Achieving Universal Health Coverage through Health Financing Reform: Ethiopian Showcase

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Abstract

Objective: This article aim to analyze the Ethiopian health care financing reform, by aggregating the system into its constituent part, and examine isolated relationships, in which, the policy interventions and results can be more readily measured and evaluated, and propose any further recommendation. Besides, the study examines how members of health insurance scheme access, utilize, and meeting their benefits package without financial hardship, which later might guide the decision-makers in managing the trade-off that will inevitably arises as the financing system evolves.

Methods: Desk reviews of government policy documents, proclamations, and health system financing strategy were scrutinized. Moreover, scholarly, peer-reviewed journals, and scientific literatures search were conducted through various approaches focusing mainly on the health system financing and the path to universal health coverage direction that has currently encountered around the world today. The articles reviewed for this study includes from electronic databases on the Internet, specific article searches, and published articles. The following databases namely the World Bank, the World Health Organization, the EconBase (Elsevier), Walden University Library, and Abt Associates Inc. were thoroughly navigated.

Results: Membership to a health insurance scheme is crucial to improve the health status as well as foster productivity by the provision of health care services and reducing out-of-pocket payment at the time of illness. The Ethiopian showcase embraces two risk pooling arrangements, namely Social Health Insurance (SHI) and Community Based Health Insurance (CBHI) schemes, which gives financial protection and access to health care services at the time of demand. Accordingly, the CBHI scheme's members are able to access health care benefits without financial hardship when they actually seek care.

Conclusion: The existing health insurance schemes are a profound health care financing program, attributable for inclusiveness, diversity, and further researching, which in turn lends to positive social change through multitude comings paving a way to universal health coverage achievement, sustained economic and social development, and improvement in health outcomes. Furthermore, it may contribute to strengthen home-grown approaches, bestowing recommendations to the implementers, organizations or any other researchers by disclosing the successes, failures, as well as setbacks.

Keywords: Health care financing; Universal health coverage; Financial protection; Out-of-pocket expenditure; Access to health care; Utilization; Health insurance; Social health insurance; community based health insurance; Social protection

Abbreviations:

UHC: Universal Health Coverage; WHO: World Health Organization; EHIA: Ethiopian Health Insurance Agency; NHA: National Health Accounts; SHI: Social Health Insurance; CBHI: Community Based Health Insurance.

Introduction

Numerous studies have focused on the universal health coverage concept, context and functions at individual or group level. And more is known about on how to suggest achieving this direction because of the focus on health care services and financing appearing in conjugate

manner. World Health Organization defines Universal Health Coverage as all people have access to services and (all) do not suffer financial hardship paying for them, where most studies have focused on its designs, and features to the broader directions for progress. The most important challenge encompasses getting single mix of policy to enhance sufficient funds, using the available funds efficiently to raise the needed revenue, and subsequent decisions executed to allocate funds to health and health related activities to maximize benefits and balance on the population covered [1]. This is a noticed gap in the literature. Achieving universal health coverage is a perennial problem, and until implementers at all level recognize it, the problem will continue. More pragmatic and home-grown research are needed for feasible approach with concerns for ensuring that everyone, including vulnerable groups can have protection against financial risk for any given level of expenditure. The interplay between mobilizing sufficient revenue, efficiently use of revenue, and the subsequent decisions to allocate budget to health are decisive factors to maximize health benefit.

Country experiences suggest that coordination of policy action between the interplay among ministries of health and finance is dominantly essential to move closer to UHC or sustain the gains already achieved. Adoption of UHC programs has been contingent on a strong executive or political party leadership, outlining a range of tailored policy, financial and social instruments, which will be bundled together to make the intervention effective and meaningful from a long-term system building perspective. The health care financing functions include revenue raising, pooling of funds, and purchasing of services and benefit packages [1]. However, moving towards UHC is a process of progressive realization where, it is about making progress on several fronts for all people: the available range of services (consisting of medicines, medical products, health workers, infrastructure and information); the proportion of costs of services covered; and the proportion of the population covered [1,2]. So, this progress requires the ability to identify and overcome obstacles as well as the commitment and collaboration across diverse stakeholders.

