Policy Dialogue

Improving Health Care Financing in Ethiopia

Report
Dire International Hotel, Adama, Ethiopia
Saturday, 07 June 2014

This report was prepared by Technology Transfer and Research Translation Directorate, at the Ethiopian Public Health Institute

What is a policy dialogue?
A structured discussion focused on an evidence-based policy brief
The agenda from the policy dialogue is attached as Appendix 1

Who participated in the dialogue?
People with relevant expertise and perspectives, including policymakers, civil society, the mass media and researchers
The complete list of participants is attached as Appendix 2

What was the aim of the policy dialogue?
That discussion and careful consideration should contribute to well-informed health policy decisions
The dialogue did not aim to reach a consensus or make decisions

What is included in this report?
Views, opinions and insights of individual participants reported without attribution
The opinions included in this report reflect the understanding (or misunderstanding) of individual participants in the dialogue
These opinions may or may not be consistent with or supported by the policy brief or other evidence
It should not be assumed that the opinions and insights in this report represent a consensus of the participants unless this is explicitly stated
Nor should it be assumed that they represent the views of the authors of this report

This policy dialogue was informed by the following policy brief: Improving Health Care Financing in Ethiopia.
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Key messages

The following statements represent views, opinions and insights of individual participants in the policy dialogue.

The Problem

- The existing low government expenditure in the health sector is better manifested when the budget allocated to the sector is seen in comparison with other sectors like education and agriculture.
- Lack of leaders’ commitment should be considered as one problem in the health care financing. Because leaders are not willing and committed in the implementation of strategies to improve the poor health care financing of the country.

Policy options

- There are only two options mentioned as an option for improving health care financing, the evidence brief should have tried to come up with more options to help improve healthcare financing of the country such as air ticket taxation and other innovative health care financing schemes.
- It was also suggested that private insurance should have been mentioned as one option.
- One of the options mentioned social health insurance, is practiced in Ghana but was not successful. Therefore it requires careful considerations before implementation.

Implementation Considerations

- As a result of the existing poor quality health care service and low motivation of service providers, people might not be willing to contribute premium and be member of such system.
- Some cultural and religious beliefs of the community may not support insurance schemes; therefore careful consideration of the schemes is critical.

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The problem

In addition to points mentioned under the problem section of the evidence brief, lack of leaders’ commitment should be considered as one problem in the health care financing. That is, leaders are not willing and committed in the implementation of strategies to improve the poor health care financing of the country. There also exists deliberate price ceiling with the intention to rise revenue in some health centers and this hinders patients from using health facilities and causes impoverishment when the poor comes to health facilities.

Some participants did mention that the existing low government expenditure in the health sector is better manifested when the budget allocated to the sector is seen in comparison with other sectors like education and agriculture.

Other participants stated that shortage of human resource with the required skill and expertise in properly administering and running the health sector finance is also another cause for the poor health care finance and this should be mentioned in the evidence brief.

Some others still mentioned that given the prevailing problems in the health care financing, the term health care financing itself is not clear and misleading for both users and service providers. It is perceived as a mere collection of money. Therefore, solving the problem of health care financing should begin by clarifying the term itself.

Another participant expressed that the insurance coverage in Africa has reached about 44% on average, however in Ethiopia; it is less than 1%. Therefore it is good to mention this fact to show how much the country’s health care financing in terms of health insurance coverage has lagged behind compared to other African nations.

On the other hand some participants have said the existing problem with the health care financing is not shortage of finance, rather the way ‘woredas’ (districts) spend the budget allocated to them from federal and regional governments. Assuming the health sector has good support from donors and partners, ‘woreda’ administrators tend to transfer budget allocated for the health sector to other sectors.

Policy options

There are only two options mentioned as an option for improving health care financing, the evidence brief should have tried to come up with more options to help improve healthcare financing of the country such as air ticket taxation and other innovative health care financing schemes.
One of the options mentioned, social health insurance, is practiced in Ghana but was not successful. As a result Ghana is in crisis. Therefore it requires careful considerations before implementation.

