An Evidence-Based Policy Brief

IMPROVING HEALTH CARE FINANCING IN ETHIOPIA

Full Report

Included:
- Description of a health system problem
- Viable options for addressing this problem
- Strategies for implementing these options

Not included: recommendations
This policy brief does not make recommendations regarding which policy option to choose

Who is this policy brief for?
Policymakers, their support staff, and other stakeholders with an interest in the problem addressed by this policy brief

Why was this policy brief prepared?
To inform deliberations about health policies and programmes by summarising the best available evidence about the problem and viable solutions

What is an evidence-based policy brief?
Evidence-based policy briefs bring together global research evidence (from systematic reviews*) and local evidence to inform deliberations about health policies and programmes

*Systematic review: A summary of studies addressing a clearly formulated question that uses systematic and explicit methods to identify, select, and critically appraise the relevant research, and to collect and analyse data from this research

Executive Summary
The evidence presented in this Full Report is summarized in an Executive Summary

This evidence brief was prepared by the Technology Transfer and Research Translation Directorate of the Ethiopian Public Health Institute.
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Competing interests
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Suggested citation

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www.evipnet.org/sure

The Evidence-Informed Policy Network (EVIPNet) promotes the use of health research in policymaking. Focusing on low- and middle-income countries, EVIPNet promotes partnerships at the country level between policymakers, researchers and civil society in order to facilitate policy development and implementation through the use of the best scientific evidence available.
www.evipnet.org
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Preface

The purpose of this report

The purpose of this report is to inform deliberations among policymakers and stakeholders. It summarises the best available evidence regarding the design and implementation of policies for improving health care financing.

The report was prepared as a background document to be discussed at meetings attended by those engaged in developing policies on health care financing and people with an interest in such policies (stakeholders). It is not intended to prescribe or proscribe specific options or implementation strategies. Rather, its purpose is to allow policy makers and stakeholders to systematically and transparently consider the available evidence about the likely impacts of different options improving health care financing in Ethiopia.

How this report is structured

The executive summary of this report provides key messages and summarises each section of the full report. Although this entails some replication of information, the summary addresses the concern that not everyone for whom the report is intended will have time to read the full report.

How this report was prepared

This policy brief brings together global research evidence (from systematic reviews) and local evidence to inform deliberations about improving health care financing in Ethiopia. We searched for relevant evidence describing the problem, the impacts of options for addressing the problem, barriers to implementing those options, and implementation strategies to address these barriers. We searched particularly for relevant systematic reviews of the effects of policy options and implementation strategies. We supplemented information extracted from the included systematic reviews with information from other relevant studies and documents. (The methods used to prepare this report are described in more detail in Appendix 1.)

Limitations of this report

This policy brief is based largely on existing systematic reviews. Summarising evidence requires judgements about what evidence to include, the quality of the evidence, how to interpret it and how to report it. While we have attempted to be transparent about these judgements, this report inevitably includes judgements made by review authors and judgements made by ourselves.
**Why we have focused on systematic reviews**

Systematic reviews of research evidence constitute a more appropriate source of evidence for decision-making than relying on the most recent or most publicised research study. We define systematic reviews as reviews of the research literature that have an explicit question, an explicit description of the search strategy, an explicit statement about what types of research studies were included and excluded, a critical examination of the quality of the studies included in the review, and a critical and transparent process for interpreting the findings of the studies included in the review.

Systematic reviews have several advantages. Firstly, they reduce the risk of bias in selecting and interpreting the results of studies. Secondly, they reduce the risk of being misled by the play of chance in identifying studies for inclusion or the risk of focusing on a limited subset of relevant evidence. Thirdly, systematic reviews provide a critical appraisal of the available research and place individual studies or subgroups of studies in the context of all of the relevant evidence. Finally, they allow others to appraise critically the judgements made in selecting studies and the collection, analysis and interpretation of the results.

While practical experience and anecdotal evidence can also help to inform decisions, it is important to bear in mind the limitations of descriptions of success (or failures) in single instances. They may be useful for helping to understand a problem, but they do not provide reliable evidence of the most probable impacts of policy options.

**Uncertainty does not imply indecisiveness or inaction**

The SUPPORT summaries included in this report did not show the direct impact of both CBHI and SHI in reducing out-of-pocket expenditure. Hence their effects on out-of-pocket expenditure cannot be certain. Nonetheless, policymakers must make decisions. Uncertainty about the potential impacts of policy decisions does not mean that decisions and actions can or should not be taken. However, it does suggest the need for carefully planned monitoring and evaluation when policies are implemented.

"Both politically, in terms of being accountable to those who fund the system, and also ethically, in terms of making sure that you make the best use possible of available resources, evaluation is absolutely critical."

(Julio Frenk 2005, former Minister of Health, Mexico)
The problem: Poor health care financing

Background
Achieving universal and equitable access to quality health care requires a sustainable financial resource base that meets the health needs of the population, without causing impoverishment. Such access can contribute to the attainment of national development goals and economic growth through improved health status (WHO 2005). However, globally there exists an enormous mismatch between countries’ health financing needs and their health spending (Gottret 2006).

The World Health Organization (WHO) defines health financing as the “function of a health system concerned with the mobilization, accumulation and allocation of money to cover the health needs of the people, individually and collectively, in the health system.” It states that the “purpose of health financing is to make funding available, as well as to set the right financial incentives to providers, to ensure that all individuals have access to effective public health and personal health care” (WHO 2000).

