Evaluation of Achievement and Challenges of health care reform using Community-based health insurance in Ethiopia

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Abstract

As part of Health care financing system, the Ethiopian government has introduced Community-based health insurance (CBHI) and Social Based health insurance. The aim of this paper is to examine the challenges and achievements of healthcare reform using community-based health insurance in Ethiopia. In this study, narrative reviews were employed in order to analyze the data collected from secondary sources. The study concludes that since 2014, coverage of CBHI district has been increasing, eventually going from 161 in 2014 to 827 (of which 770 launched) in 2020. CBHI is not able to cover reimbursement costs for health facilities due to a disjointed pooling system; lack of political commitment to developing and cooperating with the CBHI scheme are challenge affecting the implementation of CBHI in Ethiopia. Based on the finding recommendation were suggested in order to solve the challenges of CBHI implementation.

Keywords: Health care reform, Community-based health insurance, Implementation, Achievements, Ethiopia

Introduction

The Ethiopian government recognized a strategy for health financing in nineteen ninety-eight that intended an expensive range of edges. It is obvious that in order to implement one reform. It should be supported by regulation (Legitimized). Therefore, the Ethiopian government-endorsed reform initiatives through regional legislation and executed them in line with model implementation. In 2004, the actual execution was initiated by three regions, such as Oromiya national regional state, SNNP, and Amhara, after they made ratification and legitimization of regional proclamations, regulations, and directives after serious conversion and meeting within their regional council (caaffe in the case of Oromiya national regional state), regional cabinets, and regional health bureaus. In order to ensure long-range health finance sustainability Ethiopian HCFS acknowledged that the cost of people's health care should be financed via different mechanisms among that; executing health care system withholding and utilization, a tax-exempt system for the poor, standardize exemption services, establish and review user fees, introduce a private wing in public hospitals, outsource non-

government services promote the autonomy of the health care system by introducing a system of government (Zelelew, 2014).

As part of HCFS, the Ethiopian government has introduced CBHI and SHI. Both are focusing on saving people from unexpected health costs and reducing the number of people dependent on out-of-pocket payments besides this, domestic financial resources for health and achieving UHC.

Community-Based Health Insurance is part of University Health Coverage designed by the Ethiopian government with the help of different stakeholders such as USAID and Abt Association and started in 2011. As part of UHC, CBHI is a comprehensive and sustainable risk protection system planned to expand good health service in an equitable and accessible way to all.

According to the NHA (2017), the source of Ethiopia's HCF is still comprised of three sources: external funding (aid and donations), which account for 35%), domestic government sources (From the federal government and regional governments, which account for 32%); and out-of-pocket spending (from payments made by inpatients and outpatients during service taking). One of the limitations of the CBHI in most developing countries is that the scheme is highly dependent on the external source of finance. As a result, such schemes are relatively small, indigent, and low-income groups are registered and may not have a large enough risk group to exceed the operating cost. The aim of this paper is to examine the challenges and achievements of health care reform using community-based health insurance in Ethiopia using secondary sources, which include both published and non-published materials (journals, articles, and government reports regarding health care reforms, including the EHIA CBHI performance report).

1. CBHI Practices In Africa Focus On Ethiopia

The per capita expenditure on health spending in Ethiopia was very poor before 1998, in the 1980s to mid-1990s; it fluctuated between USD 1.20, was below the average per capita in sub-Saharan Africa of 6.70 USD (FMOH, 1998). Resource allocation has also been biased in favor of hospitals and urban areas. Utilization fees levied at health facilities did not reflect the cost of health care, and all revenue collected was remitted to the government treasury. There was little or no insurance coverage in the country. Private sector participation in health has been limited. All of these circumstances make access to health care a challenge for many households. To address this issue, the Council of Ministers approved a strategy for funding healthcare in 1998. Its objectives were to mobilize additional resources from internal and external sources, to improve efficiency, in particular by transferring resources to primary care, and to ensure sustainability of quality health services. It also aimed to improve community participation and the delivery of health services (EHIA, 2015)

When we compare the per capita expenditure on health from 1990 to 2018 (which is 28 years), it is US $ 24, which is 3.30% of the GDP (WB). When we see this data, it is well less than the per capita average for SSA.

