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ASSESSMENT OF URBAN COMMUNITY-BASED HEALTH INSURANCE SCHEMES IN AMHARA AND SNNP REGIONS

September 2021

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USAID Health Financing Improvement Program

The USAID Health Financing Improvement Program supports the Ethiopian government in its efforts to further strengthen and institutionalize health care financing reforms and initiatives to provide accessible, high quality, primary health care services for all Ethiopian citizens with reduced financial barriers. Led by Abt Associates, the program is implemented in collaboration with core partners Breakthrough International Consultancy, the Institute for Healthcare Improvement, and Results for Development, and resource partner Harvard T.H. Chan School of Public Health.

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Cover Photo: Community-based health insurance beneficiaries with their insurance identification card. Photo credit: Ayenew Haileselassie, Abt Associates.

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ACRONYMS

CBHI	Community-Based Health Insurance
COVID-19	Coronavirus 2019
EHIA	Ethiopian Health Insurance Agency
EPSA	Ethiopian Pharmaceuticals Supply Agency
FGD	Focus Group Discussion
HEW	Health Extension Worker
ID	Identification (Card)
KII	Key Informant Interview
OOPE	Out-of-pocket Expenditure
NGO	Non-governmental Organization
SNNP	Sothern Nations, Nationalities, and Peoples' (Region)
USAID	United States Agency for International Development

1. INTRODUCTION

1.1 BACKGROUND

The government of Ethiopia began implementing community-based health insurance (CBHI) in four regions, as a pilot program in 2010. It did so to promote financially accessible and good-quality health care services for people living in rural areas and those who work in the informal sector in urban areas. Over the past 12 years, CBHI schemes have mainly been established in rural areas. Implementation of CBHI in urban settings started in Yirgalem town administration in January 2011 and has been expanded to other towns. Currently (as of June 2020), there are about 40 urban schemes in Amhara region and 32 in Southern Nations, Nationalities and Peoples' (SNNP) region.

The government of Ethiopia wishes to expand the CBHI program to all urban and rural areas of the country, so that all people have financial access to health care. Lessons learned from the experiences of urban centers in Amhara and SNNP will help fine-tune the design elements of urban-based CBHI schemes.

1.2 STATEMENT OF THE PROBLEM

Current CBHI design features are similar in urban and rural settings except for differences in the contribution amount. However, because the urban setting differs from the rural in terms of socio-economic, epidemiological, technological, and other characteristics, the design of the CBHI implementation model should consider these unique urban features (See Table 1). Until now, no comprehensive study has been done to inform urban CBHI design in Ethiopia. It is in this context that this assessment of urban CBHI practices was conducted.

1.3 SIGNIFICANCE OF THE STUDY

The assessment will generate evidence on how the existing urban schemes are functioning in terms of design features such as community mobilization; member eligibility, registration, and access to health facilities; contribution setting and collection; and governance.[1] The evidence generated will be used to adapt design parameters for sustainable implementation of CBHI in urban settings.

1.4 OBJECTIVES OF THE ASSESSMENT

The assessment explored the design features of CBHI schemes and their implementation in eight urban centers. It aimed to draw lessons about the design of urban CBHI that can be used to adapt designs parameters. The specific objectives were to:

a) Explore the relevance of design features of CBHI scheme in urban settings; and

b) Assess the financial sustainability of the schemes.

[1] A more complete list of design features includes governance structure, community mobilization, membership eligibility, members registration, premium setting and collection, membership renewal, community engagement, ID card provision, identification of eligible population and indigents including payment of their contribution by third party, benefit package, health service utilization, reimbursement mechanism, staffing, subsidy (general and targeted), risk management.

2. LITERATURE REVIEW

The literature on CBHI in the urban context at both the global and local level is scant. What is available focuses on urban slums and the urban formal sector. The team working on this study has tried to extract from the literature as well as from primary sources what makes the urban setting different from the rural setting for effective CBHI implementation. The characteristics of people in the urban informal sector differ from those of the rural population in various aspects. For example, their employment and therefore residency are often short term, and many move around as they search for jobs. This demands a different approach for the CBHI benefit package, level and types of service providers, registration, targeting, amount and timing of membership contribution payments, and payment method.

In rural areas, for instance, schemes can make it easier for people to pay their annual contribution by scheduling payment during the harvest season. People in the urban informal sector are paid on a monthly, weekly, or daily basis, and sometimes irregularly. Studies have found that the timing of paying the contribution matters to enrollment. Carrin et al. (2005:803), who looked at schemes in developing countries, observed that "schemes in urban areas were more inclined to establish monthly or quarterly contributions so as to match the income patterns of urban informal sector workers."

Geographic access to a health facility is another determinant of CBHI enrollment and renewal. Because a significant number of people in the urban informal sector move in search of jobs, they do not have a permanent residence, and so their access to health services cannot be tied to a specific health facility. CBHI in the urban context should be flexible, offering mobility of benefits, that is, allowing members to access health facilities that are close to where they currently reside. Without this, these people are less likely to join and renew membership. Carrin et al. (2005:804) found that distance to a health facility is critical to accessing health services. For instance, in the Gonosasthya Kendra scheme in Bangladesh "… membership among the two lowest socio-economic groups appeared to be related to distance: up to 90% of that target population from nearby villages subscribed, whereas only 35% did so for the target population in the distant villages." The same is true in Rwanda. "In the Rwandan Project Study, it was also found that households who lived <30 minutes from the participating health facility had a much larger probability to enroll in the community based health insurance than those who lived farther away" (Schneider and Diop 2001, in Carrin et al. 2005:804).