In light of this, the Federal Ministry of Health (FMoH) in Ethiopia has developed and implemented a health care financing strategy since 2005 (Health Sector Development Plan III). This strategy focuses mainly on improving the efficiency of allocation and utilization of public sector health resources. Like most African countries the health financing system in Ethiopia is pluralistic, with funds originating and flowing through several sources and mechanisms, including: the government, grants and loans from bilateral and multilateral donors, private contributions and other sources, including contributions from private employers (FMoH 2010a). Although health care financing has improved significantly over the years as a result of the health care financing strategy, inadequate health care financing remains a major challenge for the health system of the country (FMoH 2010b). By addressing this problem, the current system of health care financing can be strengthened and sustainable resource mobilization, allocation and utilization, as well as equitable health system utilization, can be improved. The objective of this Evidence Brief is therefore to show the size and major causes of the problem under consideration and to suggest possible policy options that can strengthen the health care financing of the country.

Size of the problem
Total health spending in Ethiopia has increased from US$1.2 billion in 2007/08 to US$1.6 billion in 2010/11 (FMoH 2014). Though it has increased, spending on health is still far from sufficient to purchase good health care for all citizens (www.healthsystems2020.org). The country’s overall health care is under–financed both in absolute terms and when compared to Sub-Saharan Africa (SSA) standards. For instance, the per capita national health expenditure for the country was reported to
be US$ 20.77 during the year 2011 (FMoH 2014) while the SSA average was US$ 93.65. This per capita health expenditure for Ethiopia is also well short of the WHO’s recommended US$ 30-40 per person needed to cover essential health care in low-income countries (www.tradingeconomics.com).

According to the World Bank, the out-of-pocket health expenditure in Ethiopia (i.e., the proportion of total health expenditure that is paid privately by individuals and households) was measured at 79.87% in 2011 (http://data.worldbank.org). This figure is higher than the 62.2% in Sub Saharan Africa during the same period (http://data.worldbank.org).

There is also a persistent budget deficit in the health sector in Ethiopia. For instance, the budget committed for the different strategic health objectives during the 2011/12 financial year was 30% less than the required amount for that year. During the same period, various strategic objectives within the Health Sector Development Plan IV did not have adequate budgets. For example, the total required budget for the delivery of quality health services was US$ 12,661,000 and the total amount committed by the government was US$ 7,157,000 - a 34% gap (FMoH 2011/12). This suggests that the resources available may not be sufficient to deliver quality health care.

Another important indicator of the problem of health care financing is the maternal mortality rate, which has not shown significant improvement since 2005. One of the reasons for this lack of progress is the under-financing of maternal health services, not only compared to other countries but also compared to other services. Total reproductive health expenditure in 2010/11 was US$ 224 million (constituting 14% of total health spending) (FMoH 2014). During the same period, spending per woman of reproductive age (15-49 years) was not more than US$ 12 - not adequate to improve the health status of women nor to improve access and use of reproductive health services (FMoH 2014, FMoH 2010b).

**Factors underlying the problem**

The causes of inadequate financing for health care in the country include: low government spending on the health sector; strong reliance on out of pocket expenditure; inefficient and inequitable utilization of resources; and poorly harmonized and unpredictable donor funding.

**Low government spending on the health sector**

Health care financing in Ethiopia has over the years been characterized by low government spending (Rechard 2009). For example, during the year 2010/11 the total government health expenditure (from internal revenue and loan) was estimated at US$ 265,128,091 and the total government expenditure was US$ 4,734,188,679 (FMoH, 2014). Thus the share of total government spending that was allocated to health was about 5.6 percent. This is low compared with the Abuja Declaration commitment of African countries to raise the share of government expenditure for health to 15
percent (Laurent et al, 2012). The annual aggregate budget for the health sector is also less than required. For instance, the budget allocated to the health sector for the year 2012/13 was below the amounts needed to deliver quality care (FMoH 2012/13).

Per capita health expenditure is also far below what is targeted by the government. For instance, though there has been a relative increase in per capita national health expenditure, this only reached US$ 20.77 in 2010/11 (FMoH 2014). If trends continue, the per capita spending will fail to reach the US$ 34 recommended by WHO Commission on Macroeconomics and Health (FMoH 2006) and the target of US$ 32.2 for the year 2015 proposed in the government’s Health Sector Development Plan (FMoH 2010b).

**High reliance on out-of-pocket payments**

In order to reduce the likelihood of catastrophic financial expenditures for health service users, the WHO recommends that direct out-of-pocket payments at the point of service should not exceed 15-20% of total health expenditure (WHO 2010). In Ethiopia, around 79.87% of total health expenditure is derived from household out-of-pocket payments (http://data.worldbank.org), which is the most regressive way of funding health care (WHO 2012). The reliance on this payment mechanism creates financial barriers to accessing health services and puts people at risk of impoverishment (FMoH 2010b, Ataguba 2008) especially low income countries like Ethiopia.

Reproductive health care provides an example for poor health care financing. Although this area of health care is highly donor financed, households contribute more than one-fourth of spending, at the time of illness. Often the cost of care is prohibitive or at least sufficiently large that it causes a delay in the decision to seek and use care (FMoH 2010b). In addition, evidence from urban Ethiopia reveals that as user fees increase by 1%, the probability of demanding care from public providers decreases by about 25%. Furthermore, the poor spend a greater proportion of their income on health care than the better off: studies have shown that the poorest spend 15% of their income on health care while wealthier groups pay only 5.7% of their income. Visits to private clinics have also been found associated with income level. The likelihood of visiting a private clinic by the medium income group was about 1.5 times higher than the low income group. Similarly, the high income group visited private clinics 3 times more than the low income groups (Ashagre 2004). These different studies suggest that burdening poorer households with user fees will reduce their access to and use of health services (Guda 2007, Richard 2009).