Even though different healthcare financing reforms have been formulated and implemented by the Ethiopian government, their effect on healthcare utilization is not that significant. A study conducted by USAID reveals the former health care reforms have not significantly affected rates of use of health services, as ‘’up to 36% contacts per person per year have been maintained’’(Solomon et al, 2015). This was due to the service cost, especially for the households who could not pay these rates at the time of service (ibid). Accordingly, in 2011, Ethiopian government drafted the CBHI, aiming at the people working in the informal sector of the economy to protect them from risky financial costs and to have modern health facilities.

The Ethiopian government, take initiative to establish a community health project that brings together payments made by members into fund that covers the costs of basic health care; therefore, members have access to local health care centers when they are ill (USAID, 2019). The project was drafted and executed by the Ethiopian government under the special effort of different stakeholders to achieve UHC by improving the overall financial protection of healthcare (Solomon et al., 2015).

In 2011, the Community health insurance was initiated for the first time within thirteen districts selected from Tigray, Amhara, Oromiya, and Southern Nation Nationality and peoples Regions (EHIA, 2015). Since then, the federal government, with the collaboration of the regional governments, has started to scale up the CBHI to the rest of the regions and woredas to increase the number of members.

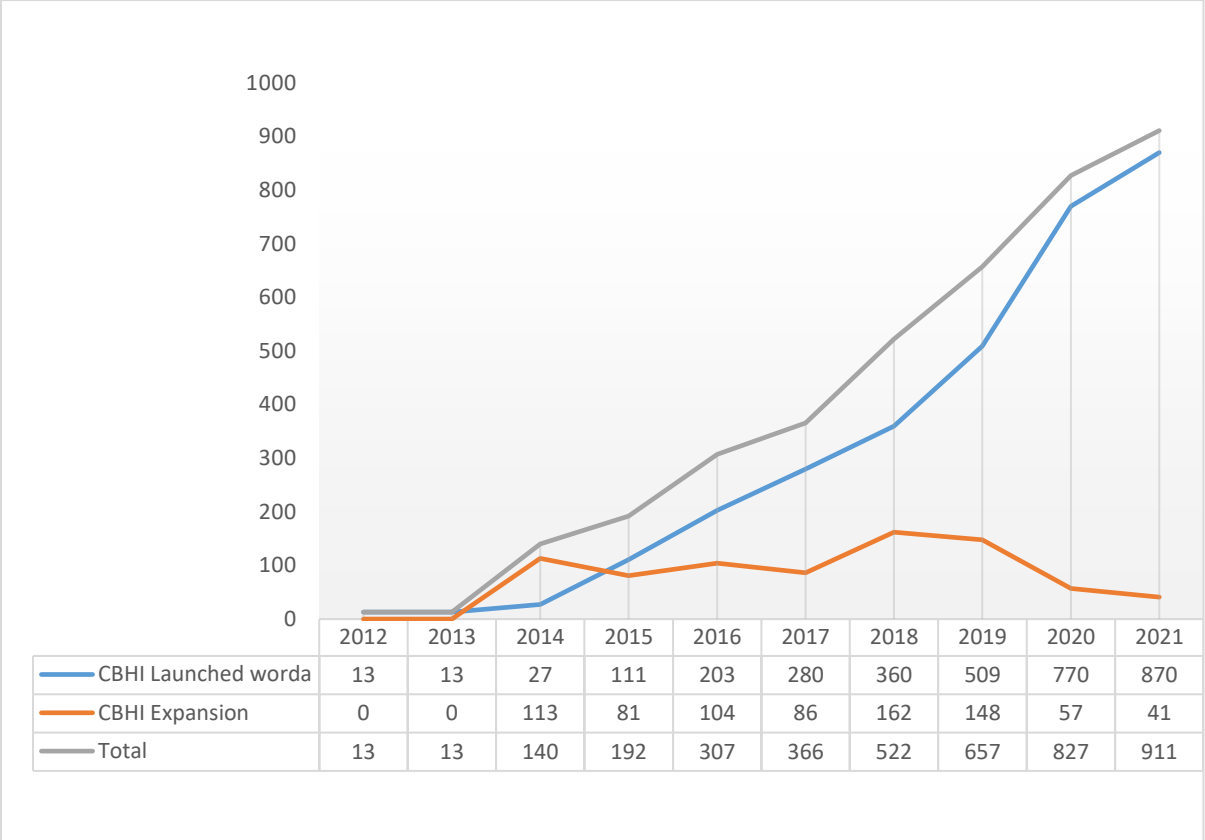
According to EHIA (2021), since 2014, the expansion of the scheme has been gradually increased from 161 towards 827 (of which 770 launched) in 2020.