Another feature that distinguishes urban CBHI from rural CBHI is that urban residents are more aware of health benefits and tend to seek care more often than rural residents. Enrollment is highly likely to match the type and quality of services offered: the greater the quality, the higher the probability of enrollment. A typical example of this is found in Ghana. Ghana has modified the rural scheme model to suit the impoverished urban setting, which is largely communities in the urban informal sector. Despite their socio-economic status, these communities are more likely to visit private facilities, which often are able to offer higher-quality health services than public facilities. For this reason, the urban CBHI model requires higher-quality health services, including access to private facilities. The lessons drawn from the above discussions were incorporated into our study methodology and thus informed our data collection (see Section 3.2).

3. METHODOLOGY

3.1 STUDY DESIGN

The appropriate study design for the assessment of CBHI implementation in the urban setting, one that will generate the required evidence, will take into account the design features, how they are being implemented, and challenges encountered (Table 1) from the urban perspective.

Table 1: Evaluation matrix: Design features against what is being practiced and challenges

Design features	Existing design	Practice/ implementation	Challenges	Recommendation
• Community mobilization system				
• Membership				
• Contribution setting and collection mechanism - Contribution setting and community engagement - Collection system - Incentive				
• Defining and identifying eligible households - Paying - Indigent				
• Health service utilization - Mechanisms in place to contain overutilization - Health service delivery				
• Health service fee-setting mechanisms and EHIA/CBHI level of engagement				
• CBHI structure and staffing pattern - Size of staff - Professional mix				
• Risk mitigation mechanisms - Fraud management - Period to deposit collected contributions in CBHI bank account				

Source: Study team compilation from different directives and guidelines

Note: EHIA=Ethiopia Health Insurance Agency

Four urban characteristics were identified, with their implications for urban CBHI design (Table 2).

Table 2: Urban characteristics and their implications for CBHI design

Characteristics	Implication to the design features
High mobility of the eligible population	1. Requires different approach from that of the rural context for mobilization, registration, targeting, timing/collection of payment, and membership renewal 2. Accessing services cannot be tied to specific health facility
Challenges in classifying the eligible informal sector	Difficult to identify eligible population
High health-seeking behavior and better access to higher-level health facilities	1. Requires higher contribution rate to ensure scheme's financial stability 2. Given the proximity of higher-level health facilities, makes overutilization of hospital services more likely (in terms of money budgeted for hospital utilization and/or copayment-payment) 3. Has a high risk of moral hazard both from suppliers (providers) and consumers (beneficiaries) of services
Households are overburdened by high and increasing cost of living	May require flexible payment mechanisms (not once a year but instead two or three times) and a larger subsidy

3.2 DATA SOURCES AND DATA COLLECTION

The study used both primary and secondary data sources collected through interviews and administrative reports as follows:

a) Qualitative data

- Key informant interviews (KIIs) of government officials at various levels (primary source)
- Focus group discussions (FGDs) with members and non-members of CBHI (primary)
- Review of documents on CBHI design, directives, and guidelines and administrative reports on status of CBHI schemes (secondary)

b) Quantitative data

- Administrative data on CBHI schemes (secondary)

Semi-structured interview guides were used to conduct KIIs and FGDs. Key informants were selected based on their roles and responsibilities related to CBHI, and the experience and information they have in the program. FGD participants were selected in consultation with woreda CBHI staff.

3.3 SAMPLING

The selection of regions and urban centers was made using a purposive sampling method. The sampling frame includes schemes in Amhara and SNNP regions. The sampling procedures followed are described below.

Four regional states (Amhara, Oromia, SNNP, and Tigray) are implementing CBHI. Different towns in the regions charge different premiums. Only urban schemes in Amhara and SNNP regions are included

in this study. The urban schemes in Oromia and Tigray were established recently and are excluded from the study because it is too early to assessment their processes and performance.

For each of the two study regions, four urban schemes were purposively selected based on their year of establishment and proximity to each other. To ensure they are representative, the size of the towns also was considered: two in each region are zonal-level towns and two are small towns. The selected towns are presented in Table 3.

Table 3: Sampling distribution, Amhara and SNNP

Region	Town	Scheme establishment
Amhara	Bure	2016/17
	Finote Selam	2013/14
	Kemise*	2015/16
	Haik	2016/17
SNNP	Butajira	2016/17
	Worabe	2015/16
	Bodity	2017/18
	Sodo	2017/18

* It was not possible to obtain the required primary data from Kemise due to security reasons and it was replaced with Dangila CBHI scheme. Later, secondary information on the performance of the Kemise scheme was obtained through EHIA Dessie branch and both schemes are included in the analysis, as appropriate.

Tables 4 and 5 show the distribution of FGDs and KIIs in each region and selected town and the total number of FGDs and KIIs held.[2]

Table 4: Number and distribution of FGDs and KIIs in SNNP

		Bodity	Butajira	Sodo	Worabe	Total
FGDs	Members	**3**	**1**	**1**	**1**	**6**
	Non-members	-	-	-	**1**	**1**
KIIs		1. Town mayor 2. Health center head 3. CBHI coordinator 4. Contribution collectors **Total: 4**	1. Town mayor 2. Health center head 3. CBHI coordinator 4. Contribution collectors **Total: 4**	1. Town mayor 2. Health center head 3. CBHI coordinator 4. Contribution collectors **Total: 4**	1. Town mayor 2. Health center head 3. CBHI coordinator 4. Contribution collectors **Total: 4**	**16**
		EHIA branch office: Hosaena Branch				**1**

[2] One town in each region was selected for a non-member FGD based on years of scheme existence (the oldest one).

