Ethiopia Health Insurance Agency

CBHI Members' Registration and Contribution 2011-2020 GC

CBHI Trend Bulletin

[
September, 2020]

Terminology:

Community Based Health Insurance (CBHI):-is a type of health insurance program that provides financial protection against the cost of illness and improving access to health care service for communities engaged in the informal sector.

Target subsidy: - Budget support Secured by woreda and region to cover contribution of indigent households to become health insurance members**.**

Launched woreda: - those woredas which have been established CBHI institution and started giving health service as per the health insurance benefit package

Expansion woreda: those woredas which have been started CBHI promotion and mobilization campaign but not established CBHI institution to insure health service provision as per the health insurance benefit package

Explanatory Notes:

- All years in this publication, unless otherwise stated, are in Ethiopian Calendars.
- All membership coverage information provide in the table is from launched woredas
- If there is incomplete information in all tables, unless otherwise noted, they are not started implementing CBHI in that year

This Bulletin has been prepared by Insurance Members registration and contribution collection Directorate, EHIA September, 2020

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Table of Contents

List of Figures

List of Tables

PREFACE

The growing need for systematic monitoring and evaluation has given more significance to the availability of adequate and timely information for informed decision making at all level, which requires digitalized information system. However, still, the health insurance system information in Ethiopia has been depending on routine data reported manually at each level. Therefore, as part of improving the quality of information in 2013, the agency decided and prepared health insurance system monitoring and evaluation manual which will improve the quality of health insurance information system. In addition, online members registration and claim submission software is developed and under pilot testing in Tigry region Kilete Awulalow woreda, to digitize the information system so that the accuracy and timeliness of the information to be improved.

Therefore, this CBHI bulletin is prepared in order to show CBHI progress update and disseminate to all partners, researchers and community and other stakeholders to have firsthand information.

Hopefully, this bulletin will continue to be prepared as deemed necessary.

The Ethiopian health insurance agency would like to acknowledge all branch offices and stakeholders and above all members of the directorate for providing information, feedback and aspiration on production of this bulletin.

Introduction

Health care Financing is one of the key input components of the health system to raise adequate funds for health to protects people from financial risk, allocates resources, and purchases goods and services in ways that improve quality, equity, and efficiency. In Ethiopia, poor health care financing remains a major challenge for the health system that leave households vulnerable to impoverishment from catastrophic health expenditures and limiting access to essential health services among the poor. The Ethiopian health care system has made tremendous efforts to reform the health system in order to mobilize adequate resources and promote efficient use to ensure health care access for all segments of the society without financial hardship.

Health insurance is considered as one of sustainable health financing mechanism in the Ethiopian health care financing strategy to create equitable health service access to citizens by sharing risk through solidarity principles. Two types of health insurance system are proposed in the strategy, the first one is social health insurance (for formal sector employee) and the other one is community-based health insurance (for informal sector).

Social health insurance (SHI) Proclamation was approved by the Council of Ministers and by Parliament in July 2002, while preparatory activities and amending the legal frame work (based on community feedbacks) has been under way. Community based health insurance (CBHI) is implemented as one of the main ways to reach out the community engaged in the informal sector specially the rural and low-income communities of Ethiopia. CBHI which was pilot initiated in 13 woredas in 2003, has been achieved remarkable progress through multi stakeholder engagement, and currently addressing nearly 7 million households in 770 districts throughout the country, while generates more than 1.6 billion birr.

Therefore, it is important to disseminate information on the progress and yearly achievements of the health insurance program. This bulletin is mainly focus on the CBHI progress in woreda & population coverage, and revenue collected. The data is compiled from routine health insurance report and aggregated at national and regional level. The CBHI trend at national level accommodates all information starting from 2003, while the regional trend (due to lack of data) is assessed only for the last strategic period.

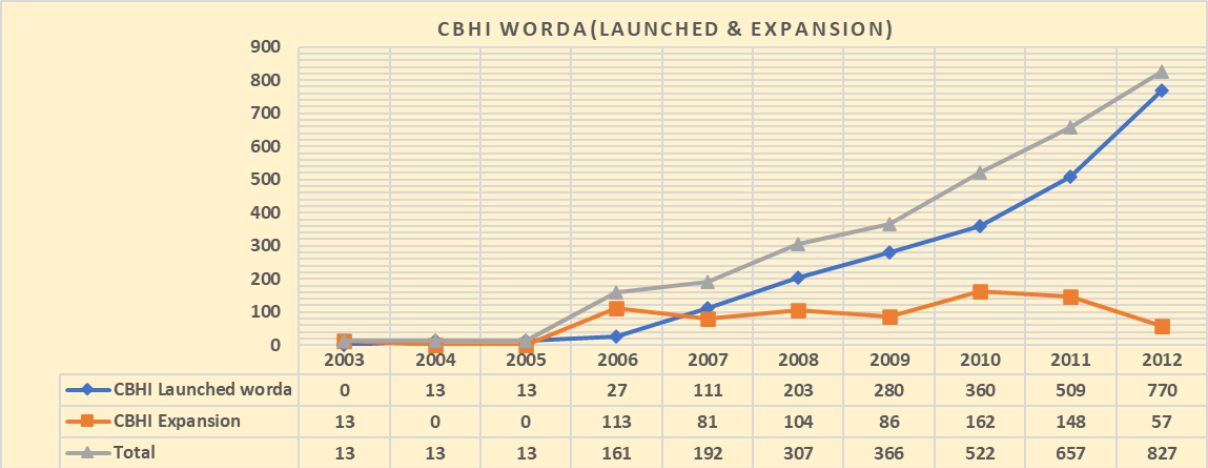
NATIONAL & REGIONAL COMMUNITY BASED HEALTH INSUANCE TREND 2003-2012E.C

1. National CBHI Trend 2003-2012

1.1 CBHI Woreda Coverage

In 2003*, CBHI pilot was first started in 13 woreda from four regions (Tigry, Amhara, Oromoya and SNNP), while it continued until 2006. The pilot opportunities and challenges have a spear head effect expansion initiative made in collaboration with federal and regional governments.