In order to Executing the scheme effectively there are some circumstances considered for those are presence of a negligible level of quality care provision, institute enough institutional practice and strategy, as well as responding to the needs felt by insurance management, clear political commitment, drafting controlling bases, clear pledge in order to help the indigent member of the community to be the member of the schemes and making the membership criteria as mandatory (Ibid).

2. CBHI Membership Expansion In Rural Areas Of Ethiopia

Due to the significant rise in the cost of health services, citizens are forced to incur huge expenses that lead to impoverishment as well as much suffering and death from preventable disease. These issues become serous for the people living in the rural parts of the country who have no formal health insurance while they feel sick because they may have no cash on hands.

As result the Ethiopian government has been attempting to scale up the CBHI since 2014, by including the non-pilot woreda's and regions that were not included in the 2011. Beside, CBHI proclamation was drafted by the Ethiopia government in 2022 and approved by the members of parliament.



	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021
CBHI Launched worda	13	13	27	111	203	280	360	509	770	870
CBHI Expansion	0	0	113	81	104	86	162	148	57	41
Total	13	13	140	192	307	366	522	657	827	911

Figure 1: CBHI Woreda[2] Launched and expansion

Source: EHIA, 2021

As the data in the above fig 1 show that new woreda has significantly increased since the launching of the schemes when we see the difference between 2012 and 2021, there are 857 new woredas launched under the CBHI membership. In 2012 and 2013, the CBHI expansion to the launched woreda was zero because it was a time period in which CBHI was at the trial stage and only implemented in selected pilot regions and woredas, namely Oromiya national regional state, Tigray, SNNPR, and Amhara. In the history of the Ethiopia CBHI scheme, the expansion of the scheme to the rest of the woredas within the launched CBHI regions started after 2014, Based on the lessons drawn from the launch of CBHI during the pilot year (2011-2013), and the expansion initiatives taken by federal and

[2] Woreda (District) is administrative division of Ethiopia, managed by local government. It is the second lowest tiers of local government followed by Kebeles (Villages).

regional governments in collaboration since 2014, the following table present the distribution of newly launched woredas and expansions made to the existing regions.

Table 1: Regional distribution of newly launched and expanded schemes

Years	2016		2017		2018		2019		2020	
Region	Launched (Laun.)	Expansion (Expan.)	Laun.	Expan.	Laun.	Expan.	Laun.	Expan.	Laun.	Expan.
Amhara	76	17	104	7	133	23	149	31	176	6
Oromiya	70	61	109	33	124	73	201	45	281	13
SNNP	40	27	49	28	70	37	88	45	148	25
Tigray	17	1	18	18	21	15	29	7	36	0
B/Gumuz	NA	NA	NA	NA	2	1	2	6	3	4
A.Ababa	NA	NA	NA	NA	10	0	40	0	120	0
Hareri	NA	NA	NA	NA	0	9	0	9	5	4
Afar	NA	NA	NA	NA	0	1	0	1	1	0
Gambella	NA	NA	NA	NA	0	3	0	3	0	3
Diredaw	NA	NA	NA	NA	0	1	0	1	0	1
Somali	NA	NA	NA	NA					0	1
Total	203	106	280	86	360	163	509	148	770	57

Source: EHIA, 2021

As shown in the above table 1, among the regions, Oromiya national regional state (1,010) leads in the launching of the CBHI to the new woredas (7850, and the registering of the new members (225) to the already enrolled woredas (CBHI expansion woredas), followed by the Amhara region (722), on the launching of new woredas (638), and whereas SNNP is better than the Amhara region in the expansion of the CBHI (increasing the membership of enrollment), that is 162, and the total performance of the SNNPR is 557, of which 395 was newly launched. The list is for the Somali region, which a launched in one woreda only. In this case, further effort is required by the concerned body.

