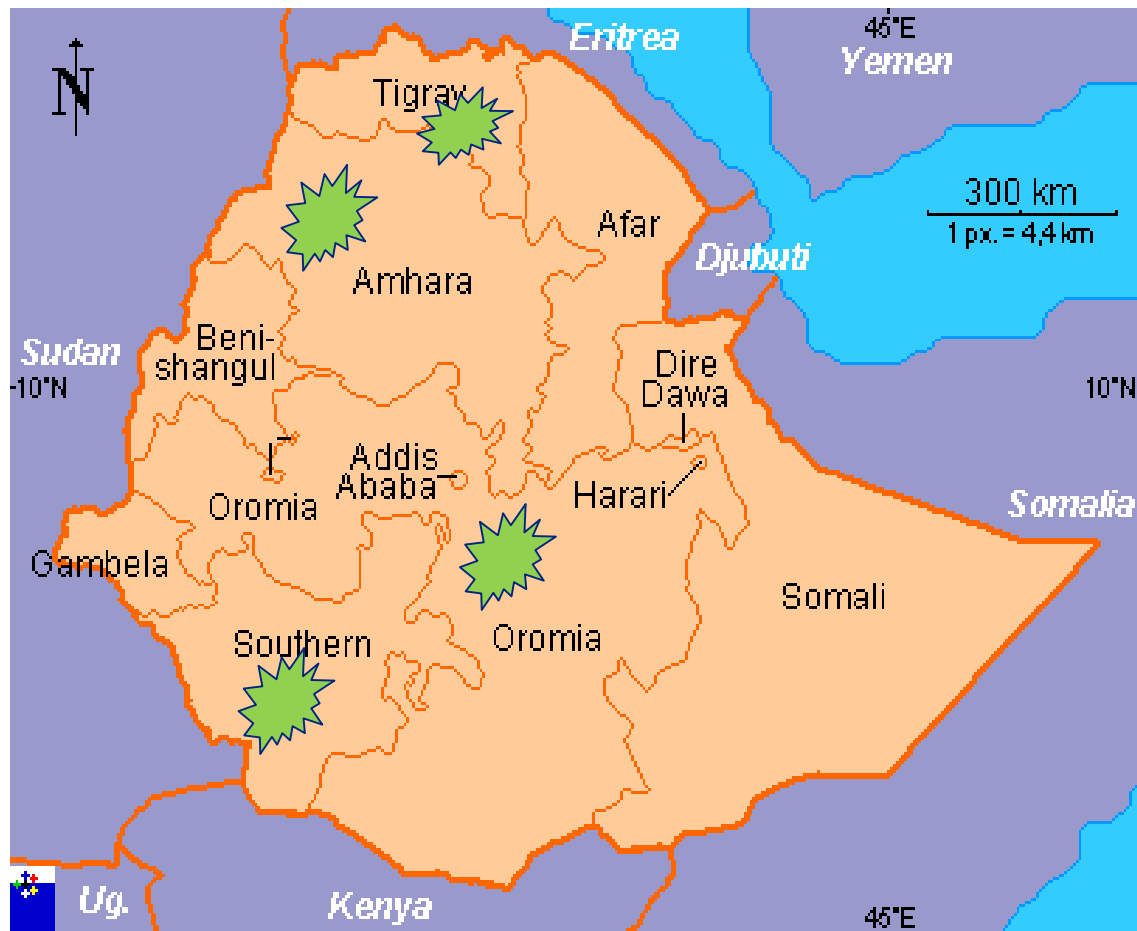
- ▶▶ > 85% of Ethiopians dependent on the informal sector
- ▶▶ Household OOP spending accounts 34% of THE
- ▶▶ Very low health service utilization (0.3 per capita visit per annum)
 - ➔ This is despite increased availability of quality health services
- ▶▶ Build on existing community solidarity, trust,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