Figure 1. CBHI woreda coverage (Launched and Expansion)



	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
CBHI Launched worda	0	13	13	27	111	203	280	360	509	770
CBHI Expansion	13	0	0	113	81	104	86	162	148	57
Total	13	13	13	161	192	307	366	522	657	827

Source: Abt (2004 to 2006E.C) &EHIA MRCCD Annual Reports (2007 -2012E.C)

**In 2003, CBHI mobilization was initiated in these 13 districts, however, the actual service provision was started in 2004.Therefore, there is no data in 2003.*

In due course, the coverage of CBHI woreda has been eventually increasing from 2006 to 2012. Currently, number of woreda in Ethiopia is estimated as 1100, while

CBHI woreda coverage reached at 75% in 2012 fiscal year.

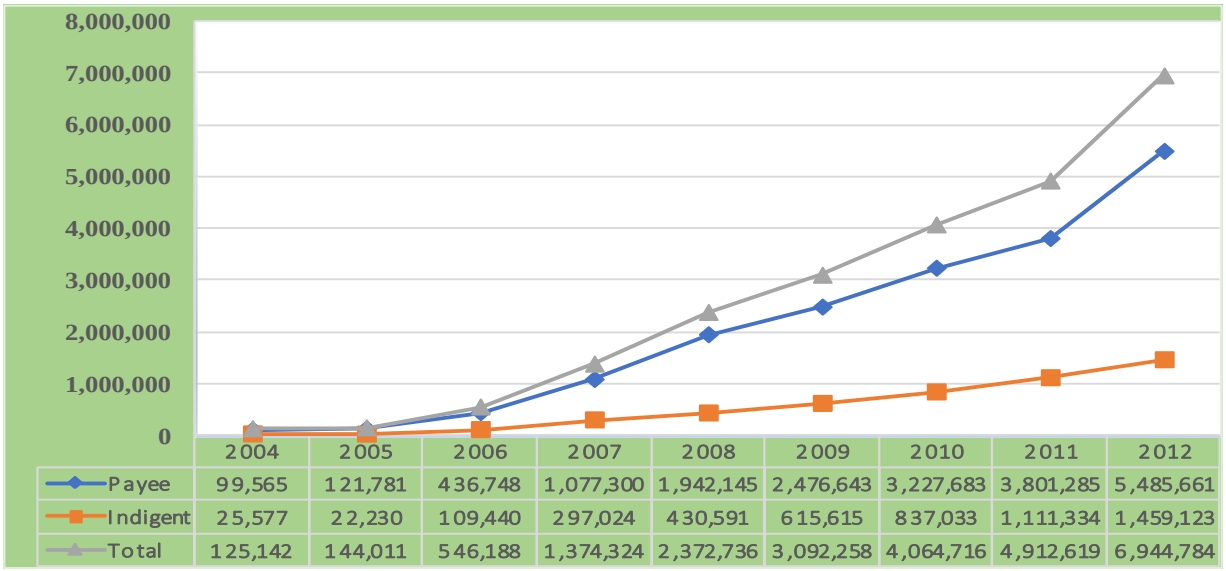
However, as majority of these CBHI woreda are from these four big region and Addis Ababa city, it requires especial support for the remaining region to ensure equity in health access as well as to support the country's ambition towards achieving universal health coverage

1.2 Number of CBHI members & ITS Coverage

Community Based health insurance is a yearly contract agreement made between member and the insurance scheme on annual advance payment made by the members. All regions have directives guiding the implementation process including the defined period of registration (a maximum of three months) time.

Therefore, the existing CBHI members are expected to renew before the expiry of their contract (before end of defined registration period) and the new members has also register within this period. Figure 2 below, shows that the number of households enrolled in CBHI each consecutive years.

Figure 2. CBHI Members (Paying and Indigent)



	2004	2005	2006	2007	2008	2009	2010	2011	2012
Payee	99,565	121,781	436,748	1,077,300	1,942,145	2,476,643	3,227,683	3,801,285	5,485,661
Indigent	25,577	22,230	109,440	297,024	430,591	615,615	837,033	1,111,334	1,459,123
Total	125,142	144,011	546,188	1,374,324	2,372,736	3,092,258	4,064,716	4,912,619	6,944,784

Source: Abt (2004 to 2006E.C) &EHIA MRCCD Annual Reports (2007 -2012E.C)