**Unpredictable and poorly harmonized donor funding**

Donor funds in Ethiopia are unpredictable and not sufficiently harmonized with national priorities and mechanisms (Laurent et al, 2012). For example, of the amount committed by the Global Fund for HIV and TB programs for the year 2012/13 only 35% and 30% respectively was disbursed. During the same period other donor partners like UNFPA and USAID also failed to fully disburse the amount
that they had pledged (FMoH 2012/13). Thus, such gaps between aid commitment and actual disbursement results in less predictability of aid. This in turn can cause ineffective and distorted uses of resources. One of the major reasons for this very low disbursement rate was the lack of donor harmonization (Alemu 2009).

Ethiopia’s fifth national health account shows that key areas of the health sector are heavily financed by donors (FMoH 2014). However, as outlined in HSDP IV, resource commitments by the 14 development partners working in Ethiopia for the next five years of the health sector development plan are expected to decline (FMoH 2010b). This raises the question of the sustainability of various donor supported services.
Policy options:

Poor health care financing of the country is the result of various causes. However, this evidence brief seeks to address one of the major causes – high reliance on out-of-pocket payments through risk sharing mechanisms. These mechanisms are given emphasis because they are effective health financing techniques that have been used in LMIC and also they are currently under consideration by the government. Risk sharing mechanisms (such as insurance schemes) are strategies to reduce large out-of-pocket payments for health care and to overcome financial barriers to accessing health care. Health insurance schemes come in different forms (Community-based health insurance, Social Health Insurance and Private insurance), defined mainly by the source of financing for the insurance premiums. A country may choose or combine several different forms to maximize population coverage. Hence, in supporting/improving the health care financing of the country, the following policy options are considered: 1) Community based health insurance 2) Social health insurance.

Policy option 1:
Community-based health insurance

Community based financing is defined as ‘a generic expression used to cover a large variety of health-financing arrangements like microinsurance, community health funds, mutual health organizations, rural health insurance and community involvement in user-fee management’ (Dror and Preker 2002). Although all of these schemes vary in their scope, size and implementation, they usually share three characteristics (Preker & Carrin 2004):

- they are based on a collective entity that may be defined on a geographical, professional, religious basis, etc.
- the beneficiaries of the scheme usually belong to populations with no other access to health financing protection
- enrolment to these schemes is voluntary.

The schemes can be broadly defined as not-for profit pre-payment plans for health care that are controlled by a community that has voluntary membership (Gottret 2006).

CBHI is increasingly championed as an alternative to user fees to improve equity in access to medical care in low-income countries (Bennett 2004). Establishing community based health insurance schemes presumed to improve health care financing in a country, and has the potential to increase utilization, better protect people against (catastrophic) health expenses and address issues of equity of
access. CBHI is also a health care financing option that may help to extend coverage to rural communities and the informal sector.

**Current Practice in Ethiopia**

In Ethiopia, CBHI was introduced in 13 pilot ‘woredas’ (or districts) in 2011. The objectives of launching CBHI were to improve financial access to health care services; increase resource mobilization; improve quality of health care services; and strengthen community participation. Although the CBHI scheme is still being piloted, it is planned that all members of communities who are employed in or earn a living through the informal sector will be obliged to be members of the scheme. An autonomous health insurance institution at a federal level is being established to manage the health insurance fund, provide overall guidance and undertake monitoring and evaluation of both the CBHI and Social Health Insurance schemes. There are two provider payment modalities in the current pilot implementation of the scheme. One is on the base of capitation (based on a predetermined amount per patient). The other is based on fee-for-service. Currently there are plans to expand the pilot CBHI program within four administrative regions of the country: Amahara, Oromiya, SNNP and Tigray (FMoH 2012/2013).

**Impacts of community-based health insurance**

A SUPPORT summary (Motaze 2014) of a systematic review (Acharya 2012) evaluated the impact of community based health insurance on out-of-pocket expenditure and health service utilization by comparing the application of community health insurance with no insurance. The systematic review, based on studies from three countries, found that (also see Table 1):

- It is uncertain if community based health insurance decreases out-of-pocket expenditure.
- Community based health insurance may lead to increases in the utilisation of health services.

**Table 1:** Community based health insurance compared with no insurance
Table 1: Community based health insurance compared with no insurance

