

Executive Summary

IMPROVING HEALTH CARE FINANCING IN ETHIOPIA



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 evidence brief for?

Policymakers, their support staff, and other stakeholders with an interest in the problem addressed by this evidence brief

Why was it prepared?

To **inform deliberations** about health policies and programmes by **summarizing the best available evidence** about the problem and viable solutions

What is an evidence brief for policy?

Evidence briefs for policy 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

Full Report

The evidence summarised in this Executive Summary is described in more detail in the [Full Report](#)



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

Key messages

The problem

Poor Health Care Financing

Poor health care financing remains a major challenge for the health system of Ethiopia. It leaves households vulnerable to impoverishment from catastrophic health expenditures, and slows progress towards health improvements such as the Millennium Development Goals by limiting access to essential health services among the poor.

Important barriers to improved health care financing include:

- Low government spending on the health sector
- Strong reliance on out of pocket expenditure
- Inefficient and inequitable utilization of resources
- Poorly harmonized and unpredictable donor funding.

Policy options:

Community based health insurance and social health insurance are two potential strategies to address the poor health care financing in the country.

1. Community-based health insurance is an alternative to user fees to improve equity in access to medical care particularly to those rural communities and the informal sector. It has the potential to increase utilization, better protect people against (catastrophic) health expenses and address issues of equity. The effects of community-based health insurance on decreasing catastrophic out-of-pocket expenditure are uncertain. However, it may increase the utilisation of health services.
2. Social health insurance is a form of mandatory health insurance for formal sector employees, including retirees and pensioners. It is meant to improve access to health services by removing catastrophic health expenditure at the point of service delivery. The effects of social health insurance both on decreasing catastrophic out-of-pocket expenditure and health service utilization are uncertain.
 - Given the limitations of the currently available evidence, there is a need for rigorous evaluative research prior to wide spread implementation for all the options.

Implementation strategies:

A combination of strategies is needed to effectively implement the proposed options

Barriers to implementing both options include lack of awareness and negative perception, moral hazard, fraud and corruption and inefficiency in the health care delivery. The strategies to implement the proposed options include:

- Information dissemination, awareness creation and sensitization activities,

- Strong community participation,
- Proper record keeping and accounting, and
- Creating competitive environment among health service providers.

The problem

Poor health care financing is one of the major challenges for the health system of Ethiopia (FMoH 2010). Although the health financing in Ethiopia comes from a variety of sources, direct out-of-pocket spending accounts for a significant portion of health sector spending in the country. Such significant out-of-pocket payment creates financial barriers to access to health services and puts people at risk of impoverishment. The objective of this evidence brief therefore is to summarize the best available evidence describing the problem of poor health care financing in Ethiopia and potential solutions for addressing the problem. We have focused on tackling one of the causes in particular – strategies to reduce out-of-pocket payment because large share of the total health expenditure of the country is in the form of out-of-pocket expenditure. Furthermore addressing this problem might improve the health service utilization by the poor.

Size of the problem

The total health spending in Ethiopia is still far from adequate to buy good health care. The per capita national health expenditure for the country was reported to be US\$ 20.77 in 2011 (FMoH 2014). This is very low compared to the Sub-Saharan Africa average which was US\$ 93.65 during the same period (www.tradingeconomics.com). This figure is also well short of the WHO's recommended US\$ 30-40 per person needed to cover essential health care. The World Bank estimation indicates out-of-pocket health expenditure in the country was 79.87% in 2011. This figure is higher compared to the 62.2 % in Sub Saharan Africa during the same period. Another indicator of the problem is the persistent budget deficit. In 2011/12 financial year alone, the budget committed for the different strategic health objectives was 30% less than the required amount for that year (FMoH 2012/13). This suggests that the resources available may not be sufficient to deliver the required quality health care.

Cause of the problem

Factors contributing to the poor health care financing 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). According to the recent national health account the share of total government health spending was not more than 5.6 percent of the total government expenditure (FMoH 2014). This is low compared with the Abuja Declaration commitment of African countries to raise the share of health expenditure to 15 percent.

High reliance on out-of-pocket payments

High out of pocket expenditure at the point of health service delivery increases the likelihood of catastrophic financial expenditures for health service users. In Ethiopia, around 34% of total health expenditure comes from household out-of-pocket payments (FMoH 2014). Such significant out-of-pocket payment creates financial barriers to access to health services and puts people at risk of impoverishment (WHO 2012). Different studies suggest that burdening poorer households with user fees will reduce their access to and use of health services (FMoH 2010, Ataguba 2008).

Unpredictable and poorly harmonized donor funding

Ethiopia's fifth national health account shows that key areas of the health sector are heavily financed by donors (FMoH 2014). However donor funds in Ethiopia are unpredictable and not harmonized with national priorities and mechanisms (Laurent 2012). For example out of the committed amount by the Global Fund for HIV and TB programs for the year 2012/13 only 35% and 30% was disbursed for the two programs respectively. During the same period other donor partners like UNFPA and USAID even failed to totally disburse the amount they have 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.