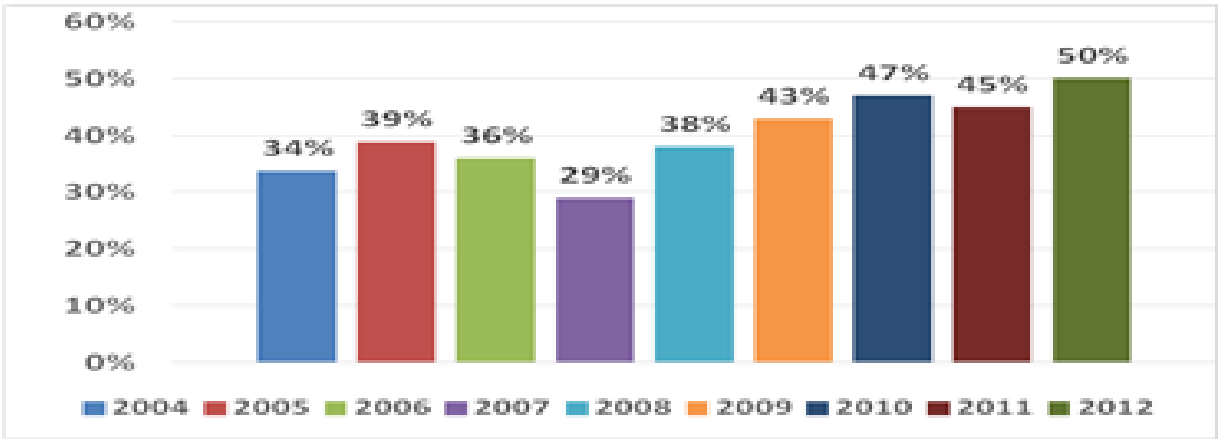
The above graph shows that parallel to increase in woreda coverage, CBHI enrollment Trend from 2004 – 2012 shows increasing overtime, while it grown from 125,142 in 2004 to 6,944,784 (nearly 7 million) in 2012 fiscal years.

Taking 4.6 average family sizes, the above figure tells us about 32.2 million people have been enrolled in CBHI program and able to get health service in 2012 fiscal year.

With the assumption that 85% of the total population is involved in informal sector and the country has 100 million populations, CBHI enrollment coverage in 2012 fiscal year accounts about 37% of population in informal sector. The following two bar-graphs are representing members' renewal & coverage rate from CBHI eligible households in launched CBHI woredas.

1.3 CBHI Members Renewal and Coverage Rate

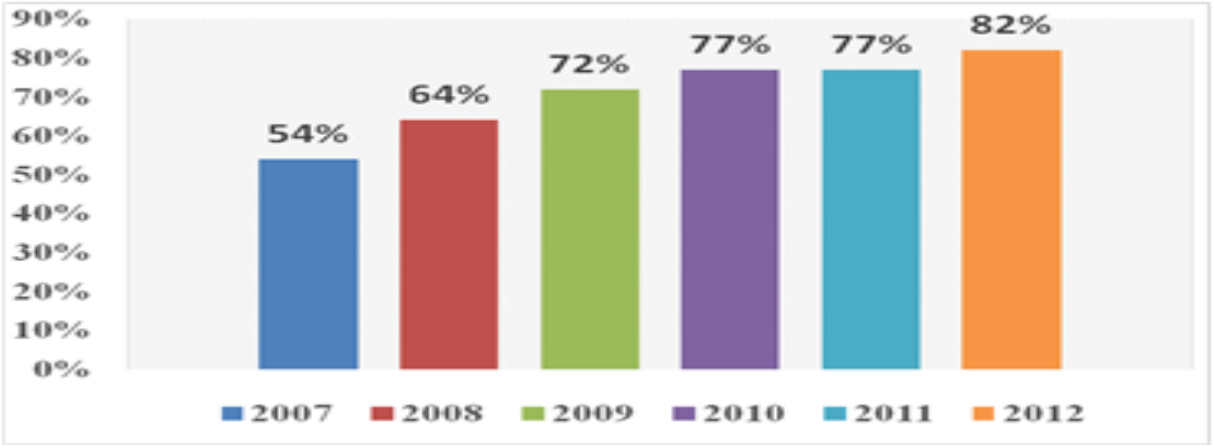
Figure 3. CBHI membership coverage rate



Source: Abt (2004 to 2006E.C) &EHIA MRCCD Annual Reports (2004 -2012E.C)

CBHI members coverage across these years, (active members per eligible house hold by 100%), have been increasing, with sightly fluctuation in the year 2006 and 2011. However, during 2007, it was much more decreased perhaps because of overlapping national election program with CBHI mobilization period.

Figure 4 CBHI Members Renewal Rate



Source: EHIA MRCCD Annual Reports (2007 -2012E.C)

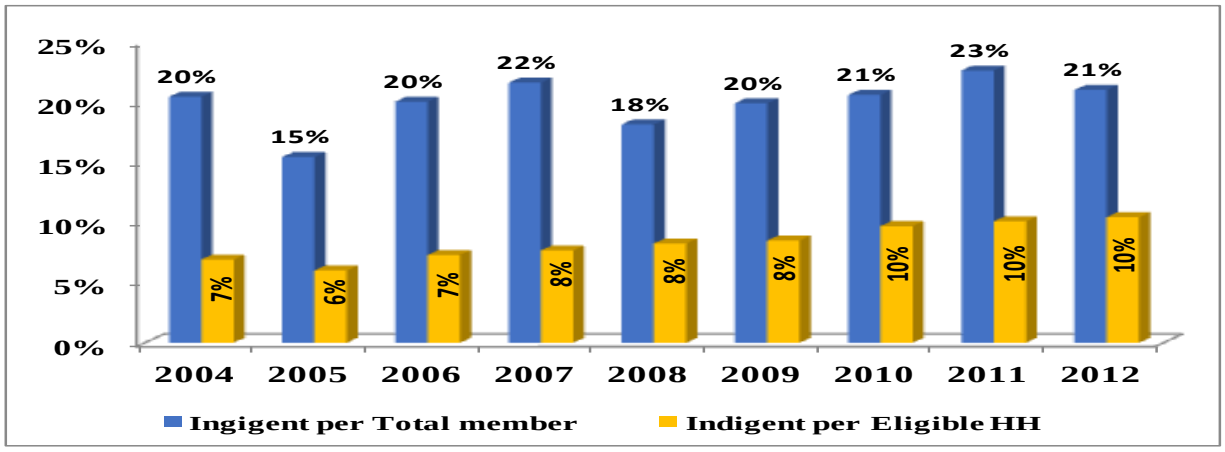
The renewal data, in previous bar graph, indicates the steadily increment in membership renewal rate at each year from 54% in 2007 to 82% in 2012.Though the renewal shows incremental rate, in actual number, there are significant number of dropouts at each year. Therefore, dropout is still a challenge to sustain CBHI program, and it is mainly due to

voluntary health insurance system, in which wealthy and healthy people freely opt to join/not to join and or to exit from CBHI membership which erodes the core principle of solidarity.