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



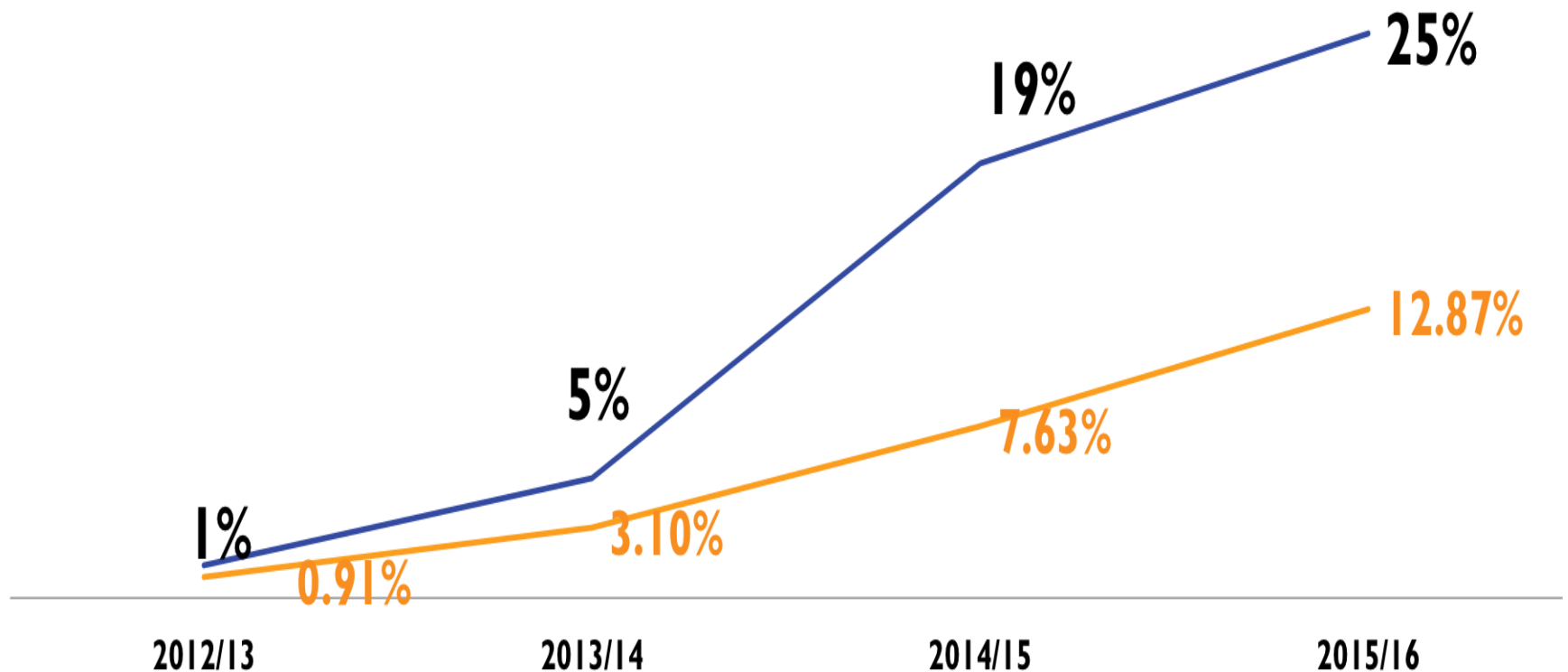
CBHI role play in the market

Scale-up (2): Status updates

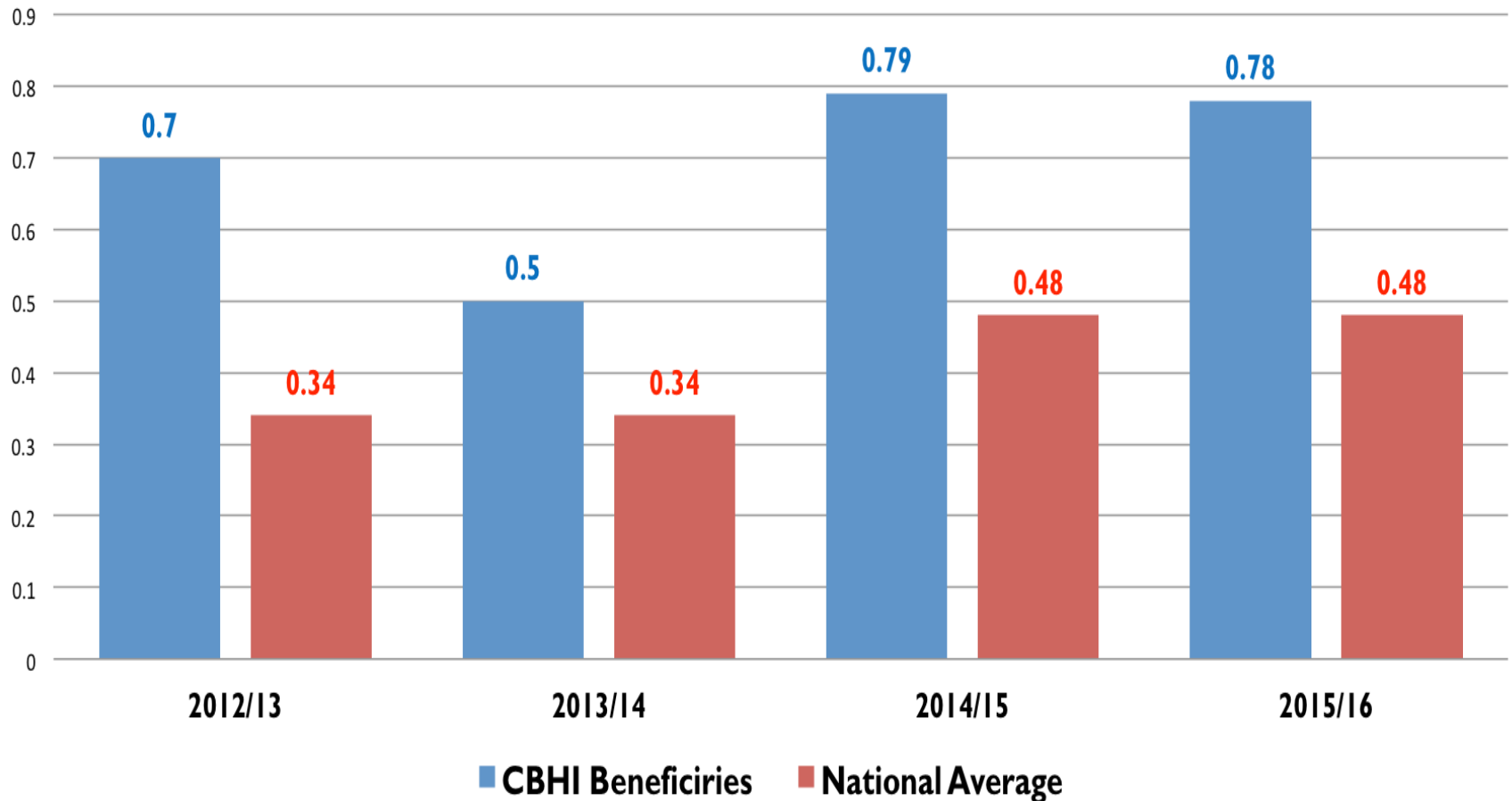
- ▶▶ CBHI is being expanded in the four regions + Benshangul-Gumuz and Addis Ababa
 - ❖ CBHI being scaled-up to 350 additional districts (227 launched)
 - ❖ About 6.6 million households (37.9% of eligible HHs) covered (19.1% of them poor HHs)
 - ❖ Together with the pilot 11.3 million beneficiaries protected 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