Methodology

Desk reviews of government policy documents, proclamations, and health system financing strategies were scrutinized. Besides, scholarly and peer-reviewed journals and scientific literatures search was conducted through various approaches focusing mainly on the health system financing and the path to universal health coverage direction that is currently encountered around the world. The literature search was conducted through various approaches: Articles reviewed for this study included from electronic databases on the Internet, specific article searches, and published articles; Databases searched were the World Bank, the World Health Organization, the EconBase (Elsevier), Walden University Library, and Abt Associates Inc.. The key terms used during searches were health care financing, universal health coverage, financial protection, out-of-pocket expenditure, access to health care, utilization, health insurance, and social protection.

Background

Good health is a desired state to wellness of human being and to prolong economic, social and political development pursuing healthy society and global fastening. The World Health Organization defines Universal Health Coverage as the provision of preventive, curative and rehabilitative health service without causing financial hardship when getting these services. Because of the multiplicity of actors and the complexity of interactions that influence health coverage, this context is not cinch as identifying key factors that enhance or erode coverage, services, and, financial protection are daunting tasks. Many factors influence health status and a country's ability to provide quality health services for its people, where the social determinants of health particularly make millions of people to suffer in different directions [3]. Hence, approaches should be outlined and framed to mobilize more money for health embedded on different functions of health financing policy to meet universal health coverage (UHC) goals. In this regard, financial protection is at the heart of UHC and improving financial protection is a central focus of health financing policy.

Discussion

A healthy society exert itself as a policy inducing framework, where its anthropology explores the cultural and philosophical layout with its figures, discourses and ideology with the full realm of processes, relationship, and implementation [4,5]. Therefore, the anthropology of

policy contribute the belt of potential perspective with ethical consideration in the arena of public policy formulation through a multitude of interviews, critics, and debates which give rise to positivity of the context, globalization and building blocks lending to the credence of public policy [6]. Hence, policy is a maneuver of social change encompassing an array of fair advantages as well disadvantages attempting to address public issue. Different countries exert different intensity to fulfill their policy and bring positive social changes to their citizen through their policy making process and makeup. Accordingly, the Government of Ethiopia (GoE), is struggling to implement and fulfill its public policy through different approaches, in which, health policy is among others. It has been more than two decades since development of infrastructure, workforce and implementation of a multitude financial risk protection approaches including health financing reform, to make the country approachable to Universal Health Coverage. In alignment to this, a sustainable and inclusive strategy to ensure human welfare and social protection for the population among other policies has been outlined as growth and transformation framework. As universal health coverage objectives can serve as vital mechanisms for improving the health and welfare of the citizens, while laying the foundation for economic growth and competitiveness grounded on the principles of equity and sustainability, the existing steps of the country may lead to achieve this development object [7-9].

In Ethiopia, the public sector remains a major recipient of health sector resources. Parallely, private health care providers both for profit and non-profit are mainly concentrated in urban areas where less than 20% of the population resides within it and receives only 16% of the total national expenditure on health [10,11]. Perceiving this situation, in 1998G.C, the Government of Ethiopia (GoE), endorsed Health Care Financing Strategy by the Council of Ministers, with the aim to improve and diversify resource mobilization for the health sector; to ensure equitable and efficient resources allocation and use; and to provide financial protection for its citizens. This context will instrument the shifting of out-of-pocket payment (oop) to pre-payment modality and provide financial protection to access affordable health services package attributable to social justice. However, as the country's National Health Accounts entails, shortage of money at the time of illness contributes about 41 percent among the five reasons impeding health care services utilization postulating for financial protection measures emphasizing a shift of out-of-pocket payments to pre-payment payment modality such as health insurance system [10]. The national health care financing strategy articulated the importance of good governance, and accountability in which the followings instruments are included accordingly: establishment of governance bodies with the community ownership; retention and utilization of revenues within health facilities; fee exemption and waiving mechanism; establishment of private wing; and outsourcing of non-clinical services.

Consequently, the country Ethiopia, has endorsed two risk-pooling arrangements namely community-based health insurance (CBHI) and Social Health Insurance (SHI). Social Health Insurance, targeted for the formal sector, is backed by a proclamation, where it acts as a notable signal of government's commitment to provide access to health entitlement. The scheme will cover any employee (except the Defense Forces) with over three months of service and includes public officials, management staff, judges, prosecutors, members of the police, members of the House of Peoples' representatives, salaried members of the house of the Federation and salaried labor union officials and their dependants [12,13]. This might cover about ten to eleven percent of the

population. A range of efforts and legal instruments related to social insurance scheme has been in situ, but the initiation time is not yet specified.