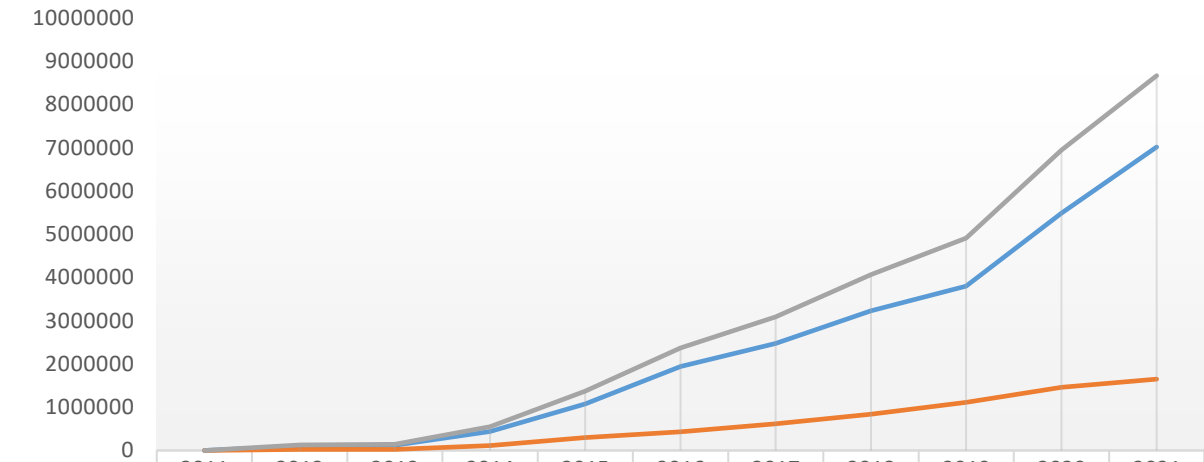
So, based on the above data, the CBHI performance (expansion of the CBHI) in the above three a region is so far good, but commitment and efforts from stakeholders responsible for the CBHI's operation are still required.

3. CBHI Registration And Types Of Membership

According to the CBHI proclamation No (2020), membership is defined as anyone in the informal sector who is a member of the schemes. Aside from that, involvement must be on the family level, and registration must be done by the head of the household.

The main factors that determine CBHI enrollment by households are premium affordability, unit of enrollment (having an adequate membership rate), distance to the premium collection, quality of health care service, and trust (WHO, 2003).

Commonly, there are two types of membership in CBHI: paying members and indigent (non-paying members).



	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021
Payee	0	99 565	121 781	436 748	1 077 3	1 942 1	2 476 6	3 227 6	3 801 2	5 485 6	7 017 5
Indigent	0	25 577	22 230	109 440	297 024	430 591	615 615	837 033	1 111 3	1 459 1	1 649 4
Total	0	125 142	144 011	546 188	1 374 3	2 372 7	3 092 2	4 064 7	4 912 6	6 944 7	8 667 0

Figure 2: CBHI members from 2011-2021

Source: EHIA, 2021

Corresponding to the number of CBHI woreda (launching and expansion), membership inclination from 2012-to 2021 shows robust progress. At the time of launching CBHI, the total active members were 125,142 in 2012 and, 960,369 in 2020. By taking the average family size, the above fig 2 reveals that about 32.2 million households participated in the schemes by 2020, which may roughly account for 36% of the population in the informal sector.