<table>
<thead>
<tr>
<th>People</th>
<th>Poor people including those in the informal sector</th>
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<tbody>
<tr>
<td>Settings</td>
<td>Low- and middle- income countries (Burkina Faso, China and India).</td>
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<tr>
<td>Intervention</td>
<td>Community-based health insurance</td>
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<tr>
<td>Comparison</td>
<td>No health insurance</td>
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<table>
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<tr>
<th>Outcomes</th>
<th>Impact</th>
<th>Certainty of the evidence (GRADE)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Utilisation of health services</strong> (use of different types of health facilities including public and private; use of specific health services like diabetes care or pre-natal care; visits to physicians; outpatient / inpatient services; use of formal / traditional medicine)</td>
<td>All three studies that reported this outcome found higher utilisation of health services among those enrolled in community-based health insurance schemes.</td>
<td>☑️☑️☑️ Low</td>
</tr>
<tr>
<td><strong>Out-of-pocket expenditure on health services</strong></td>
<td>Two studies measured this outcome. A decrease in OOP expenditure was reported for one study while the results of the other study were seen as not valid due to a small sample size.</td>
<td>☑️☑️☑️ Very low</td>
</tr>
<tr>
<td><strong>Health outcomes (e.g., glucose control in diabetic patients, infant mortality and health status of communities)</strong></td>
<td>One study reported improvements in health outcomes.</td>
<td>☑️☑️☑️ Very low</td>
</tr>
<tr>
<td><strong>Equity</strong></td>
<td>One study found an increase in health outcomes for the poor and 1 study reported a decrease in utilisation of health services by poor individuals in the CHI scheme.</td>
<td>☑️☑️☑️ Very low</td>
</tr>
</tbody>
</table>

GRADE: GRADE Working Group grades of evidence (see above and last page)
Quality of evidence was assessed as low for utilisation of health services because the results reported were from both RCT and observational studies.
Quality of evidence was assessed as very low for OOP expenditure, health outcomes and equity. This is due to inconsistency and results from non-randomized and observational studies.
**Applicability, equity, costs, monitoring and evaluation**

**Applicability**
Given the settings of included studies (low and middle income countries), it is likely that the results of this review could apply to many low-income countries. As Ethiopia is a low income country the finding from these studies can be considered applicable. Particularly, as the majority of the country’s population (83%) resides in rural areas, the CBHI scheme can be helpful. Furthermore, the majority of the health service providers in Ethiopia are government run. This is also good opportunity to apply SHI and CBHI schemes as insurance schemes are not primarily for profit and require high government subsidy at their very start.

**Equity**
There are no data on whether inequalities can be reduced for disadvantaged groups like the physically and mentally impaired groups. However, the disadvantaged groups that have limited financial resources and who can hardly afford health expenditures but often have greater health care needs could benefit from social and community health insurance. When a large number of people contribute to the insurance pool it enables health care expenditures to be spread out over a large population and a few individuals do not carry the financial burden of their diseases. This can reduce the catastrophic out-of-pocket health expenditure on the poor and increase utilization of health service which results in equity.

**Economic considerations**
There are no data available from low resource settings on cost effectiveness of the schemes. However, there are important economic consequences of rolling out insurance schemes that cover a large proportion of the population. Spreading out the burden of health costs will entail payment from those who are able to afford with less or no payment from individuals with no or very little earnings. Payments for the latter group may need to be subsidized by the government. When insurance schemes are extended to cover large group of population, they may bring economics of scale and be more cost effective.

On the other hand making health insurance more widely available may lead to overburden of health care services. Health care services might find difficult to cope with increasing demand.

**Monitoring and evaluation**
Outcomes such as health care expenditure, equity, quality of care and health outcomes (like disease morbidity and mortality) have to be monitored in order to evaluate the effectiveness of insurance schemes. Baseline information should be gathered ahead of the regular monitoring and evaluation of the schemes performance. This monitoring should be continuous and should be of sufficiently high
quality to enable informed decisions and adjustments to be carried out. Conducting performance evaluation meetings with service providers, clients and insurance administrators, evaluating routine reports, feedback from customers and reviewing documents and research outputs may be some of the additional considerations in monitoring and evaluation of insurance schemes. The following are some of the key indicators of monitoring and evaluation system. Population coverage rate, Membership growth rate, Renewal rate, Drop-out rate, Premium collection rate and Incurred claims ratio.

**Policy option 2:**

**Social health insurance**

Social health insurance (SHI) is one of the principal methods of health financing globally. It is a form of mandatory health insurance for formal sector employees, including retirees and pensioners. Most social health insurance schemes combine different sources of funds: these schemes are usually financed by earmarked payroll and pension contributions (from employer and employees) (Charles & Alex 1994, FMoH 2008). In addition, governments often contribute on behalf of people who cannot afford to pay themselves. SHI entitlement is linked to a contribution made by, or on behalf of, specific individuals in the population (WHO 2004).

Like CBHI schemes, SHI is meant to improve access to health services by removing catastrophic health expenditure at the point of service delivery, particularly for formal sector employees and their families (FMoH 2008).

**Current Practice in Ethiopia**

The Social Health Insurance Proclamation was ratified by Parliament in July 2010, however, it is not implemented to date. There is an initiative to establish an SHI scheme incrementally, gradually expanding its coverage to include all employees in the formal sector (FMoH 2008), including retirees and pensioners. The potential members of the SHI are formal sector employees of public or private organizations in the country, including the retired and pensioners. The plan is to make citizens of the country in formal employment beneficiaries through contributions constituting 3% of their salary. A member is eligible to enroll in the SHI program with his or her spouse and children under 18 years of age. Regarding service provider selection, public facilities are planned to be the major service providers. However private facilities that have gone through accreditation process and agreed to provide the service at established tariff can be considered.
Impacts of social health insurance

A support summary (Motaze 2014) of a systematic review (Acharya 2012) evaluated the impact of social health insurance by comparing application of social health insurance with no insurance. The systematic review found that (also see Table 2):

- It is uncertain if social health insurance reduces out-of-pocket expenditure and improves utilization of health services among those insured in low- and middle-income countries.