Table 5: Number and distribution of FGDs and KIIs in Amhara

		Bure	Finote Selam	Kemise	Haik	Total
FGDs	Members	**1**	**1**	**1**	**1**	**4**
	Non-members		**1**			**1**
KIIs		1. Town mayor 2. Health center head 3. CBHI coordinator 4. CBHI Section (Kebele office) **Total: 4**	1. Town mayor 2. Health center head 3. CBHI coordinator 4. CBHI Section (Kebele office) **Total: 4**	1. Town mayor 2. Health center head 3. CBHI coordinator 4. CBHI Section (Kebele office) **Total: 4**	1. Town mayor 2. Health center head 3. CBHI coordinator 4. CBHI Section (Kebele office) **Total: 4**	**16**
		EHIA branch offices: Debre Markos and Dessie				**2**

4. RESULTS AND DISCUSSION

4.1 COMMUNITY MOBILIZATION

Key informants reported that community mobilization for renewal and new members takes place over about three months, between December and February, every year in all towns visited. Mobilization is carried out at different levels: town, kebele, and ketana/block/village levels using different platforms, and household level via house-to-house visits.

As per CBHI design, different bodies are expected to be involved in community mobilization. Key among them are the CBHI board, town administration, health office, CBHI staff, kebele administration, and village volunteers. Mobilization is supported by the regional health bureau (by issuing directives), zonal health department/zonal CBHI coordination committee (by monitoring activities through supervision), EHIA branch office (by providing technical and financial support), and health centers in each town (by creating awareness through their regular health education activities). Social groups like Idirs, women's and youth associations, arts clubs, religious leaders, opinion leaders, and elders also support community mobilization by demonstrating about and advocating on the benefits of CBHI using different platforms.

As reported by CBHI staff in towns, mobilization begins by reviewing the performance of the preceding year. A high-level meeting of the town leadership including the CBHI board review past community mobilization performance based on how successful the town was in renewing existing members and enrolling new ones, and potential challenges for the upcoming community mobilization. At this high-level meeting, strategies are formulated to address the challenges. Each town cabinet member is assigned to a specific kebele and is responsible for overseeing renewal and enrollment of new members. The cabinet members also help disseminate information on CBHI to the eligible population, do sensitization and awareness raising on CBHI, and review daily activities and report to the mayor.

This town-level discussion is cascaded to the kebele level, where the discussion is led by the town cabinet member assigned to that kebele. As at the town level, the kebele administration is involved in community mobilization. To reach the community, kebele cabinet members are assigned to each village and are responsible for community mobilization there. Each village appoints one responsible person who is accountable to the kebele leader. Every day/every other day, this person reports to the kebele leader and once a week there is a town-level meeting to discuss progress and challenges. The meeting sets the direction for effective community mobilization over the following week. These activities continue until the renewal/enrollment period ends.

Community mobilization also involves sensitization and awareness creation of the various social groups mentioned above. The town administration uses sub-kebele structures (villages) to sensitize the community. Well-known and trusted individuals are either assigned by the kebele administration or elected by the village, and they work voluntarily within their village. They are largely responsible for community mobilization, which includes time-consuming house-to-house visits to create awareness of the CBHI program, especially during the membership renewal/ enrollment period.

Even though kebeles do the bulk of community mobilization, town CBHI schemes have the ownership role. They coordinate the activity, distribute membership forms to kebeles, and ensure the documentation of each member is done properly. Town administrations provide various resources during membership renewal/ enrollment periods. For example, they provide vehicle-mounted loudspeakers (montarbos) to deliver messages, an effective way to reach a large number of people in a short period of time. Town CBHI schemes send flyers and brochures to the kebele administration, which then distributes them for awareness creation.

The schemes also conduct community mobilization, supported by the zonal administration and regional health bureaus. Implementation guidelines and manuals, and trainings on how to use them, are provided by the zonal CBHI coordination committee, zonal health departments, and the regional health bureau.

The community mobilization effort in Bure (Amhara) uses an interesting approach. Bure uses the arts club to present short drama and dialogue in different forums to mobilize the community. The zonal EHIA office provides budget support for this. The town CBHI staff reported that this has helped increase enrollment and renewal. The CBHI scheme under the health office in each town plays the leading and ownership role in the mobilization effort.

The other platform used for community mobilization in all visited towns is the health center. Each health center holds a morning health education meeting with clients who come to the facility for outpatient services. The town health office, including CBHI employees, use this platform to create awareness on CBHI benefits, the objectives of CBHI, and issues related to CBHI. They also promote CBHI by describing how CBHI members in their communities were saved from large medical expenses to demonstrate specific benefits of CBHI membership to the community. These health center meetings have not been held regularly during the past year due to the risk of spreading Coronavirus 2019 (COVID-19).

The major challenge to this community mobilization approach is lack of or inadequate incentives for those who carry out the largest share of the mobilization activities (see also Section 4.3.2). Another problem is that community mobilization is not well planned – specifically, not integrated with the annual plan of the health office and hence is not budgeted. It may not be possible to sustain community mobilization using volunteers for a yearly "campaign." Community mobilization should be institutionalized by making it part of the annual plan and allocating the required budget.