1.4 Coverage of Indigent CBHI Members

Households who are unable to pay and were entitled for fee waiver in the woreda, are expected to be registered in CBHI scheme as indigents and the regional government must secured their annual contribution to the scheme. Every woreda has to nominate households who are unable to pay based on the health care financing fee waiver selection criteria, but there are challenges in selection process and appropriate size of poor households because of budget requirement from the regional government to be secured for the selected indigents.

Figure 5. Indigent coverage



Source: Abt (2004 to 2006E.C) &EHIA MRCCD Annual Reports (2004 -2012E.C)

During these years, the percentage of indigent from active members is roughly around 20% with slightly downward fluctuation in 2005 and 2008 fiscal years. Similarly, the indigent coverage rate was eventually increased (except 6% in 2006), from 7% in 2004 to 10% in 2010 - 2012 fiscal years. However, the coverage rate of indigents from CBHI eligible households at each year is far below than the poverty line 23.5% of the country (UNDP,2018), which requires the commitment of regional government to improve the minimum proportion (10%) of indigent from eligible.

2. Regional CBHI Trend (2008 -2012E.C)

2.1 CBHI woreda coverage by Region

The regional CBHI trend analysis is focused on regional CBHI woreda, regional CBHI members (paying & indigent), Renewal & Coverage rate, Indigent coverage, regional money collection and federal general subsidy by region. Except CBHI woreda, all other data analysis is representing only in CBHI launched woredas in respective regions.

In principle, for a woreda to start CBHI, 50 and above population of the woreda has to agree. But beyond that, convincing the community to join and administrative burden is the biggest challenge that needs political commitment and integration among all stakeholders. Therefore, implementing in emerging regions remained a challenge.

CBHI implementation at regions was implemented only in four regions until 2009. In 2010 Addis Ababa and Benishangul/Gumuz, and in 2012 Afar (1woreda) and Harari (5 woredas) started CBHI. However it has been a year-long activity in Somali, Gambella and Diredawa but has not been launched yet.

Table 1 Regional CBHI woreda

Number of CBHI Worda by Region(EFY)										
Region	2008		2009		2010		2011		2012	
	Launched	Expansion	Launched	Expansion	Launched	Expansion	Launched	Expansion	Launched	Expansion
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
Tigry	17	1	18	18	21	15	29	7	36	0
Ben/Gumuz					2	1	2	6	3	4
AA					10	0	40	0	120	0
Hareri					0	9	0	9	5	4
Afar					0	1	0	1	1	0
Gambella					0	3	0	3	0	3
Deri/city					0	1	0	1	0	1
Somali									0	1
National	203	106	280	86	360	163	509	148	770	57

Source: EHIA MRCCD Annual Reports (2008-2012E.C)

2.2 Regional CBHI members (Paying and Indigent)

Although the health insurance implementation progress in Ethiopia is considered as a success, the national insurance membership enrollment rate has not exceeded 50 % of the eligible household during the implementation period, while there is significance coverage among regions (see table 2&3)

Table 2, HH Enrolled in CBHI, by region

Regional CBHI members (Payee & Indigent)										
Region	2008 E.C		2009 E.C		2010 E.C		2011 E.C		2012 E.C	
	Payee	Indigent	Payee	Indigent	Payee	Indigent	Payee	Indigent	Payee	Indigent
Amhara	1,018,561	140,046	1,278,322	221,285	1,671,833	357,037	1,744,302	387,766	2,047,093	481,412
Oromiya	388,519	204,851	554,247	295,562	591,152	329,856	1,109,207	526,932	2,046,037	679,340
SNNP	321,022	33,813	489,300	59,680	773,274	81,880	614,602	98,273	854,503	132,761
Tigry	214,043	51,881	154,774	39,088	167,747	59,568	275,227	77,850	375,759	108,003
Ben/Gumuz	-	-	-	-	13,483	3,000	5,040	1,560	14,410	3,527
Addis Ababa	-	-	-	-	10,194	5,692	52,907	18,953	137,942	49,371
Hareri	-	-	-	-					6,708	3,909
Afar	-	-	-	-					3,209	800
TOTAL	1,942,145	430,591	2,476,643	615,615	3,227,683	837,033	3,801,285	1,111,334	5,485,661	1,459,123

Source: EHIA MRCCD Annual Reports (2008-2012E.C)

2.3 CBHI Members Renewal and Coverage by Region

During the strategic period (2008 to 2012), the national CBHI members' coverage is 38%, 43%, 47%, 45% and 50%, consecutively. Therefore, regions which have coverage above the national average are: - Amhara, SNNP and Tigry region in 2008; Amhara & SNNP regions in 2009; Amhara, Benishangul & A/Ababa City in 2010; Amhara, Tigry & A/Ababa City in 2011 and 2012 fiscal years, while others have coverage below the national average.