It was also suggested that private insurance should have been mentioned as one option. A query was raised why policy options already under consideration by the government were proposed as a policy option. It was explained by the authors of the evidence brief that the evidence brief also aimed at assessing evidence behind the policies the government is pursuing.

Impact of community-based health insurance in reducing out-of-pocket expenditure is reported as uncertain in the evidence brief document. However, this is not the case in some of the ‘woredas’ currently under pilot implementation. Out-of-pocket expenditure is significantly reduced. There are good indications in this regard.

Ownership of community-based health insurance in pilot implementation ‘woredas’ was mentioned as poor while needs more clarity in this regard.

### Implementation considerations

One of the barriers mentioned, scattered settlement of rural people does not work for majority of rural residents in the country; rather it might be the case for pastoralist areas alone.

As a result of the existing poor quality health care service and low motivation of service providers, people might not be willing to contribute premium and be member of such system.

Absence of equal treatment between cash and insurance clients was mentioned as one of the barriers to service utilization. It has been the case in some pilot ‘woredas’ that health service providers discriminate between cash clients and insured users.

Less commitment and attention of leaders in implementing insurance scheme was also mentioned as a barrier.

Premiums might not be enough to support running costs.

The existing lengthy bureaucratic system might complicate and delay the cost reimbursement process for service providers. And this may result in frustrating service providers.

There is no pilot testing for SHI, implying the possibility of problems in the future.

Unemployment might be aggravated, since employers might reduce number of their employees to have few staffs for whom they are liable for insurance contribution.
Health professions in the country are exempted from user fees. However in SHI scheme they are expected to pay premiums. This might result in the dissatisfaction of care providers and might even develop resistance to the scheme.

The pilot CBHI is currently supported and subsidized by the government. Hence the clear impact of the scheme cannot be seen whether it has achieved its intended aim. Therefore the quality of the pilot implementation is questionable.

In the case of SHI if both husband and wife are employed to the formal sector, the premium collection from both parties might negatively affect the family income. And this might aggravate poverty and compromise the quality of family life.

Some cultural and religious beliefs of the community may not support insurance schemes; therefore careful consideration of the schemes is critical.
### Appendix 1: Agenda

Supporting the Use of Research Evidence (SURE) for Policy in African Health Systems Project  
(Adama, 07 June 2014)

<table>
<thead>
<tr>
<th>Time</th>
<th>Activity</th>
<th>Responsible Person</th>
</tr>
</thead>
<tbody>
<tr>
<td>8:00-9:00AM</td>
<td>Registration</td>
<td>Wude and Ahmed</td>
</tr>
<tr>
<td>9:00-9:15 AM</td>
<td>Objective of the policy dialogue &amp; Overview of TTRTD</td>
<td>Dr. Mamuye Hadis</td>
</tr>
<tr>
<td>9:15-9:50 AM</td>
<td>Going through the executive summary</td>
<td>Prof. Damen H/M (Moderator)</td>
</tr>
<tr>
<td>9:50-10:00 AM</td>
<td>Procedure and rules of the dialogue</td>
<td>Moderator</td>
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<tr>
<td><strong>10:00-10:30AM</strong></td>
<td><strong>Tea/Coffee break</strong></td>
<td></td>
</tr>
<tr>
<td>10:30-11:30 AM</td>
<td>Problem section of the evidence brief</td>
<td>Moderator</td>
</tr>
<tr>
<td>11:30-12:30 PM</td>
<td>Policy options section of the evidence brief</td>
<td>Moderator</td>
</tr>
<tr>
<td><strong>12:30-2:00PM</strong></td>
<td><strong>Lunch Break</strong></td>
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<tr>
<td>2:00-3:00 PM</td>
<td>Implementation considerations</td>
<td>Moderator</td>
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<tr>
<td>3:00-3:15 PM</td>
<td>Way forward</td>
<td>Moderator</td>
</tr>
<tr>
<td>3:15-3:30 PM</td>
<td>Closing remarks</td>
<td>Dr. Yibeltal A.</td>
</tr>
<tr>
<td><strong>3:30-4:00PM</strong></td>
<td><strong>Tea/Coffee break</strong></td>
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Competing interests
None

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