All the community mobilization activities – door-to-door visits by kebele cabinet members, kebele/public servants, health extension workers (HEWs), and village volunteers and loudspeaker announcements – are effective in reaching every household. However, KII and FGD participants in all visited towns reported the kebele public servants and village volunteers are the most effective, because they know each other and the neighbors they are visiting. FGD discussants confirmed that they got adequate information (on which health care services are covered and which are not, on the contribution and referral system, etc.) from these workers prior to joining CBHI, which enabled them to make an informed decision. They also mentioned messaging from montarbos and roadside banners during the enrollment/renewal period, and radio and television advertisements as sources of information about CBHI.

In sum, the KIIs and FGDs showed that the community is well aware of CBHI benefits, excluded services, contributions, and how the system works, meaning awareness creation and community mobilization was successfully carried out. Key actors in community mobilization are the town administration, kebele administration, and village-level elected/recommended individuals and public servants. The KIIs revealed, however, that the zone health department and zone CBHI board has a very limited or no role in community mobilization, even though CBHI design makes them responsible for supporting community mobilization.

4.2 ELIGIBILITY FOR CBHI

4.2.1 PAYING MEMBERS

CBHI is regulated based on regional health bureau directives of both regions. The SNNP Directive No. 005/2012 was issued in 2019. According to Art. 8/1 of the directive, membership in the CBHI scheme is determined by a majority vote of the kebele residents' meeting; if the decision to join the scheme is made, every resident of the kebele including those who work in the informal sector are eligible for

membership (Art. 8/2). The directive clearly defines "those in the informal sector" as all persons who are engaged in any economic and service sectors, not employed by others, making a living out of agriculture, trading, and small businesses, and includes all those who are outside of the payroll system.

Similarly, Amhara issued the revised Directive No. 1/2010 in November 2017, which clearly defines the paying eligible. Art. 2.3 and 10.7 state that the paying eligible are people engaged in the informal sector who are not pensioners, non-governmental organization (NGO) employees, or public servants. Furthermore, employees and owners of enterprises whose employees number less than 10 are eligible to join CBHI by paying annual contribution. If one spouse in a household is in one of the above groups – pensioner, NGO employee, public servant, employee of an enterprise with a staff of not less than 10, or owner of an enterprise with staff not less than 10 – they are not eligible. Dangila town generally adheres to the above directives and thus considers 75% of its population as belonging to the informal sector; In one departure from the directive, Dangila enrolls employees and pensioners whose monthly salary is less than 1,500 Birr. [3]

Not all towns and schemes interpret what constitutes the informal sector in the same way. In SNNP, for instance, most key informants do not understand the targeting of CBHI to the urban informal sector. Eligibility for CBHI membership follows a simple rule that is unrelated to the informal sector. Any resident of the town except government employees and pensioner are eligible to become CBHI members, as long as they pay the annual contribution. Moreover, persons who are considered to be in the formal sector, such as traders and business people in the private sector, can join CBHI; the key informants could not explain why. Some people in the informal sector have not been allowed to enroll in CBHI simply because they could not present documentation such as proof of residence in the towns.

Sodo town even encourages well-off residents to join CBHI on the grounds that they pay the scheme membership contribution but are unlikely to use health center services much. Key informants in the other towns said that they are looking into how they can copy this practice. But they also admitted there are challenges in allowing these ineligible people to enroll into CBHI. Some argued that it is morally unacceptable to enroll the well-off but not poor pensioners. It also violates the directive.

There were other instances, in all visited towns, in which ineligible people were found to be enrolled in CBHI. This happens deliberately and by honest mistake. Some kebele cabinet members allow ineligible people to join CBHI for two reasons. One is when a household member is a cabinet member. The other is when a kebele cabinet members does not want to deal with the complaints of a pensioner or otherwise ineligible household as they are very poor. In a few cases, ineligible people are allowed to enroll by mistake and when this is identified, corrective measures are taken. For instance, some households try to enroll under the name of a spouse who fulfills the criteria for informal sector (as allowed in Dangila town). There is no system to identify this. If somebody later informs CBHI staff or if CBHI staff happen to know that the member is not eligible, the membership is immediately cancelled. In Bure, the CBHI office informed by letter the kebele administration where the ineligible enrolled household resides. But in most cases, kebeles resist correcting mistakes. Because ineligible enrollment is increasing, the CBHI office presented the case to the board in 2013, and the board clearly directed the kebeles to take remedial action. Why the CBHI office does not take action is unclear. This is still a gray area that needs to be fixed.

In addition, each village and kebele has assigned kebele cabinet members to coordinate renewal, new enrollment, and contribution collection. These people should be responsible and accountable for any mistakes they made. The problem, however, is that most of these people work for free and it is morally unacceptable to penalize them, particularly if their mistake is unintentional. This is another gray area that needs to be fixed.

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[3] We did not check whether this is contained in the in the bylaws of the scheme.

To recap, identifying the paying eligible population is difficult. Schemes do not have any guiding/operational manual. Scheme staff do not have a system or objective information for identifying households who are in the informal sector.[4] The current practice seems to be that schemes are trying to enroll anyone who is willing to pay except public employees, either to increase the enrollment rate in order to score high or to increase scheme revenue as financial problems emerge. This will be a serious problem when social health insurance is implemented. There is a need to clarify and produce an operational manual that makes clear who in the informal sector is eligible. The scheme in consultation with revenue authorities at different levels and offices in charge of small and microenterprises should produce such a manual to help scheme staff and the town administration to generate objective information so as to identify households in the informal sector.