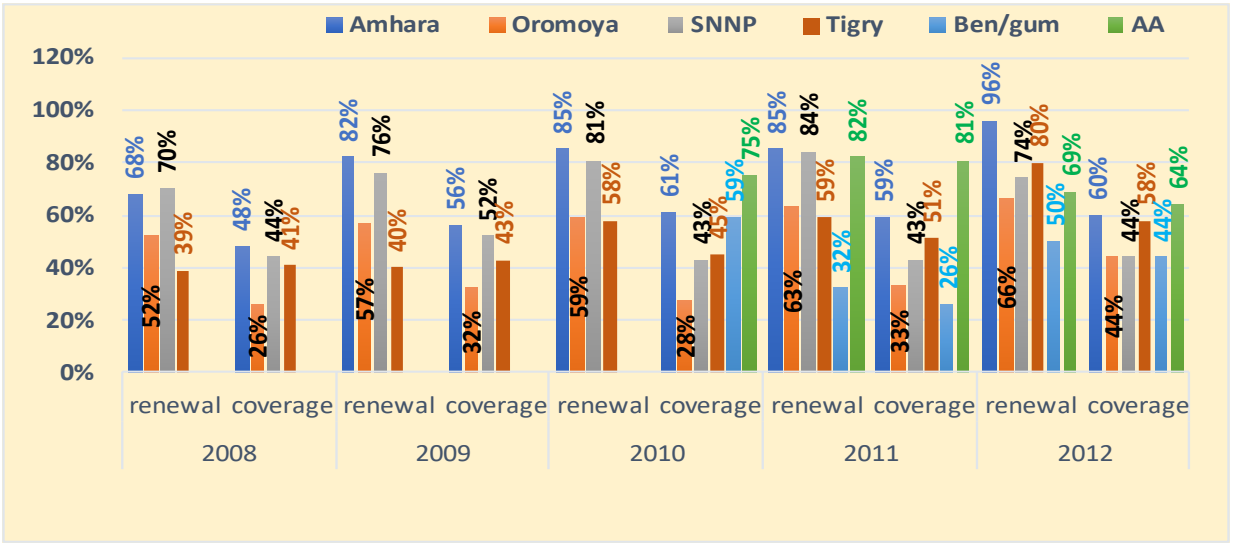
Table 3. Regional CBHI Members Renewal & Coverage rate

Regional members Coverage (Payee & Indigent) -EFY										
	2008		2009		2010		2011		2012	
Region	renewal	coverag	renewal	coverage	renewal	coverage	renewal	coverage	renewal	coverage
Amhara	68%	48%	82%	56%	85%	61%	85%	59%	96%	60%
Oromiya	52%	26%	57%	32%	59%	28%	63%	33%	66%	44%
SNNP	70%	44%	76%	52%	81%	43%	84%	43%	74%	44%
Tigry	39%	41%	40%	43%	58%	45%	59%	51%	80%	58%
Ben/Gumuz						59%	32%	26%	50%	44%
A/Ababa						75%	82%	81%	69%	64%
National	64%	38%	72%	43%	77%	47%	77%	45%	82%	50%

Source: EHIA MRCCD Annual Reports (2008-2012E.C)

The graph below represented the same data for these regions that have renewal rate (i.e launched before 2012).

Figure 6 CBHI Members Renewal & Coverage by Regions (2008-2012)



Source: EHIA MRCCD Annual Reports (2008-2012E.C)

During the strategic period, the national CBHI members renewal rate is 64%, 72%, 77%, 77% and 82%, consecutively. Therefore, regions which have coverage above the national average are: Amhara & SNNP regions in 2008, 2009, 2010 &2011; and only Amhara region in 2012 fiscal years, while others have renewal rate below the national average.

2.4 Indigent Coverage by Region

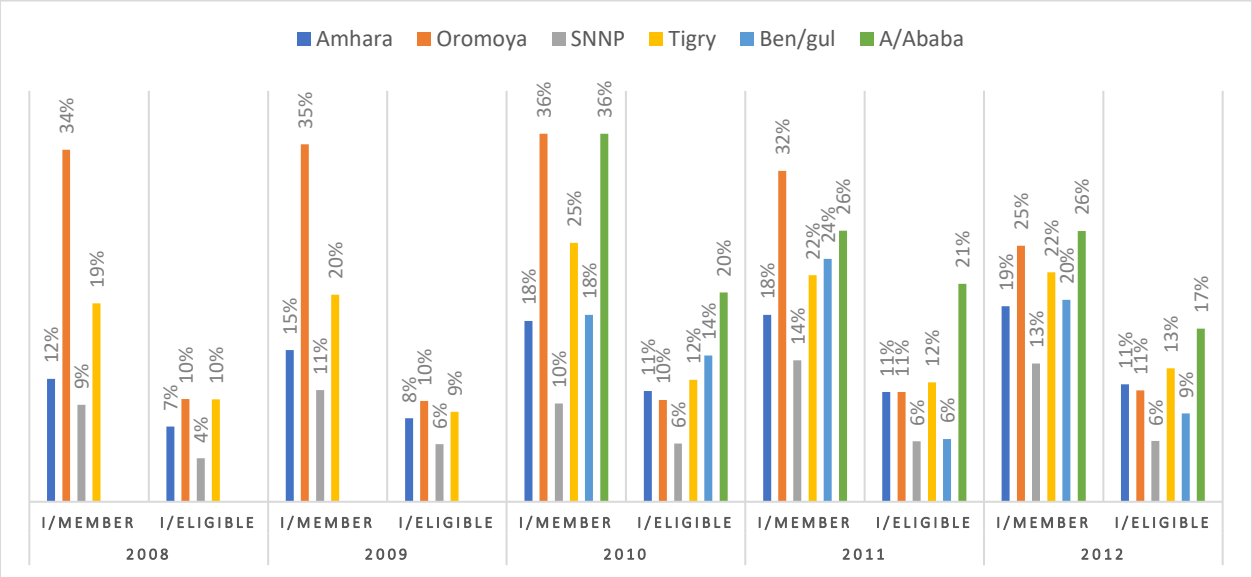
Table 4 Coverage of Indigent CBHI Members, by region