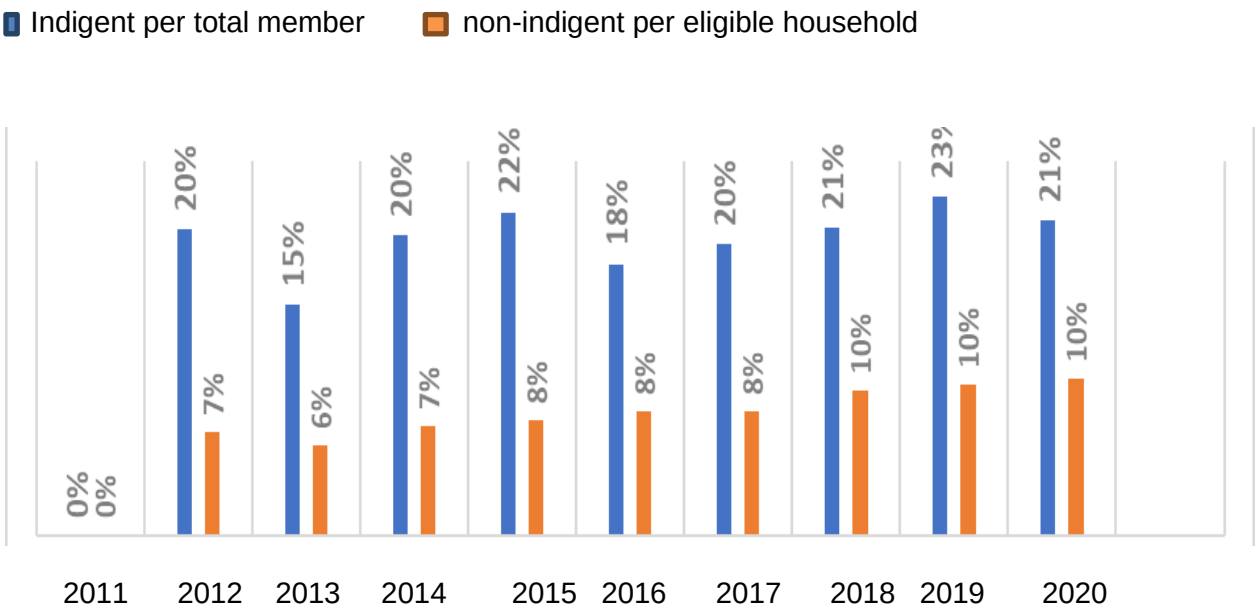


Figure 3: Proportion of Indigent with active members and CBHI eligible household
Source: EHIA, 2021

As shown in Figure 3, the proportion of active members in need was around 20% in 2012, fluctuating slightly in the financial years 2013 and 201. Similarly, the coverage rate for those in need increased in the latter (except for 6% in 2013), from 7% in 2012 to 10% in the financial years 2018-2020. However, the coverage of those in need from households eligible for CBHI is well below the country's 23.5% poverty line each year (UNDP, 2018), which requires a commitment from regional governments to improve the minimum rate current needs (10%) from eligible households.

When we see the indigent coverage rate of the CBHI members during the whole strategic period (2011-2020), the non-paying active CBHI members and yearly CBHI eligible households in Addis Ababa followed by Oromiya national regional state and Tigray, achieve almost equal to the national average.

4. Challenges Of CBHI In Ethiopia

Even if the progress of each region in CBHI expansion and new werda enrollment is good in most regions, expect the woredas, such as Somalia, Harari, Afar, Gambela, and Diredawa, to require much effort. Both demand and supply side challenges are responsible for less implementation of CBHI (Namomsa, 2019).

The following are the major challenges affecting the development of the CBHI in Ethiopia:

The CBHI was unable to cover reimbursement costs for health facilities because of a disjointed pooling system

Disjointed pooling system is due to monies raised by CBHI members are not adequately pooled or managed. In other words, there is a problem with the CBHI system's collection, and distribution of funds. This can make it difficult to cover the price of health-care facilities.

The lack of political commitment to developing and cooperating with the CBHI scheme

In case of Voluntary based CBHI membership without adequate government assistance and resources, overcoming the various barriers and problems associated with executing the CBHI plan becomes difficult. In adequate funding for the system may result from lack of political commitment, limiting its ability to cover reimbursement expenses for health facilities. It also results in a fragmented pooling structure in which funds received from CBHI members and other sources (donations and grants) are not adequately managed and allocated to cover healthcare bills. Furthermore, a lack of political commitment may result in a lack of coordination and collaboration between government and other stakeholders which limit the CBHI scheme's implementation and efficacy.

There is a shortage of basic health facilities, mainly medicine in health facilities

Members are supposed to buy medicines from private drug vendors. This suggests that the healthcare system is unable to provide its members with necessary pharmaceuticals, necessitating reliance on private suppliers. Acquiring medicine from private vendors may impose additional financial strain on individuals because they must bear the expense of the medicines themselves. This reduces the effectiveness of Community-based health insurance (CBHI) Plans. The CBHI major goal is to provide its members with affordable and accessible health care services. However, requiring members to purchase drugs from private vendors contradicts the scheme's aim and may impede its success.

Poor document management by the scheme administration

Most of the registration membership registration process is takes place is via paper work (it is not digitalized). This leads to inadequate record keeping system of the members and Lack of defined procedures for document handling. It might result in mistakes in member records, making evaluating eligibility for health care services or calculating reimbursement costs for health facilities problematic. It can also stymie the efficient processing of claims and reimbursement requests, resulting in delays and inefficiencies in the administrative process. Furthermore, poor document management have impact on lack of transparency and accountability within the CBHI system, as tracking and auditing the movement of cash and resources can be difficult.

There are various factors contributed for lack of development digitalizing health care system of Ethiopia as the study conducted by Gutama (2023) reviled that lack of ICT infrastructure, a lack of computer skills, a lack of budget, a management style, and a lack of

enabling legislation were the most common problems in the deployment of ICT in the Ethiopian health care system.