4.2.2 NON-PAYING (INDIGENT) MEMBERS

Per the design of the CBHI program, identification of households that are eligible to be non-paying CBHI members is to be transparent and carried out by kebele cabinet members and assigned/elected workers from the villages. It is assumed that these people know the economic status of each household. But there is no operational manual/guideline for how indigents are to be identified, or for how the 10% of the population identified as indigent is to be is calculated or how indigency is distributed across kebeles. KII and FGD participants gave different definitions for identifying indigents. These included "those who cannot afford to pay the contribution by saving at least one Birr per day per family," "those who are the poorest of the poor," and "those who cannot visit health facilities when they are sick." The CBHI directive advises schemes to work with their local Social and Labour Affairs Office for identification of indigents. Not all towns do this. Nor is the process transparent everywhere. There should be clear criteria and a process for all towns and a double-check mechanism to ensure transparency.

In Amhara, the 2017 directive tried to rectify these gaps; its Art. 11.1 stated that selection of indigents should follow the fee waiver system for poor people as presented in part 5 of regulation 39/1998. But no town follows it. From the discussion with key informants and FGD participants, this is left to the subjective judgment of those who are expected to identify indigents by house-to-house visit.

Amhara has tried to improve transparency. In the towns that the assessment team visited, names of eligible households identified by kebele cabinet members in rural kebeles (under the town administration) are presented at church and other forums and the community is asked to comment on their status. For town kebeles, this is done at village meetings. The list of households that is validated through this process is further reviewed at the kebele level. The list from each kebele is consolidated by the town administration and shared with the health office (CBHI scheme) for budget purposes and identification (ID) card preparation. This is practiced in most of the visited towns every three years. Indigent status can be renewed automatically for two years.

In SNNP, the process of selecting indigents is not transparent. Departing from CBHI design, the list is not presented for verification in large community groups. According to KII and FGDs participants, this has led to the exclusion of households that should have been included and the inclusion of households that are better-off than those left off the list of indigents. When there are challenges to the final list, the town administration intervenes in the kebeles. Community members often make their complaints on indigent selections in person at the CBHI scheme.

With regard to the proportion of indigents, most towns consider up to 10% of their residents as indigent (Art. 11.1, Directive No. 1/2013 of Amhara region). As mentioned in Section 4.2.1, Dangila town takes an approach that differs from the directive. The scheme considers 75% of the town

[4] The only clear information that is applied across all visited towns is that public servants and pensioners are not eligible.

population as engaged in the informal sector and calculates the maximum number of indigents as 10% of the population in the informal sector.

How this 10% is applied across kebeles is not clear in most towns. Whether it is distributed proportionally to each kebele or a matter of simply accepting the list that comes from each kebele is not clear. It seems most schemes simply accept the kebeles' lists and the town level assesses if this is too many households (more than 10% of residents). In Finote Selam, the indigent target is not applied across all kebeles proportionally. The level of poverty in each kebele is considered, though it is subjective. As long as it is within the 10% limit at the town level, there can be different proportions of indigents at the kebele level; that is, some kebeles could have more than 10% of their population as indigent and others could have less. The Finote Selam approach should be considered as a best practice, as poverty is not usually distributed equally among kebeles.

As per the CBHI directive, identification of indigents is carried out once in three years. The directive allows for cancelling and adding indigents every year depending on the economic status of each household, but schemes do not do this generally. There are, however, some individual cases in which the kebele administration notified the town health/CBHI scheme during renewal time to add or remove some indigent members. The zonal health department/CBHI coordination committee also has instructed the town CBHI scheme to add people as indigents every year. For instance, for the current fiscal year, Dangila town was told to include an additional 46 people as indigents, and Bure added 55. Unless there is this kind of notification from the kebele/zonal CBHI, every indigent can renew for two years with no questions asked.

One anomaly of the CBHI design is exclusion of retired government employees from CBHI membership and the benefits of indigent status. A significant number of pensioners are living on a few hundred birr per month. These people operate in the informal sector and are among the poorest of the poor – a significant number of indigents are better off than some pensioners. The question of pensioners not being allowed to enroll as paying CBHI members was mentioned in almost all discussions. Despite the exclusion of pensioners in CBHI design, many CBHI schemes register pensioners as paying member by pretending they do not know their occupational status.

What needs to be fixed is the system for identifying eligible population both for paying and indigent CBHI membership. Now, this task is largely left to the subjective assessment of kebeles and volunteer contribution collectors from villages. No training to do this is provided by EHIA branch offices, regional health bureaus, zonal CBHI boards, or other structure. The schemes in collaboration with the regional planning commission, EHIA, and regional health bureau need to produce a guideline that makes clear the operation of CBHI in urban areas in the following areas: i) how the 10% is calculated, ii) distribution of the 10% target across kebeles, iii) defining the informal sector according to clear criteria so that people will not have difficulty in identifying households, and iv) defining indigents according to clear criteria. Without such guidance, it will be very difficult to operationalize CBHI in urban centers.

4.3 ENROLLMENT AND CONTRIBUTIONS COLLECTION

4.3.1 ENROLLMENT AND SCHEME ESTABLISHMENT

In both SNNP and Amhara, membership decisions at the kebele level are taken by a majority vote (see Art. 8.1 and 2 of Directive No. 005/2012 of SNNP and Art. 9.1 of Directive No. 1/2010 of Amhara region). Once the kebele decides to join CBHI, every eligible household in the kebele is expected to join. In the regulation and directive, the kebele is the decision unit for membership and membership eligibility is making a living from the informal sector. In actuality, membership decisions are made at the household level; that is, the household is the decision unit.