Indigent coverage by Region (in EFY)										
Region	2008		2009		2010		2011		2012	
	I/member	I/Eligible	I/member	I/Eligible	I/member	I/Eligible	I/member	I/Eligible	I/member	I/Eligible
Amhara	12%	7%	15%	8%	18%	11%	18%	11%	19%	11%
Oromoya	34%	10%	35%	10%	36%	10%	32%	11%	25%	11%
SNNP	9%	4%	11%	6%	10%	6%	14%	6%	13%	6%
Tigry	19%	10%	20%	9%	25%	12%	22%	12%	22%	13%
Ben/gul					18%	14%	24%	6%	20%	9%
A/Ababa					36%	20%	26%	21%	26%	17%
Hareri									37%	12%
Afar									20%	9%
National	**18%**	**8%**	**20%**	**8%**	**21%**	**10%**	**23%**	**10%**	**21%**	**10%**

Source: EHIA MRCCD Annual Reports (2008-2012E.C)

During the last five years, indigent coverage both from yearly CBHI active member as well as from yearly CBHI eligible household, seams better in Addis Ababa city, Oromoya and Tigry regions (having nearly equal or above the national average proportion), as compared Amhara region, while SNNP regions has very low indigent coverage at across the period. The next bar graph represents the same data for these regions launched CBHI before 2012 fiscal year.

Figure 7. Indigent Coverage Per Members & Per Eligible Household, by Region (2008-2012EFY)

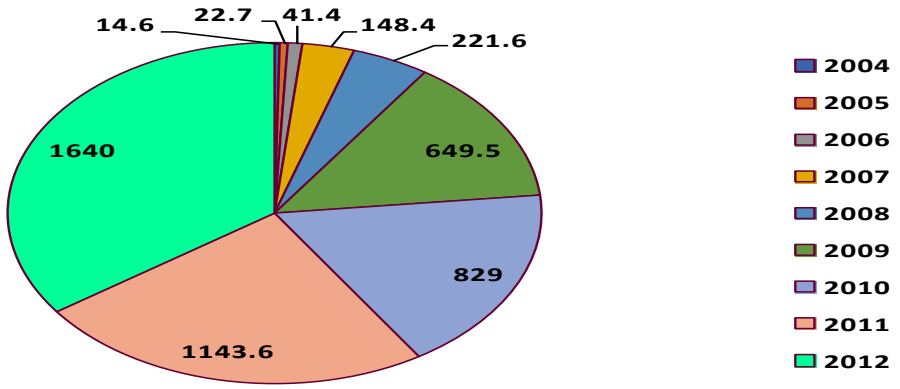


However, though the indigent members proportion from active members looks better, the proportion with eligible household (even in Addis Ababa, Oromoya & Tigray regions), is very low as compared with 23.5% of national poverty line (UNDP, 2018).

4. CBHI MONEY COLLECTION

CBHI revenue is collected from there source: - Annual contribution from member, General and targeted subsidy and other innovative income like bazaar, donation etc. Targeted subsidy is an amount of money secured for households who are unable to pay (70% of the annual contrition amount from regional government and 30% from woreda) it is only SNNPR where the woreda secured all targeted subsidy. The federal government subsidizes 10% of the total contribution to strengthen the financial capacity of the CBHI scheme.

Figure 8. CBHI Money Collections (Contribution & Target Subsidy (in millions)



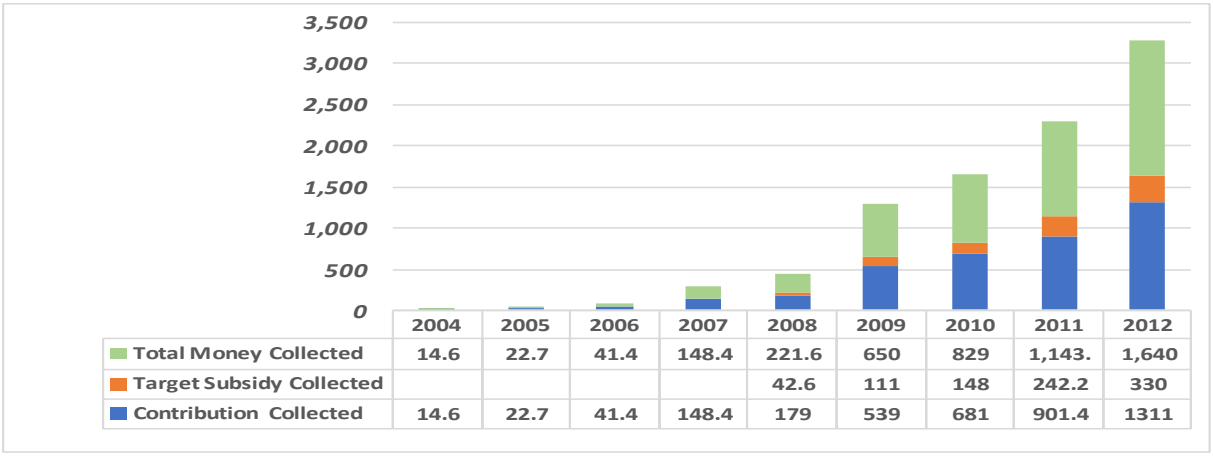
Source: Abt (2004 to 2006E.C) &EHIA MRCCD Annual Reports (2004 -2012E.C)

The above bar-graph shows that total sum of contribution collection (paying contribution plus target subsidy for indigent) at each fiscal year. During pilot years, it was below 42 million birr, while it sharply increased from 148.4 million birr in 2007 to 1.640 billion birr in 2012.

