Community Health Financing: Lessons from Ethiopia

Presented at the Institutionalizing Community Health Conference

March 28, 2017
Johannesburg, South Africa
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$)

- 1995/96: $4.50
- 1999/00: $5.60
- 2003/04: $7.10
- 2007/08: $16.10
- 2010/11: $20.77
Background (3): Sources of health finance

Sources of financing, 2010/11 NHA

- Rest of the world: 49.9%
- Households: 33.7%
- Government: 15.6%
- Federal Government: 5%
- Regional and Local Government: 8%
- Parastatals: 2%
- Others: 0.8%
- Government: 15.6%
Background (4): Health outcome trends

Under 5 Mortality Rate - Trend

Sources:
* UN Inter-Agency Group for Child Mortality Estimation: 2013
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
- **KII:** 144 KIIIs 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 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

<table>
<thead>
<tr>
<th>Year</th>
<th>Geographic Coverage</th>
<th>Population Coverage</th>
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<tbody>
<tr>
<td>2012/13</td>
<td>1%</td>
<td>0.91%</td>
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<tr>
<td>2013/14</td>
<td>5%</td>
<td>3.10%</td>
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<tr>
<td>2014/15</td>
<td>19%</td>
<td>7.63%</td>
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<td>2015/16</td>
<td>25%</td>
<td>12.87%</td>
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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

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<thead>
<tr>
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<th>Visit</th>
<th>Reimbursement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital</td>
<td>9%</td>
<td>29%</td>
</tr>
<tr>
<td>Health Center</td>
<td>91%</td>
<td>71%</td>
</tr>
</tbody>
</table>
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
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Thank you!

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