Table 2: Social Health Insurance compared with no insurance
Table 2: Social Health Insurance compared with no insurance

<table>
<thead>
<tr>
<th>People</th>
<th>Poor people including those working in the informal sector</th>
</tr>
</thead>
<tbody>
<tr>
<td>Settings</td>
<td>Low- and middle- income countries (Nicaragua, Mexico, Colombia, Georgia, Ghana, China, Vietnam, Egypt and Indonesia)</td>
</tr>
<tr>
<td>Intervention</td>
<td>Social health insurance</td>
</tr>
<tr>
<td>Comparison</td>
<td>No health insurance</td>
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<table>
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<tr>
<th>Outcomes</th>
<th>Impact</th>
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</tr>
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<tbody>
<tr>
<td><strong>Utilisation of health services</strong> (use of different types of health facilities including public and private; use of specific health services like diabetes care or pre-natal care; visits to physicians; outpatient / inpatient services; use of formal / traditional medicine)</td>
<td>15 studies reported this outcome. Eleven studies reported higher utilisation of health services and 4 studies found no increased utilisation among the insured.</td>
<td>4 Very low</td>
</tr>
<tr>
<td><strong>Out-of-pocket expenditure on health care services</strong></td>
<td>10 studies reported this outcome. Seven studies found reduced OOP expenditure among insured participants while 3 studies found opposite effects.</td>
<td>4 Very low</td>
</tr>
<tr>
<td><strong>Health outcomes</strong> (e.g., glucose control in diabetic patients, infant mortality and health status of communities)</td>
<td>Five studies reported this outcome. Three studies found little or no improvement in health outcomes for the insured and 2 studies found improvements in health outcomes.</td>
<td>4 Very low</td>
</tr>
<tr>
<td><strong>Equity</strong></td>
<td>Four studies reported increased utilisation of health services by poor individuals while 2 studies found no effect of SHI on the poor. This comparison was not made for the other outcomes.</td>
<td>4 Very low</td>
</tr>
</tbody>
</table>

GRADE: GRADE Working Group grades of evidence (see above and last page). Quality of evidence was assessed as very low because most of the studies used observational designs and there was inconsistency in the results for the reported outcomes.

*Applicability, Equity, Economic considerations, monitoring and evaluation*

(See discussion on Page 14)
Implementation considerations

Community based health insurance and social health insurance are two potential options for improving health care financing in Ethiopia, in addition to other existing financing schemes. The implementation of these two options includes both opportunities and challenges. It is therefore important to consider possible barriers and enablers, so that benefits arising from enablers can be taken as an opportunity while properly addressing the barriers.

Enablers for implementation of these options (Community-based health insurance and social health insurance) in Ethiopia include:

- Existence of a strong government commitment to improving health care financing so as to enhance the health status of Ethiopians. (FMoH 2008, FMoH 1998)
- The on-going implementation of the health care financing reforms.
- The existence of high out-of-pocket expenditure is an indication of the capacity and willingness of households to pay for health services, which is a necessary precondition for establishment of health insurance.
- Existence of local institutions like ‘edir’ (community groups that collect funds for funeral costs), ‘equb’ (rotating credit association or a rotating fund) etc where people contribute a certain amount of money regularly (usually monthly) are important entry points for establishing health insurance.
- The existence of Micro-finance Institutions in all regions, with networks that extend to the community level, offer a good opportunity for expansion of health insurance. They can serve as a means of reaching rural communities particularly to collect premiums.
- The steady economic growth of the country is likely to enhance the capacity of the government to subsidize health insurance schemes

Table 3: Barriers to the implementation of CBHI
### Table 3: Barriers to the implementation of CBHI

<table>
<thead>
<tr>
<th>Barriers</th>
<th>Descriptions</th>
<th>Implementation strategies</th>
</tr>
</thead>
</table>
| The existing health service is inadequately equipped and staffed. Low quality health service. | Poor health service infrastructure and human power to provide the services to which insured people are entitled. (Facilities might find it difficult meeting raised demand by the insured). | • Accreditation should be introduced and strictly adhered to.  
• Improving facility readiness (improving the supply of medical, pharmaceutical and other equipments.)  
• Expand supply of covered services by investing in infrastructure and/or building clinical skills  
• Capacity building of existing staffs |
| Seasonality of income | Since rural communities are dependent more on agricultural activities, households earnings also vary seasonally making collection of premiums difficult | • A flexible premium collection mechanism could be introduced for the informal sector schemes, such as collecting premium from farmers during the harvest period (24) |
| Geographically scattered settlements and mobility of pastoralists | The scattered settlement of agricultural households and the relative mobility of pastoralist may raise the costs of premium collection. | • “Door-to-door” (or hut-to-hut) outreach by insurance workers.  
• Enrolment through professional associations, unions, or cooperatives  
• Introducing flexible payment schedules |
| Lack of awareness and negative perception towards health insurance | Rural communities may not be aware of the benefits of health insurance. Therefore may not be interested in it as the benefits of insurance are not immediate | • Information dissemination, awareness creation and sensitization activities focusing on the benefits of health insurance.  
• Community mobilization (25). |
| Discrimination between cash and insurance users | Discrimination between cash clients and insured users. Service providers may give priority for cash clients. | • Issuing service users (both insured and cash users) with similar colored ID cards. (Developing a system which blinds care providers.) |
| Bureaucracy in cost reimbursement | Lengthy administrative bureaucracy in cost reimbursement for service provider institutions may not be efficient that providers may frustrate. | • Shortening the bureaucracy as much as possible |
| Lack of trained personnel | Planning, coordinating and monitoring health insurance schemes require new technical expertise, which may not adequately exist in the public sector. | • Capacity building based on identified gaps.  
• Sharing experience of other countries with experience of running CBHI |
<table>
<thead>
<tr>
<th>Barriers</th>
<th>Descriptions</th>
<th>Implementation strategies</th>
</tr>
</thead>
<tbody>
<tr>
<td>The existing health service is inadequately equipped and staffed. Low quality health service.</td>
<td>Poor health service infrastructure and human power to provide the services to which insured people are entitled. (Facilities might find it difficult meeting raised demand by the insured.)</td>
<td>• Accreditation should be introduced and strictly adhered to.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Improving facility readiness (improving the supply of medical, pharmaceutical and other equipments.)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Introducing continuous monitoring and evaluation system</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Building capacity of existing staffs</td>
</tr>
<tr>
<td>Burden of payroll contributions may increase unemployment</td>
<td>The burden as a result of deduction from payroll might lead to unemployment or force workers to leave the formal sector.</td>
<td>• Introducing other types of insurance schemes such as CBHI parallel to SHI scheme so as to reach people in the informal sector.</td>
</tr>
</tbody>
</table>