The ongoing war in Ethiopia

Because of the ongoing war in various parts of Ethiopia, most public health infrastructures such as health posts and healthcare facilities have been damaged. It is very difficult for CBHI workers to go from place to place convincing households to join CBHI.

Covid-19 pandemic

The pandemic has posed additional challenges to the implementation of community-based health insurance (CBHI) in Ethiopia, including resources constraints and disruptions in health care services.

5. Research Methodology

The main objective of this study is to evaluate the achievements and challenges of health care reform using community-based health insurance. The Main data sources for this study were peer-reviewed publication, articles, and government and Non-government reports on Community-based health insurance. According to Baumeister and Mark (1997) narrative review can be used to compares management and health care research. In this study narrative review were employed in order to analysis the data collected from secondary sources. A literature review was utilized to collect, criticize and synthesize the body of literature on practices, challenges and achievements of community-based health insurance that has been authored and published. Until July 1, 2023 published content was searched using internet databases. These studies were found using the keywords challenges OR CBHI OR achievements OR advantages OR CBHI OR Ethiopia.

Conclusion

In the 1998 the Ethiopian government recognized a strategy for financing health care that intended an extensive variety of reform edges. In order to ensure long-range health finance sustainability, Ethiopian HCFS acknowledged that the cost of people's health care should be financed via different mechanisms. As part of HCFS, the Ethiopian government has introduced CBHI and SHI. Both are focusing on saving people from unexpected health costs and reducing the number of people dependent on out-of-pocket payments. Besides this, domestic financial resources for health and achieving UHC, The source of Ethiopia's HCF is still comprised of three sources: external funding (aid and donations, which account for 35%), domestic government sources (from the federal government and regional governments, which account

for 32%), and out-of-pocket spending (from payments made by inpatients and outpatients during service taking).

Community-Based Insurance is part of Universal Health Coverage designed by the Ethiopian government with the help of different stakeholders such as USAID and Abt Association and started in 20111. Since 2014, the expansion of schemes in different districts coverage of CBHI has been increasing, ultimately going since 161 in 2014 to 827 (of which 770 launched) in 2020. Since 2014, the Ethiopian government has been attempting to scale up the CBHI by including non-pilot areas and regions that were not included in 2011 Besides this CBHI proclamation, drafted by the Ethiopian government for the first time in 2022 and approved by the members of parliament, membership inclination from 2012 to 2021 shows strong progress corresponding to the number of CBHI woreda (launch and expansion). At the time of launching CBHI, the total active members were 125, 142 in 2012 and 6,960,369 in 2020. Using the 4.6 average family sizes, approximately 32.2 million people are expected to be enrolled in the CBHI program by 2020, accounting for approximately 36% of the population in the informal sector. In 2012, the proportion of active members in need was around 20%, with slight decreases in the 2013 and 2016. Similarly the coverage for those in need eventually increased in 2018 which reach ten percent. However, each year the coverage of those in need of households eligible for CBHI is less than the poverty line, with 23.5% of the country. Major challenges affecting the development of the CBHI in Ethiopia: The CBHI was unable to cover reimbursement costs for health facilities due to a disjointed pooling system. Other challenges of the CBHI include a lack of political commitment to developing and cooperating with the CBHI scheme; a shortage of basic health facilities, primary medicine in health facilities, forcing members to purchase it from private drug vendors; and below scheme yearly financing, Ongoing war Ethiopia and covid-19 pandemic.

Policy Recommendation

To overcome the above challenges and make the CBHI performance sustainable, actions such as planning and executing a multi-stage pooling strategy to ensure cross-subsidization among the regions in the scheme implementation and to make the service rendering in line with the referral system, enhancing and promoting the role of political commitment through focusing on the specific goals of the CBHI, working with different stakeholders and partners like Pharmaceutical fund and supply agency in order to solve the problem of medical supply and shortage, Improving the procurement and distribution process to ensure an adequate supply of medications in health care institutions, Improving health-care facilities' ability to manage and store medications effectively, Investigating collaborations with pharmaceutical companies or international organizations to ensure a steady supply of medicines for healthcare facilities, Providing financial assistance or subsidies to CBHI

members for the purchase of medicines, particularly those who cannot afford the expense, Monitoring and evaluating the availability and accessibility of medicines in healthcare facilities on a regular basis in order to detect and address any gaps or issues, continuously working on the CBHI expansion in order to solve the financial shortage of the scheme, and digitizing CBHI scheme membership premium collection.

Conflict of Interset

The author declares that there is no conflict of interest from any individual or institution regarding submission of this article.

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