Therefore, one can conclude that CBHI program is generating a huge amount of money and becoming a potential source of the country health care financing system. However, as the CBHI pooling is still at woreda level, which is very fragmented, considerable number of CBHI woredas have been becoming insolvent at different years. The bar graph below indicates the paying contribution and target subsidy collected during the same period.

Note that before the agency established to the best of its ability (2007), the program was fully managed by regional governments with the support of development partner, and hence, targeted subsidy data was not available and it is not included in this document.

Figure 9, CBHI Money Collection (Contribution VS Target Subsidy)

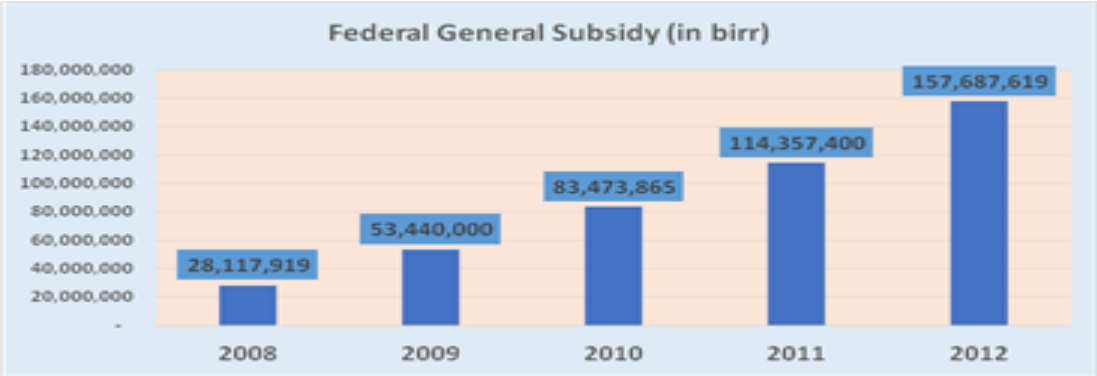


	2004	2005	2006	2007	2008	2009	2010	2011	2012
Total Money Collected	14.6	22.7	41.4	148.4	221.6	650	829	1,143.	1,640
Target Subsidy Collected					42.6	111	148	242.2	330
Contribution Collected	14.6	22.7	41.4	148.4	179	539	681	901.4	1311

Source: Abt (2004 to 2006E.C) &EHIA MRCCD Annual Reports (2004 -2012E.C)

As per number of CBHI woredas and enrolment increased at each fiscal year, CBHI paying contribution and indigents target subsidy collection data have also increased side by side. During the last strategic period, the contribution collection increased from 179 million birr in 2008 to 1.311 billion birr in 2012 fiscal years. Similarly, the target subsidy, funded by regional governments, increased from 42.6 million birr in 2008 to 330 million birrs in 2012 fiscal years.

Figure 10. Federal General Subsidy



Source: EHIA MRCCD Annual Reports (2008-2012E.C)

The federal government has also been financially supporting the CBHI scheme through general subsidy fund. Therefore, the above graph represents the general subsidy, which is calculated as 10% of total collected money, and it has been radically increased from 28 million birr in 2008 to 157.7 million birr in 2012 fiscal years.

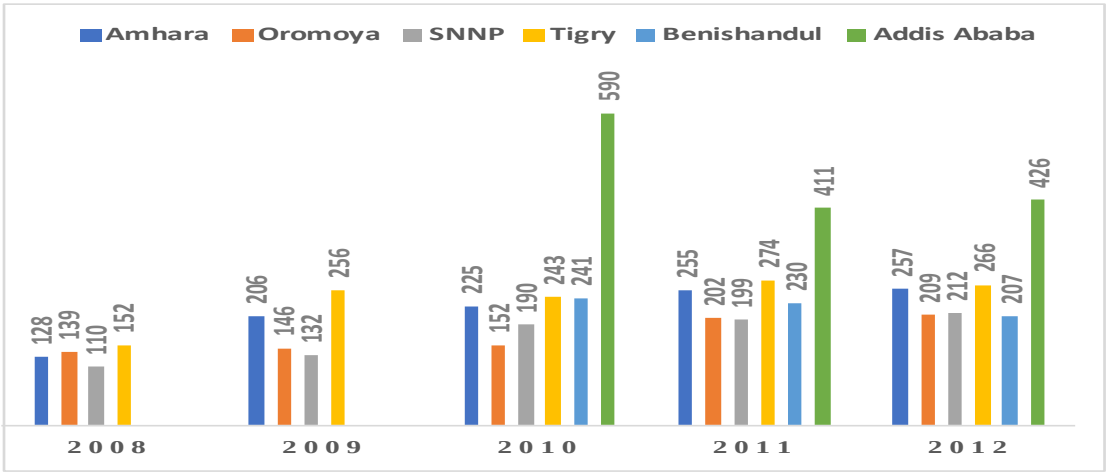
The federal government general subsidy was 25 % of the total money collected but has dropped to 10 % since 2008.