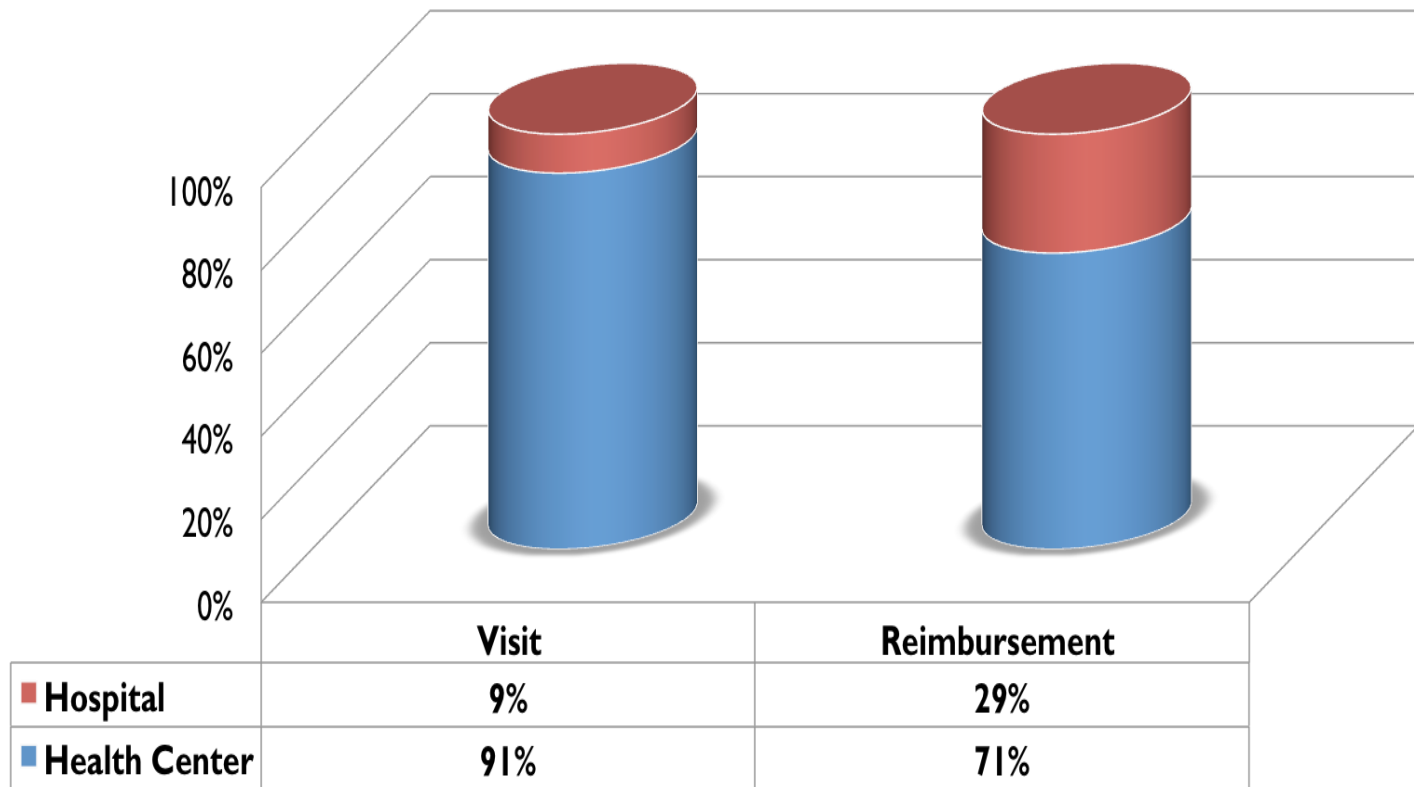
— Geographic Coverage — Population Coverage



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



Scale-up (5): CBHI beneficiaries health services utilization and reimbursements by type of health facilities



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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Thank you!



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