Table 4: Barriers to the implementation of SHI
<table>
<thead>
<tr>
<th>Barriers</th>
<th>Descriptions</th>
<th>Implementation strategies</th>
</tr>
</thead>
<tbody>
<tr>
<td>The level of solidarity within a society might be low</td>
<td>Interest of individuals to support other individuals might be low</td>
<td>• Community mobilization (25)</td>
</tr>
<tr>
<td>Bureaucracy in cost reimbursement</td>
<td>Lengthy administrative bureaucracy in cost reimbursement for service provider institutions may not be efficient that providers may frustrate.</td>
<td>• Shortening the bureaucracy as much as possible. • Introducing efficient cost reimbursement systems.</td>
</tr>
<tr>
<td>Unemployment as a result of reduction of employees by employers.</td>
<td>Private employers might reduce number of their employees to reduce insurance premiums.</td>
<td>• Incorporating all organization to the SHI program irrespective of their size and number of employees they have.</td>
</tr>
</tbody>
</table>
Next steps

The aim of this policy brief is to foster dialogue and judgements that are informed by the best available evidence. The intention is not to advocate specific options or close off discussion. Further actions will flow from the deliberations that the policy brief is intended to inform. These might include, for example:

- Monitoring and evaluation of the suggested policy options and implementation strategies
- Consideration of appropriate implementation strategies for each of the policy options mentioned
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Appendices

Appendix 1. How this policy brief was prepared

The methods used to prepare this policy brief are described in detail elsewhere.\textsuperscript{vi, vii, viii}

The problem that the policy brief addresses was clarified iteratively through discussion among the authors, review of relevant documents and research. Research describing the size and causes of the problem was identified by reviewing government documents, routinely collected data, searching PubMed and Google Scholar, through contact with key informants, and by reviewing the reference lists of relevant documents that were retrieved.

Strategies used to identify potential options to address the problem included considering interventions described in systematic reviews and other relevant documents, considering ways in which other jurisdictions have addressed the problem, consulting key informants and brainstorming.

We searched electronic databases of systematic reviews, including: the Cochrane Library (CENTRAL, Cochrane Database of Systematic Reviews), Support Summaries, PDQ Evidence, Health Systems Evidence and supplemented these searches by checking the reference lists of relevant policy documents and with focused searches using PubMed, Google Scholar, and personal contacts to identify systematic reviews for specific topics. The final selection of reviews for inclusion was based on a consensus of the authors

Potential barriers to implementing the policy options were identified by brainstorming using a detailed checklist of potential barriers (SURE guide for Identifying and addressing barriers) to implementing health policies. Implementation strategies that address identified barriers were identified by brainstorming and reviewing relevant documents.

Drafts of each section of the report were discussed with the SURE Project team based at the Norwegian Knowledge Centre for the Health Services. External review of a draft version was managed by the Norwegian Knowledge Centre for the Health Services. Comments provided by the external reviewers and the authors’ responses are available from the authors. A list of the people who provided comments or contributed to this policy brief in other ways is provided in the acknowledgements.

\textsuperscript{1}Mulrow CD. Rationale for systematic reviews. BMJ 1994; 309:597-9.


vii Supporting the Use of Research Evidence (SURE) in African Health Systems. SURE guides for preparing and using policy briefs: 5. Deciding on and describing options to address the problem. www.evipnet.org/sure

### Appendix 2. Pros and Cons of CBHI and SHI

#### Table 1: Some pros and cons of Community Based Health Insurance schemes

<table>
<thead>
<tr>
<th>Pros</th>
<th>Cons</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Local control may produce more transparency and accountability</td>
<td>• Schemes are often voluntary – but to be really effective membership should be compulsory. Communities may not have mechanisms to achieve that.</td>
</tr>
<tr>
<td>• Local financing and administrative arrangements may be attractive to citizens reluctant to use government run facilities further from their homes</td>
<td>• The populations involved in these schemes are often poor – it can be difficult to raise enough money to provide adequate coverage and these schemes often need to be supplemented by tax-based schemes.</td>
</tr>
<tr>
<td>• CBHI can be more easily combined with other community-based initiatives such as microfinance programs or local organization of occupational groups.</td>
<td>• Risk pools in CBHI can be small and schemes are vulnerable to unexpected high cost events or epidemics.</td>
</tr>
<tr>
<td>• When pre-paid and compulsory, community financing can offer a good degree of risk protection</td>
<td>• Community based health insurance depends quite a bit on capacity and organization at the local level</td>
</tr>
<tr>
<td>• Available to low-income groups and informal sector workers</td>
<td>• Small risk pools create risks for sustainability (bankruptcy of schemes is common)</td>
</tr>
<tr>
<td>• Facilitate government or donor funding to subsidize premiums to target populations</td>
<td></td>
</tr>
</tbody>
</table>