Table 5.CBHI Money Collection by Region

Regional Contribution and Target Subsidy Collection(in Million Birr)										
	2008		2009		2010		2011		2012	
Region	Contribution	Target subsidy	Contribution	Target subsidy	Contribution	Target subsidy	Contribution	Target subsidy	Contribution	Target subsidy
Amhara	100.1	13	262.7	46.3	388.8	66.9	433.3	110.4	511.5	137.3
Oromiya	48.8	19.1	169.3	48.9	89.6	50.7	244.4	86.5	455.5	113.4
SNNP	5.2	3.3	63.4	9.3	153.2	9.39	127.4	14.5	188.1	21
Tigry	24.52	7.18	43.1	6.5	42.9	14.6	73.4	23.2	90.2	31.5
Ben/Gumuz					2.78	1.19	0.865	0.651	2.9	0.81
Addis Ababa					4.14	5.23	21.8	7.71	57.2	22.6
Total	178.62	42.58	538.5	111	681.42	148.01	901.165	242.96	1305.4	326.61

Source: EHIA MRCCD Annual Reports (2008-2012E.C)

Figure 11. Total Contribution Collection Per CBHI household by Regions (in birr)

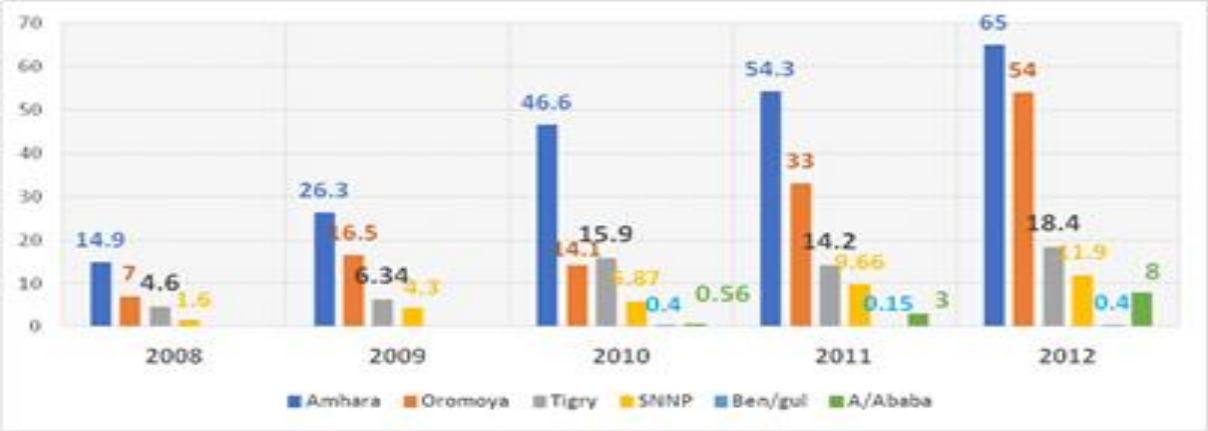


Source: EHIA MRCCD Annual Reports (2008-2012E.C)

The above bar graph represents regional total contribution collection per CBHI household at each year, so that it could be compared with regional premium at each year to see collection efficiency. Since 2011, the premium in Addis Ababa is birr 350, Benishangul/ Gumuz birr 180, and 240 birr in the remaining regions. Therefore, based on 2011 and 2012 data, Amhara, Tigry, Benishangul/Gumuz and Addis Ababa City were found in a better position in collection efficiency.

In relation to the 2010 high performance of Addis Ababa, is due to the fact that the regional health bureau subsidized huge amount of money for indigents at that specified year.

Figure 12. Federal General Subsidy by Region (in Million birr)



Source: EHIA MRCCD Annual Reports (2008-2012E.C)

5. CBHI Challenges and lesson Learnt

5.1 CBHI Challenges

- Due to fragmented pooling system, inefficient purchasing mechanism & low claim auditing in CBHI Schemes, number of schemes couldn't able to cover reimbursement expense for health facilities.
- Inadequate political commitment at all level to support and promote CBHI program
- Inadequate availability of supplies & equipment (drug, lab, diagnostics etc) in most health facilities, which highly affects membership.
- Voluntary membership gives to households to opt freely to join and to dropout as they wish, only based on their health condition.
- Many of CBHI schemes are not conduct annual finance audit which affects public trust and the schemes financial sustainability
- Gaps in members ID distribution

- Manual data collection and reporting system which hinders data quality and cause delaines in information exchange
- Lack of Appropriate organizational Structure for the health insurance system
- Mis communication on health insurance program

5.2 Lessons Learnt

- ✓ Designing and implementing multi-Stage pooling strategy (zonal, regional and national) is very important to ensure cross subsidization among schemes and to ensure service provision in line with referral system.
- ✓ It requires high level political commitment at all level for effective health insurance system
- ✓ Digitalizing CBHI schemes membership and contribution data collection is very critical to improve data quality and timely information exchange process.
- ✓ It requires practical involvement of all government stakeholders and partners to address the gap in supplies and equipment availability at all health facilities
- ✓ Voluntary CBHI membership shall be replaced with mandatory membership.
- ✓ It is important to schedule & push yearly CBHI scheme financial auditing.
- ✓ Special ID distribution strategy should be design in collaboration with regions and support its operation
- ✓ In order to minimize miscommunication, CBHI mobilization participants (communicators) shall be trained and be well oriented about the program.

"Everyone wants to live a healthy life. But our health is not in our control; we may face diseases in the future or face accidents. Keeping in view the costly treatments, it becomes very difficult for many people to bear the cost of treatment. So, it's wise decision to be a member of health insurance".

The Ethiopian Health Insurance Agency