CBHI was started in many Western African countries two dozen backs in response to user fee influence on the access and utilization of health services at the time of illness [14,15]. Ethiopian's CBHI scheme started in 2011G.C. through government initiatives, as small community responses for the provision of financial protection where enrollment is in voluntary basis [16]. The scheme targets any employer below ten employees encompassing the self employed, those in the rural farming and livestock rearing sector where more than eighty-five percent of the total populace of the country might be included. The initiation phase was piloted in thirteen districts (1.5 percent of total) located at four regional states among the nine Regional States and two City Administrations [17]. Currently, the pilot-expansion phase is being undertaken to nearly 35 to 40 percent of the country's districts. Initially, the CBHI scheme was prone to adverse selection tempting the values of the broader solidarity objective, cross-subsidization, and risk-sharing items which later suit and tackle problems to improve outcomes such as access, utilization, and provide financial protection [14,17,18]. Though reducing direct payments is probably a necessary condition, estimate of the financial burden of out-of-pocket spending for the households range between 1.07-4% of household income [10,18]. It is certainly not a sufficient condition to improve outcomes but it is equally important to decide what is being purchased (benefit design versus being covered), how health costs are covered, and how health care is paid for the health care providers, and the interplay among the target population's needs. Furthermore, the impact frequently diminishes as the socioeconomic status of the beneficiaries improves. The CBHI scheme follows an incremental policy development approach by gathering and generating evidence-based information through impact evaluation imputable for experiential guide for health policy decisions. When it's applicable for all eligible segment of population, it will cover eighty four percent of the total population.

To carry out the above risk-polling initiatives, an executive organ has been established namely Ethiopian Health Insurance Agency, an autonomous federal organ with respect to its own legal personality. The Agency or the public organization is obliged to establish and implement efficient insurance system including the revenue management raised from households, and insurance premium to pay the health costs. Working in collaboration manner with different stakeholders to attain the institutional destiny, avails an array of maneuvers and approaches serving as a diagnostic tool to prescribe the possible remedy for distinguished impairment, effective implementation of the organization's resources including information, assistances as well as matured relationship culture. The impact of collaboration on the enhancement of thought process of governance network at the level of policy making, institutional and operational level for the fulfillment of good governance, embracing the attainment of guidance, controls, coordination as well as efficient resource management in configured administrative ecosystem [19]. Hence, the Agency should strive for the creation of conducive environment to remark the public health issue for the benefits of all citizens and bolster the fulfillment of the Ethiopian Constitution which is worth of quoting: To the extent of the country's resources permit, policies shall aim to provide all Ethiopians access to public health and education, clean water, housing, food and social security [20].

Practicing a framework of UHC schemes in the country context, will have the implication for policy and future UHC research which are outlined and summarized as follows [21].

1. Affordability. Making the health services affordable for accessing and utilizing is the crucial entry point by UHC schemes. This icon will bring a favorable impact only on out-of-pocket expenditures. As evidences suggests, out-of-pocket expenditures and related measures are partial and imperfect measures of financial protection [21,22], and truly demands a holistic approach to the dimension of access namely: availability, accessibility, accommodation, affordability, and acceptability [23-25].

2. Target the poor. Various strategies may be needed to cover the poor. Pro-poor programs designed to fulfill the needs of the poor are crucial [26] imputable to close the distance between the poor and the health care services. However, keeping the eye on the non-poor has relative importance as it mitigates moral hazard effects.

3. Benefits packages to the target populations. Benefits should be closely linked to target populations' needs. In this scenario trade-off is inevitable between what and how much is covered. In doing so, there should be a careful scrutiny on cost-effectiveness of health benefits, the target population's needs such as epidemiological profile, major barriers to access, unsatisfied demand, major sources of financial hardship, and so forth.

4. Implement highly focused interventions to step toward UHC. A few studies suggest that implementing highly focused intervention, specifically focusing on the positive effects on access, financial protection, and health status outcomes are suggested step for a transition to UHC [21,22]. As there is no tailor-made path to achieve universal coverage, policy makers should undergone frequent evaluation on the country's health needs, priorities and assess the role that targeted interventions are highly recommended [8].

Analyzing the pilot impact evaluation report of the community based health insurance scheme, it is vivid that, the scheme initiation and implementation has made better and meaningful articulation addressing the target population for defined benefit package, and risk sharing which in turn contribute urgentness to the direction of universal coverage. However, as voluntary funding sources and approaches never lends a way to UHC, there should be a movement towards predominant reliance on compulsory funding resources [2]. Hence, initiating a compulsory entitlement for the CBHI scheme is vital as well as crucial. Moreover, the scheme has limitation in managing health expenditure which hinders strategic purchasing of priority health care and medicines services or resources within an allocated envelope [27]. So aligning the funding with the promised services, placing accountability, and manage expenditure growth will attributable progress to the scheme sustainability [22,27,28].

