Reflections on the Health Insurance Strategy of Ethiopia

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Introduction

Attention of the Ethiopian government has been turned to universal and sustainable health care services with decentralized financing. The government has recognized health care financing reforms, including health insurance, as part of the strategy for improving access to quality health services in an "*equitable"*, efficient and sustainable way. The social health insurance is established in accordance with Article 55 (1) of the constitution of the Federal Democratic Republic of Ethiopia, under proclamation no. 690/2010. According to the social health insurance strategy justification, the existence of high out-of-pocket expenditures is an indication of the capacity and willingness of households to pay for health service, which is believed to be a necessary precondition for the establishment of health insurance. So, the social health insurance is established to provide a basic package of essential health services to all Ethiopians at reduced out-of-pocket spending at the point of service delivery through collection of premiums to increase the resources for health facilities and utilize accountably.

The strategy document states the practice of health insurance coverage in Ethiopia has been limited; while there is a need for improved health of citizens and accelerated socio-economic development that demands expansion of health care services. Though the question of *universal coverage* in the provision of health care services has been critical, the cost sharing strategy between beneficiaries and the government is designed to keep financial problems at minimum; enabling beneficiaries to get sustainable healthcare services reducing financial barriers at the point of service delivery through health insurance schemes. Therefore, the social health insurance and community- based *health insurances are designed to provide the health care coverage to all citizens free of charge at the point of services*.

It is believed that the health insurance system adopted for a country needs to be compatible with the socio-economic situation. Accordingly, the Social Health Insurance and the Community Based Health Insurance schemes are important for achieving universal health service coverage in Ethiopia. These schemes are developed in order to make a suitable package for the different social strata. The formal and the informal sectors are to be covered under separate health insurance schemes, until the socio economic conditions are more

favorable and public awareness is adequately enhanced, to develop a single nation-wide health insurance scheme to ensure universal coverage.

Initiative

The strategy background clarifies a study conducted to assess the ability and willingness of patients to pay for health care that revealed patients are willing to pay up to double if the quality of health services is improved (*i.e*. reduced waiting time and improved availability of drugs, etc.). The existence of local indigenous institutions like *Eqqub* and *Iddir* is also believed to be an important opportunity and entry point for establishing health insurance. These community organizations are established based on solidarity, mutual trust and friendship among their members, which are the major preconditions for the establishment of community-based health insurance.

The socio-economic features of Ethiopia include a predominantly rural-agricultural and informal economy, with emerging and growing formal private and public sectors. Hence, Community Based Health Insurance is apt to, more feasible and appropriate for, the large majority of Ethiopians in the rural farming and livestock rearing economy as well as for the majority of urban people in the informal sector. While Social Health Insurance avails citizens in the formal sector- civil servants and employees of different organizations on permanent basis.

Insurance coverage

The Social Health Insurance Scheme Council Of Ministers Regulation No. 271/2012, Article 3 provides a list of health services a beneficiary will have the right to, from health facilities. These are:-

- outpatient care and inpatient care;
- delivery services and surgical services ;
- Diagnostic tests and generic *drugs included in the drug list of the agency that will be prescribed* by the medical practitioners.

Notwithstanding the provision of the above health services for beneficiaries who have concluded the contract with the Social Health Insurance Agency, the following services are excluded from the health service package. 1) Any treatment outside Ethiopia 2) Treatment of injuries resulting from natural disasters, social unrest, epidemics, and high risk sports; 3)

Treatments related to drug abuse or addiction; 4) Periodic medical checkup unrelated to illness; 5) Occupational injuries, traffic accidents, and other injuries covered by other laws; 6) Cosmetic surgeries; 7) Organ transplants; 8) Dialysis except acute renal failure; 9) Provision of eyeglass and contact lenses; 10) In vitro fertilization; 11) Hip replacement; 12) Dentures, crowns, bridges, implants and root canal treatments except those required due to infections; 13) Provision of hearing aids.

The Social Health Insurance is supposed to be financed from payroll and pension contributions made by employers and employees. Contributions from each employee are based on his or her level of income. The same percentage (flat or fixed rate) of contribution from the basic salary is supposed to be deducted from each employee to finance the scheme. An amount equal to employee's contribution is expected to be matched by the employer.

A member is eligible to enroll in the Social Health Insurance program with his or her spouse and children under the age of 18 years. A member having more than four children and/or more than one spouse can register his or her dependents as beneficiaries, but with additional monthly premium costs per the additional family members.

Nonetheless, the strategy has identified some potential hindrances for a successful implementation of these health insurances. Thus, success depends on the capacity and willingness of the community to regularly, pay their premium as it is financed by the contributions regularly collected from its members. Collecting premiums timely and properly/ genuinely will be a problem in communities where individuals' income is hardly known. Given the high level of poverty in Ethiopia, expansion of health insurance could face serious challenges *if the premium is beyond the ability of the majority of the rural and urban poor to pay*. Expanding health insurance coverage, particularly for the poor, requires tremendous resources, which could be beyond the capacity of the government and the community to obtain. Scaling up is unlikely without a concerted effort from all stakeholders. Hence, the regional and federal governments, in addition to increasing the share of health from their total budget, should create an environment conducive to the involvement of various stakeholders in the development of health insurance. *Seasonality of income, lack of information on household/individual income,* geographically scattered settlements of agricultural households and the relative *mobility of pastoralists* etc., will raise the cost of premium collection in the agricultural, pastoral and informal sector settings. As the benefits of health insurance are not immediate, insurance may not be attractive to households with

scarce resources and many competing priorities. Limited awareness or negative perception of health insurance could happen to be one of the reasons for low health insurance coverage and its expansion (particularly in the case of Community Based Health Insurance).