**Source:** Adapted from http://web.worldbank.org

#### Table 2: Some of pros and cons of using social health insurance to fund health systems

<table>
<thead>
<tr>
<th>Pros</th>
<th>Cons</th>
</tr>
</thead>
<tbody>
<tr>
<td>• The social contract structure can increase citizen’s willingness to pay, as there is greater trust that benefits will be delivered</td>
<td>• Scheme does not cover everyone; particularly SHI mostly only covers workers in the formal sector and only pools the health risks of its enrollees</td>
</tr>
<tr>
<td>• Social insurance schemes have the greatest potential for providing effective risk protection, particularly in high income countries</td>
<td>• Requires both adequate fiscal capacity of the government and popular acceptance.</td>
</tr>
<tr>
<td>• Mobilizes resources from employers for health</td>
<td>• Can result in higher real cost of labor due to higher social</td>
</tr>
<tr>
<td>• Strong support from the covered population</td>
<td>• Workers may leave the formal sector to avoid payroll taxes</td>
</tr>
<tr>
<td></td>
<td>• The small size of employees in the formal sector may make the risk pooling difficult</td>
</tr>
</tbody>
</table>

**Source:** Adapted from http://web.worldbank.org
Appendix 3. Issues to be considered in designing health insurance schemes

In designing health insurance schemes (Community-Based Health Insurance and Social Health Insurance) the following are some of the issues to be considered.

A. Service availability, quality and provider capacity

Service availability and provider capacity affect feasibility of insurance schemes at two levels:

1) The physical presence of health workers and facilities near enough to target populations and their capacity to deliver quality services covered by insurance (do they have the skills, equipment, and supplies?). Failure to address gaps in service availability and quality, may risk making existing inequities worse if insurance funds will flow to the providers already in place in wealthier, urban areas.

2) Providers’ willingness to participate in the insurance program. Providers may not be willing to participate if, for example, the insurance payments are perceived as too low, patient volume increases significantly.

B. Population coverage

In order for health insurance to reduce inequities, it must be designed to reach poor and marginalized populations. The following table summarizes some of the possible challenges and strategies to be considered.

Table 1: Some of the challenges and strategies to insure hard-to-reach populations

<table>
<thead>
<tr>
<th>Challenging Characteristics</th>
<th>Strategies</th>
</tr>
</thead>
</table>
| Geographically dispersed                                                                   | • “Door-to-door” (or hut-to-hut) outreach by insurance workers.  
  • Enrollment through professional associations, unions, or cooperatives                  |
| Difficult to communicate the concept and benefits of health insurance due to low literacy rates and unfamiliar concept of prepayment or risk sharing | Build on existing mutuelles (“Edir”) for funerals or micro-finance |
| Living at or near poverty limits ability to pay premium                                    | • Schedule premium collection with harvest            
  • Subsidize premiums. Health care providers, municipal authorities, or community leaders with social standing may facilitate the application. |
| Health providers less accessible, especially in rural areas                                 | • Expand supply of covered services by investing in infrastructure and/or building clinical skills  
  • Decentralize service from higher to lower levels of                                         |
Challenging Characteristics | Strategies
--- | ---
facilities/personnel (task shifting) | • Mobilize and use existing private resources – create public/private partnerships

Source: Adapted from *Africa Health Insurance Handbook* (Wang 2010)

**C. Benefits packages and cost containment**

Given limited available resources, it is must to make difficult choices between covering services most likely to improve population health outcomes and services that protect households from catastrophic health expenditures.

To improve health outcomes, policy makers should consider the population’s burden of disease, demographics (age, gender, location, and income), mortality and morbidity rates, epidemiological trends, historical data on service use, and evidence regarding the most cost-effective interventions.

To protect households (especially poor households) from catastrophic costs, household surveys and health facility data can be used to analyze the target population’s current pattern of out-of-pocket health expenditures. Typically, households prioritize curative care and drugs. To reduce out-of-pocket expenditures and achieve financial protection, the benefits package will likely need to cover curative outpatient services, drugs, and inpatient care. However, great care must be taken to not create incentives for unnecessary hospitalizations and overprescribing.

However, selecting an appropriate benefits package requires financial analysis. Health actuaries can help estimate the cost of the proposed benefits package to determine if sufficient resources exist to finance the package. They can estimate the costs of services using historical utilization data (e.g., medical claims, household surveys, facility data), as well as determine the potential rate of increase in use of services once health insurance is implemented, which will affect the overall cost of the benefits. The cost estimate must be compared to revenue projections.

These calculations ensure that premium rates for those participating in the scheme are affordable, politically acceptable, and sufficient for long-term viability.