In light of the above evidences, a better understanding as well as implementation of the above UHC scheme framework is essential to enhance improvement access to health care utilization as well as to boost resources for health attributable for equitable and efficient resources allocation, use, and secure financial protection to the populace. Therefore, outlining a wide array of dimensions to make sufficient perspective on the existing CBHI scheme as a foundation will enhance the outcomes, where reducing out-of-pocket financial burden at the time of illness, and allow access to affordable health benefits [4,22,28].

Conclusion

The Government of Ethiopia (GoE), exerted a numerous effort exerted to ensure the social protection of the population and combating the social determinants of health. Accordingly, a health financing reform based on prepayment, pooling and strategic spending extends a powerful means to achieve the key health system objectives of governance (organised mobilization and management of resources), value for money (need-based strategic spending), and financial risk protection (risk pooling and cross-subsidy) [10]. Hence, this home-grown health financing reform outlines a clear conjugated meaning namely health care and financial protection to all including the objectives of improving health outcomes, reducing the financial risks associated with ill health, and increasing equity [22] lending to challenge the existing financial barriers to health care. Members, individuals, and society will benefit from purchased resources as well as risks sharing across individuals. As the World Health Report remarks, the most effective way to deal with the financial risk of paying for health services is to share it, and the more people who share, the better the protection with a room for improvement is always encouraging providing impetus for fundamental change [1]. Furthermore, this reform might stimulate community-based social dynamics, solidarity, and participatory decision-making and financial management [17]. In sum, UHC is not only a health agenda but also a practical expression of social cohesion with concerns for ensuring that everyone, including vulnerable groups, can realize their right to health.

Recommendations

The Ethiopian health insurance scheme (part of health care financing reform) alleviate financial burden and enable access to equal window of opportunity regardless of ethnic-cultural background, religion, and gender within the heterogeneous nation referable to transform group identity into realm of individual identity bringing up palpable benefits such as social justice and protection against pushed poverty [4]. However, this reform demands adequate financial resources to pay for necessary health services, requiring fiscal commitment from the government, and a significant role of the health insurance agency in establishing pooling and redistributive mechanisms that ensure financial protection and equitable subsidization of coverage for the population which ultimately paves a way to UHC [2,17,21,28].

Accordingly, here are the following identified key themes to be recommended within the health financing reform.

1. Raising revenue. In Ethiopia, more than eighty percent of the population resides in informal sector, which necessitates a diversifying, and multitude of revenue. Therefore, expanding coverage to health through allocating general tax revenue might not be sufficient demanding further expansion of tax base by introducing new payroll taxes under a social insurance program, and community based health insurance with explicit earmarked commitment [1,28]. These approaches will serve as a domestic resources mobilization (DRM) mechanism useful to keep the large young population healthy, and develop a healthy pool of human capital [22].

2. Managing effective risk pooling and redistribution of resources. Providing universal coverage and financial protection for the whole population requires cross-subsidization, and risk-sharing [28]. Once multiple programs are established, it becomes fragmented, and politically difficult to merge or integrate requiring trade-offs [1]. Hence, the two risk-pooling arrangements, namely SHI and CBHI,

need a combination and joint implementation at national level (this might happen after the commencement of the social health insurance scheme) facilitating coverage expansion which in turn impact the effective redistribution to achieve equity. So this framework will sketch a unitary funding arrangement attributable for effective use of revenue, risk pooling, and cross-subsidization regardless of major challenge [2,17].

3. Managing expenditures well and ensuring value for money. Facing resource constraints in health care industry to achieve or maintain universal coverage remains unavoidable. Accordingly, health expenditures require careful regulation and management to ensure equity, fiscal responsibility, and value for money, i.e. covering the most people with access to quality services and with effective financial protection, particularly given the high rate of market failure in health services [1,28]. Hence, implementing strategic purchasing, and managing spending efficiently is critical to get the most from available funding in terms of coverage which can be achieved through putting in place expenditure management measures in a fiscally disciplined, accountable manner as well as exercising priorities within available resources [1,28]. This might happen through investing in the institutional capacity of the Agency to implement expenditure management [17,28].

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