Hence, the strategy suggests inclusive awareness creation and sensitization activities, focusing on the benefits and principles of health insurance to be critical toward implementing health insurance. Financial Subsidies to vulnerable groups and provision of loans to the insurance schemes are also recommended mechanisms to promote and develop health insurance practices in the communities with relatively lower socioeconomic status.

Assumptions

The strategy is based on assumptions that can be off beam in some respect or do not fit in to the situations in Ethiopia. It assumes:

- There are four children in a family; because, the strategy outlines the number of beneficiaries in a household to be four. This does not consider rural families' number of children. According to the Central Statistical Agency, census 2015, the average number of family size in the country is 5.2. This strategy ostracizes the family members (predominantly, children) from the health insurance benefits.
- Spouse relationship is one-to-one; as the strategy states the scheme to cover benefits for a spouse. Nonetheless, spouse relationship is not always one-to-one in the sociocultural milieu of Ethiopia. Many, especially, Muslim communities, have multiple wives. But, the health insurance benefit covers only for one of the wives a man might have.
- The strategy assumes existence of standard distributions of sickness behavior among beneficiaries; while it depends on tremendous factors for the sick to have different behavior and take a unique measure. Beneficiaries in the two schemes, social health insurance and community-based health insurance, have different life chances and life styles. Sickness behavior, therefore, varies depending on the particular beneficiary's experience, attitude and other attributes. Because, education, socioeconomic status, gender, and other characteristics of the beneficiary can affect ones sickness behavior.
- Similar illnesses and diseases are expected for both community based health insurance and social health insurance beneficiaries. However, disease and illnesses vary in different climatic zones, seasons of the year, age and sex of the beneficiary, vulnerability status, and many others. The socioeconomic status of the beneficiary, in

accordance which a member is included under either of the two schemes, is a factor for ones vulnerability of a certain health problem. Albeit, the varied nature of diseases for rural communities who make a living on farming, animal rearing, and other informal employment; and for those who live on formal employment (predominantly government employees) are surpassed.

- Challenges that implementing the strategy will face are simply related to financial problems, only. It does not assume problems of attitude to practice health insurance.

Critiques

Though it is a great endeavor to come up with the ideas of health insurance to enable citizens of all socioeconomic status to have health care services; the amount of contributions varying across different amount of salary cannot avail beneficiaries proportional to their contributions. This lets the better-paid employee cover expenses of health service to the lower paid ones. It is humanitarian; but cannot be fair as one uses the cost of someone else to get health services.

For example, there can be a family of ten children and three wives living on the salary of the family head. The salary can be in the higher category that impels the person to contribute a very high premium. The other family can be just husband, wife and four children who live on a very small salary of the husband; contributing a very small premium for their health insurance. In this case, the highest premium contributor is provided with insurance coverage for half of his family while the other is given health insurance coverage for all of his family members. This questions the principle of equity.

The benchmark to limit the number of beneficiaries in a family to insurance coverage is not adequately justified. Even though, the average number of children per family in rural families of Ethiopia is more than four, the strategy covers health insurance only for four children and one spouse. Moreover, there are some people who have multiple wives- allowed in culture and religion; especially, Muslim rural residents. Nevertheless, the health insurance covers only one of the wives, which is not again considerate to cultural values of the Ethiopian communities.

The community based health insurance scheme uses households as a unit of membership as opposed to individuals- in social health insurance. Therefore, premiums are collected based

on the number of family members, disregarding the income of the family. No matter how poor a family is, it is obliged to pay calculated sum of premium per the family size. *This contravenes the aim of the strategy: to help the poor to have better access and use of health care service*.

People may believe it as 'an ill hope to get sick' for which insurance is applicable. Some others may believe it is up to God or Allah to insure ones health to care, cure or kill. As such, worries for the health of tomorrow might be concluded unnecessary; as it is usual for rural people to live by beliefs like, 'only the creator guarantees it'. Such attitudes and beliefs could be irreversibly, changed by massive intervention of religious institutions and traditional local leaders in awareness creation trainings and teachings. However, the strategy generally, lacks understanding the role of the combined effort of religious beliefs, cultural folkways and values to the resultant implementation of the strategy. While in fact, the involvement of religious institutions and traditional local leaders is profound to change the attitude of people toward health insurance premium.

Capacity building is one of the strategic issues considered to be an essential area of intervention in the development of health insurance. Accordingly, experience sharing forums on best practices and innovative approaches are planned to put in place to achieve capable human resource, system procedures and operational tools, and organizational structures. But, 'what is the best practice?' is not defined. Whose membership to which scheme can be a "model?" is, yet, unknown.

Recommendation

Overall, it would be very important to reconsider these duds and appraise the strategy in order to make it more suitable for the Ethiopian communities living on both formal and informal employment.