Policy options

This evidence brief aims at addressing the problem of the high out-of-pocket expenditure as it is the main barrier to access health services. Options considered to reduce the prevailing catastrophic out-of-pocket expenditure in order to improve health care financing in Ethiopia includes community based health insurance and social health insurance. These two complementary options to the existing various health care financing mechanisms are described below.

Policy Option 1

Community based health insurance (CBHI)

Community-based health insurance is a voluntary, non-profit insurance scheme, formed on the basis of solidarity and collective pooling of health risks, in which the members participate effectively in its management and functioning (Dror 2002). 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.

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 support summary found that community-based health insurance may lead to increases in the utilisation of health services.

It could address one of the reasons for poor health care financing-increased reliance on out-of-pocket payment, particularly in the informal sector and rural populations. However, the effect on reducing out-of-pocket expenditure is uncertain.

Policy Option 2

Social Health Insurance (SHI):

Social health insurance (SHI) involves compulsory contributions levied largely on earnings of formal sector workers and paying of health care providers through an independent mechanism (a health care purchaser). 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) (FMoH 2008). In addition, governments often contribute on behalf of people who cannot afford to pay for themselves.

Impact 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 support summary found that 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.

Implementation considerations

Barriers to the two options and implementation strategies that address those barriers are summarised in following tables.

Table 1. Barriers and implementation strategies for option 1: Community-based health insurance

Barriers	Descriptions	Implementation strategies
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).	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • A flexible premium collection mechanism could be introduced for the informal sector schemes, such as collecting premium from farmers during the harvest period (Omoruan 2009).
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.	<ul style="list-style-type: none"> • “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	<ul style="list-style-type: none"> • Information dissemination, awareness creation and sensitization activities focusing on the benefits of health insurance. • Community mobilization (Lee 2009).
Discrimination between cash and insurance users	Discrimination between cash clients and insured users. Service providers may give priority for cash clients.	<ul style="list-style-type: none"> • Issuing service users (both insured and cash users) with similar colored ID cards. (Developing a system which blinds care providers.)

Table 1. Continued

Bureaucracy in cost reimbursement	Lengthy administrative bureaucracy in cost reimbursement for service provider institutions may not be efficient that providers may frustrate.	<ul style="list-style-type: none">• 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.	<ul style="list-style-type: none">• Capacity building based on identified gaps.• Sharing experience of other countries with experience of running CBHI
Adverse selection (Omoruan 2009)	High-risk or sick individuals are more likely to buy health insurance than low-risk or healthy individuals (Tabor 2005), since most CBHI schemes are based on voluntary membership.	<ul style="list-style-type: none">• Public education or social mobilization• Introducing government premium subsidy for the poor.
Moral hazard	The insured might get involved in a risky event knowing that they are insured.	<ul style="list-style-type: none">• Educational and awareness-raising programs as a way of redressing the balance of prevention versus treatment (Debebe 2012)• Strong community participation can facilitate health education and sensitization of members in order to promote healthy behaviours• Introducing co-payments
Fraud and Corruption	Risk of fraud or deceptions intentionally practiced by patients, providers, and CBHI staff and managers, to secure unfair or unlawful gain (Tabor 2005).	<ul style="list-style-type: none">• High level of community participation (Tabor 2005).• Proper record keeping and accounting.• Developing a system of Management of Information System (MIS) that helps to keep all information about the members (Omoruan 2009).

Table 2. Barriers and implementation strategies for option 2: Social Health Insurance

Barriers	Descriptions	Implementation strategies
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.)	<ul style="list-style-type: none"> • Accreditation should be introduced and strictly adhered to. • Improving facility readiness (improving the supply of medical, pharmaceutical and other equipments.) • Introducing continuous monitoring and evaluation system • Building capacity of existing staffs
Burden of payroll contributions may increase unemployment	The burden as a result of deduction from payroll might lead to unemployment or force workers to leave the formal sector.	<ul style="list-style-type: none"> • Introducing other types of insurance schemes such as CBHI parallel to SHI scheme so as to reach people in the informal sector.
The level of solidarity within a society might be low	Interest of individuals to support other individuals might be low	<ul style="list-style-type: none"> • Community mobilization (Lee 2009)
Bureaucracy in cost reimbursement	Lengthy administrative bureaucracy in cost reimbursement for service provider institutions may not be efficient that providers may frustrate.	<ul style="list-style-type: none"> • Shortening the bureaucracy as much as possible. • Introducing efficient cost reimbursement systems.
Unemployment as a result of reduction of employees by employers.	Private employers might reduce number of their employees to reduce insurance premiums.	<ul style="list-style-type: none"> • Incorporating all organization to the SHI program irrespective of their size and number of employees they have.

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 options

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