As discussed in Section 4.1, in Amhara region, membership registration and renewal has been done by kebele cabinet members and community volunteers, the latter either elected by the village or assigned by the kebele administration. Usually kebele cabinet members coordinate the activities and the volunteers do the actual work. The new directive has changed this. Kebele employees and public servants who reside in the village will perform these duties. In SNNP, it seems employees of kebele administration are responsible for performing them (see Art. 19, Directive No. 005/2012).

Anyone joining CBHI must fill a registration form. This is a standard form that asks for personal information. The household head is responsible for providing the information, submitting a photograph of each family member, and paying the contribution. According to key informants from the town CBHI staff and ketana/block volunteers, HEWs are assigned to each kebele/village and help members to fill out the membership form and complete the required information on the ID card. In Finote Selam, the HEWs deliver the completed membership form and ID cards to the CBHI scheme, and members collect their processed ID card from the office. In Bure, HEWs perform roughly the same tasks, but the CBHI members themselves take the ID card to the CBHI scheme to get it stamped. In Dangila town, each household head/member applies for membership/ renewal at the kebele office, where HEWs assist them. They hand in their applications to the CBHI scheme and collect their ID cards.

The practice in SNNP is similar. Kebele cabinet members are solely responsible for registering members. They ensure the core family members are authentic, and their details in the submitted forms are accurate.[5] They confirm the additional members actually live with the applying family, and verify that all other details are correct. Kebeles then prepare the family ID cards with photographs of all beneficiaries attached to it and submit them to the town CBHI scheme for verification, stamp, and issuance to beneficiaries. In most cases, members themselves collect their ID cards from the CBHI scheme; HEWs deliver uncollected cards during house-to-house visits.

Previous-year data on CBHI enrollment and renewal by paying and indigents are not readily available from schemes. They are difficult to get mainly because once the report is submitted to the higher body, the scheme does not keep the records in a systematic way. In nearly all visited towns, data for previous years were not readily available. Some data are kept in the personal notebook of the CBHI coordinator. If there is a new coordinator, then there is a need to find the previous coordinator. In Dangila, the assessment team could not get any data for previous years as the coordinator is new and we could not find the previous coordinator. This has been a problem since 2012. Although it is repeatedly brought to the attention of higher bodies and stakeholders, there has been no significant improvement. As indicated in Table 6, the renewal rate of paying members is sometimes more than 100% and also erratic. Because of this we could not draw meaningful conclusions.

Table 6: CBHI enrollment by household

Town	Year	Paying members			Indigents			Total member
		Renewal	New	Total Paying members	Renewal	New	Total indigents	
Worabe	2016/17		1,433	1,433	-	308	308	1,741
	2017/18	1,429	3,602	5,031	308	372	680	5,711
	2018/19	5,031	1,471	6,502	680	120	800	7,302
	2019/20	6,501	810	7,311	800	82	882	8,193
Bodity	2016/17		1,896	1,896		984	984	2,880

[5] The core family includes a family head, a spouse, and their children, including adopted children aged below 18 years. It also includes children whose age is more than 18 if they are handicapped or have a mental illness.

Town	Year	Paying members			Indigents			Total member
		Renewal	New	Total Paying members	Renewal	New	Total indigents	
	2017/18	1,417	794	2,211	984	35	1,019	3,230
	2018/19	2,211	2,785	4,996	477	1,019	1,496	6,492
	2019/20	3,534	3,572	7,106	824	1,019	1,843	8,949
Sodo	2017/18		3,943	3,943		1,740	1,740	5,683
	2018/19	3,092	1,598	4,690	1,740	317	2,057	6,747
	2019/20	3,201	2,089	5,290	2,057	943	3,000	8,290
Butajira	2016/17		2,672	2,672		852	852	3,524
	2017/18	2,672	851	3,523	852	30	882	4,405
	2018/19	3,523	-	3,523	882		882	4,405
	2019/20	3,523	2,676	6,199	882	22	904	7,103
Finote Selam	2016/17	1,367	189	1,556	447	362	809	2,365
	2017/18	2,090	1,052	3,142	809	165	974	4,116
	2018/19	2,235	676	2,911	974	0	974	3,885
	2019/20	2,914	977	3,891	974	226	1,200	5,091
Bure	2016/17	0	3,036	3,036	0	676	676	3,712
	2017/18	2,328	0	2,328	670	559	1,229	3,557
	2018/19	2,493	0	2,493	1,208	21	1,229	3,722
	2019/20	3,432	0	3,432	1,463	11	1,474	4,906
Haik	2016/17	867	167	1,034	556	0	556	1,590
	2017/18	525	1,019	1,544	410	286	696	2,240
	2018/19	995	233	1,228	696	26	722	1,950
	2019/20	1,435	510	1,945	722	28	750	2,695
Kemise	2016/17	2,089	351	2,440	832	0	832	3,272
	2017/18	2,538	493	3,031	832	83	915	3,946
	2018/19	2,926	476	3,402	915	48	963	4,365
	2019/20	3,166	585	3,751	963	52	1,015	4,766

Source: Town schemes

The study also tried to determine why some people enroll in CBHI and others do not. FGDs with scheme members stated that their reason for enrolling was to protect themselves from high health care costs. Some noted that even families that do not have persons with chronic conditions and do not expect to benefit from CBHI in that year joined the scheme out of a sense of community solidarity; they know their friends and neighbors will get health care service even if they do not need to do so. But the most important reason for joining, shared by all participants, is that they have at least one family member who must get health care services throughout the year.