**D. Selection and payment of health care providers**

*Provider choice*

In areas where there is a mix of providers, a key insurance scheme design decision will be the degree of freedom that beneficiaries will be given to choose their provider. Can they go to a private provider? Can they go directly to a hospital or specialist or do they need to be referred by a primary care physician?
This issue affects beneficiary satisfaction (people prefer to choose their doctor) and medical costs (people tend to choose more expensive levels of care if they are not paying for it directly). Greater provider choice may be possible if the insurer can contract private providers and contain costs. To encourage beneficiaries to use primary health care, many insurers require primary care providers to serve as “gatekeepers” who determine the medical necessity for referral to hospitals and specialists.

**Provider payment methods**

Payment methods are one of the most sensitive issues for health workers and facilities since payments directly affects their economic interests. There are many different methods and they can be used in combination. The following table summarizes the different payment methods.

**Table 2: provider payment methods: summary of characteristics**

<table>
<thead>
<tr>
<th>Payment methods</th>
<th>Unit of payment</th>
<th>Financial risk to providers</th>
<th>Incentives for providers on</th>
<th>Administrative complexity</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>Quantity of services</td>
<td>Quality of services</td>
</tr>
<tr>
<td>Fee-for service</td>
<td>Per service item</td>
<td>Provider: Low Payer: High</td>
<td>Tendency to over-provide</td>
<td>Facilitates high quality</td>
</tr>
<tr>
<td>Salary</td>
<td>Monthly payment regardless of services rendered</td>
<td>Low</td>
<td>Not large effect on quantity of service</td>
<td>Not large effect on quality of service</td>
</tr>
<tr>
<td>Capitation</td>
<td>Per patient</td>
<td>Provider: High Payer: Low</td>
<td>Tendency to under-provide</td>
<td>Quality may be sacrificed to contain their financial risk</td>
</tr>
<tr>
<td>Case payment</td>
<td>Per case of different diagnosis</td>
<td>Moderate</td>
<td>tendency to increase cases</td>
<td>Can facilitate higher quality</td>
</tr>
<tr>
<td>Line item budget</td>
<td>Budget line</td>
<td>Low</td>
<td>Tendency to under-provide</td>
<td>Quality may be sacrificed to contain costs</td>
</tr>
</tbody>
</table>

*Source: Adapted from Africa Health Insurance Handbook (Wang 2010)*

**E. Organizational structure**

While there is no single, optimal organizational structure, there are two guiding principles:
1. Build accountability into the organizational structure. Hold entities accountable for honest and effective execution of their roles through control mechanisms such as regulation, checks and balances, clearly defined management functions, and clear and enforceable contracts.

2. Build on existing organizations as opposed to creating entirely new ones for insurance administration. Look for existing capacity and competencies.

1. **Policy and regulatory functions**
   - Designing the eligibility criteria and benefits package
   - Identifying which body will manage the scheme (e.g. ministry, semi-autonomous insurance fund, community organization)
   - Setting quality standards for providers
   - Setting standards for communications with beneficiaries
   - Establishing financial regulations to ensure solvency and protect consumers (e.g. reserve requirements, regulations regarding market entry and exit, or grievance procedures for consumers or providers).

2. **Provider management**
   - Promoting quality through payment mechanisms, provider accreditation, quality audits, and other methods
   - Managing compliance with parameters set forth in contract and budget
   - Processing medical claims (if paying fee-for-service), including checking for compliance with fee schedules and benefit regulations, ensuring that patients are entitled to the benefits claimed, and preventing fraud and controlling costs through other steps.

3. **Financial management (in addition to provider payment)**
   - Financial management and planning to ensure solvency, including cash management to ensure
   - Performing actuarial analysis to anticipate and avoid potential budget deficits by taking preventive action such as raising premiums, reducing benefits, controlling costs, or revising reinsurance coverage
   - Ensuring accurate, transparent financial reporting to all stakeholders; including an annual audit by an independent accounting firm
   - Applying, if needed, risk adjustment across multiple insurance funds (e.g., operating a central risk pool or redistributing resources among district, community, or sickness funds to adjust for population differences such as age or income).

4. **Beneficiary communications/marketing, enrollment, and revenue collection**
   - Educating the public about the insurance scheme and about entitlement to benefits
• Generating demand for enrolling (in voluntary schemes); reaching out to special populations
• Reviewing and redressing grievances
• Ensuring that employers register their employees and deduct contributions properly.

5. Monitoring and information systems
• Designing and running information systems and using the information for all functions: provider, financial, and customer management
• Capturing data from providers on:
  ○ service use, diagnoses, practice patterns, clinical outcomes
• Supporting analyses of these data for management decisions to improve quality, equity, and efficiency
• Developing systems to support cost control and quality assurance and monitoring compliance by providers and beneficiaries with rules for referrals, co-payments, waiting periods, and case management.
Glossary, acronyms and abbreviations

CBHI – Community-Based Health Insurance

EPHI - Ethiopian Public Health Institute

FMoH - Federal Ministry of Health of Ethiopia

HIV - Human Immunodeficiency Virus

HSDP - Health sector development program

LMIC - Low and middle-income country

OOP – Out-of-pocket payment

RCT – Randomized control trial

SHI – Social Health Insurance

SSA – Sub-Saharan Africa

SURE - Supporting the use of research evidence (SURE) for policy in African health systems project.

TB - Tuberculosis

UNFPA - United Nations Population Fund

USAID - United States Agency for International Development

WHO - World Health Organization