We also held FGDs with non-members. They told us they had adequate information about CBHI but could not afford to join a scheme. They consider paying for future health needs a luxury. Some of them said they would consider joining if they could pay the contribution on a monthly or quarterly basis. Very poor participants stated that they could not afford any payment arrangement.

KII and FGD participants also indicated that there are people who are engaged in trade with better incomes but who do not join because they think health centers provide poor-quality services. Participants in Dangila town, where about 37% of the eligible population is not enrolled, repeated the reasons above but also stated that poor understanding of insurance as an additional reason for not

joining. In some communities, the involvement of kebele leaders is not welcomed because they associated this with politics. The most eager to join are low-income families with a family member who has a chronic illness; they are certain to pay much higher fees if they do not become CBHI members. Such adverse selection puts the scheme at a higher risk of financial unsustainability and puts pressure on the government subsidy.

Furthermore, the assessment team observed that CBHI coverage in the visited towns is low (see Table 7). For instance, among the five towns in Amhara region, enrollment is less than 50% in two towns and less than 60% in two others. The CBHI scheme in Finote Selam was established in the 2006 Ethiopian fiscal year. In the last seven years its coverage never exceeded 55%. This is a source of concern that calls for more, multifaceted efforts. The directives issued by the Amhara regional state in 2017 (Art. 7.3 of Directive No. 1/2010) and SNNP in 2019 (Art. 23.2 of Directive No. 005/2012) stated that the scheme can be established at town level provided that there is a minimum of 5,000 households residing in the town and 50% of the eligible households are enrolled and paid (Art. 7.6a of Directive No. 1/2010). Amhara strengthened this in its November 2020 Directive No. 07/2013, which states a scheme can be established at town level and can allow members to get health services only if enrolled households number at least 5,000 (Art.7.5.b). Coverage (renewal and new enrollment) relative to eligible households cannot be less than 60% (Art. 7.6). The minimum requirement of 5,000 households provides a very small base for sustainable financial mobilization. This is corroborated by the situation in most visited towns in Amhara. As seen in Table 7, most towns do not fulfill the conditions set by the directive. This is a serious concern for the financial sustainability of the schemes in the region.

Table 7: CBHI enrollment (by household) coverage (based on 2020/21 data)

Town	Total households	Eligible households	Total enrollment	Coverage (%)	Percent of eligible from total households
Bure	13,214	10,571	4,906	46.4 (2016/17)	80
Dangila	10,453	7,840	4,920	62.8 (2016.17)	75
Finote Selam	11,743	9,395	5,091	54.2 (2013/14)	80
Haik	7,497	5,997	2,695	44.9 (2016/17)	80
Kemise	10,146	8,117	4,766	58.7 (2015/16)	80

Source: Town scheme

4.3.2 COLLECTION OF CONTRIBUTION

The amount of the contribution is set by the regional health bureau/regional CBHI board/office based on studies on the cost of health services, the population's willingness to pay, and the affordability of the premium.[6] The key informants at the scheme level and zonal level could not confirm such studies had been carried out before decisions were made on the amounts of contributions and registration fees. Also, as reported by scheme staff, schemes have never been consulted on setting the amount of the contribution; however, some schemes do set their own contribution amount.

In SNNP, as per the Directive No. 005/2012, the registration fee is 10 Birr for all people. The contribution is based on the level of the town, irrespective of the size of the household. The annual contribution is 240 Birr for all towns except zonal towns (where the cost is 300 Birr) and the regional capital (350 Birr). This annual contribution covers all core family members. Other family members can

[6] See Directives for both regions.

be included by paying additional 50 Birr (zonal towns 60 Birr and regional capital 70 Birr). If the husband has additional wives, he must pay 50% of the contribution for each wife.

In practice, however, the contribution levels differ from the directive and among the towns. For registration (not paid during renewal), families pay 20 Birr in all towns. Currently the contribution for a core family is 300 Birr for Sodo town; 350 Birr for Butajira town (decided by the zone); 240 Birr for Bodity town; and 500 Birr for Worabe town (decided by the zone); persons with more than one wife add 50% of the core family payment amount for each additional wife; and households pay an additional Birr 50 for each additional family member. The contribution amount for Butajira and Worabe is higher than the amount set in the directive. The increases were made because of large financial deficits in these two schemes.

In Amhara region, the amount of the registration fee and contribution and how they are set differs significantly from that of SNNP. Registration, which is used to be 20 Birr, increased to 50 Birr (five times that of SNNP) as of this fiscal year. The contribution is set based on the size of the household and its economic status. Additional wives can enroll by paying the full amount. Non-core family members used to pay an additional 70 Birr; now, they must pay 100 Birr (see Table 8). This significant increase is due to the financial problems encountered by most schemes. Although the increases are appreciable, they might not be enough to secure the financial position of the schemes unless strong efforts are made to increase the coverage of CBHI.

Table 8: Amount of contribution in Amhara region (Birr)

	Household size			Registration	Additional family member
	1-5	6-7	8+		
Town resident	400 (350)	480 (420)	550 (490)	50 (20)	100 (70)
Taxpayer with rank of (ሐ)	450 (400)	550 (480)	650 (560)	50 (20)	100 (70)
Taxpayer with rank of (ለ)	700 (same)	850 (840)	1,000 (980)	50 (20)	100 (70)
Taxpayer with rank of (U)	1,200 (same)	1450 (same)	1700 (same)	50 (20)	100 (70)

Source: Directive No. 1/2010 of 2017 and Directive No. 07/2013 of 2020

Note: Figures in parentheses are the contribution rate used before 2020/21.

All visited towns have been implementing the new rate except Kemise, which has applied its own significantly higher rates to improve the financial position of its scheme (see Table 9). The Kemise experience (high annual contribution) should be closely monitored. If it is successful with its enrollment and renewal rate, it could be a lesson for others. Kemise uses the categorization of those engaged in informal economic activities for tax purposes.

Table 9: Amount of contribution in Kemise town (Birr)

	Household size			Registration	Additional family member
	1-5	6-7	8+		
Category of tax payer	1,000	1,200	1,400	100	500
Taxpayer with rank of (ሐ)	1,200	1,400	1,600	100	500
Taxpayer with rank of (ለ)	1,400	1,600	1,800	100	500
Taxpayer with rank of (U)	1,600	1,800	2,000	100	500

Source: Dessie EHIA branch

What is more worrisome is the contribution collection system. Collection is done through house-to-house visits, every day throughout the day for one or two months. In Amhara, collection is done at the

village level by elected/appointed volunteers and assigned kebele officials.[7] Only one kebele official can accept the money they collect, at the latest every other day, and deposit it into the CBHI account twice a week. This person also distributes receipts to village-level collectors. In Dangila town, village volunteers are allowed to directly deposit the contributions collected into the CBHI account on behalf of the kebele official, and submit the bank slip to the official. The official submits the bank slip to the town CBHI scheme once or twice a week. There is also regular contact either physically or by telephone. This limits the opportunity for the money collected to be used for other purposes.

Most visited towns are doing this, although Haik is an exception. In Haik, only kebele officials collect the contribution. Village volunteers accompany the kebele officials only to help with the collection. In Finote Selam and Haik members are not allowed to pay their contribution at the CBHI scheme office and neither they are allowed to deposit to CBHI account directly.

Collection is done during house-to-house visits made throughout the day for one or two months. This is time consuming and tiring for the collectors, who complain that there is no incentive for this laborious exercise. In SNNP, the suggested incentive of collectors being able to keep 2% of what they collect, is not implemented, and any payment is irregular and a very small amount. The discussion with the CBHI coordinator in Amhara region revealed that the incentive remuneration is effected only if the performance is more than 50% of the kebele plan for renewal and new member registration. This amount, if at all paid, is divided among many village-level contribution collectors and is very small.

In addition, when it is paid, it does not reach the volunteer collectors, who told the assessment team the following.

Town Scheme A

> I am responsible for contribution collection at village level. We are escorted by HEWs and representative of the development groups from sub-villages. Whatever I collect I will submit to the kebele-level coordinator. She is a kebele cabinet member. I have worked for the last five years (since its establishment). It is a pity that there is not any kind of incentive for this tiring work. In 2018/19, I have fought for payment and managed to get 365 Birr. Because of this the kebele administration was not happy and I refrain myself from this activity in 2019/20. This year (2020/21) the kebele administration asked me to rejoin the contribution collection. I have worked for three months with no payment. I heard 2% of the collected amount is paid for kebele officials. This is not fair.

Town Scheme B

> I am responsible for contribution collection at kebele level elected by the community (rural kebele under Bure town administration). Under this kebele there are 14 villages and each village has contribution collector elected by the village community. I will collect the money from village-level collectors every three days. I deposit to the bank every three days. I have been engaged fulltime for three to four months starting from community mobilization for the last two years with not any remuneration. I cannot continue like this. There has to be some kind of remuneration. There is rumor that kebele cabinet members are paid but we never get any incentive.

Town Scheme C

> I am employee of Kebele 02 and responsible for contribution collection for Village 1. I am supported by HEWs and representative of the development groups of sub-villages. I have to visit

[7] HEWs and leaders of the development group (of 20 to 30 households) also escort the contribution collectors for efficient and effective collection.

> 177 households for contribution collection. There are cases where I visit a household more than two times. When I visit, the house the head of the household is not around and when s/he is available there may not be enough money. After all-day house-to-house visits, I visit banks to deposit what I collected. By the time I reach there, there is a long waiting time. Furthermore, bank refuses to receive more than 5,000 Birr. We brought this issue to the attention of the CBHI scheme and the office managed to open a new account at Amhara Credit and Saving Institute and the Commercial Bank of Ethiopia also agreed to accept more than 5,000 Birr. The whole exercise is very tiring. There are people whom I know that have problems with their legs and even referred to visit Bahir Dar hospital. One volunteer ended up staying at home because of the problem with her leg. Usually we bought shoes for this purpose. Despite all these efforts we provide to the scheme, there is not any incentive. I have been serving for the last two years with no remuneration. This is very unfair.

The discussion with the town CBHI coordinator revealed that 2% is paid. But it is paid, as per the letter from the kebele, to kebele-level coordinators who are kebele officials. It is up to the coordinators to distribute money to the village volunteers, who do the actual work of house-to-house visits.

In general, there is no systematic way of handling the 2% payment. The present system needs to be reexamined – it would be better to design a system of collection and remuneration. Otherwise, volunteers many refuse to keep collecting. Likely alternatives are to allow members to pay their contribution either at the CBHI scheme or deposit it into the CBHI account directly and submit the bank slip for proof of payment. While encouraging this, the health office could also deploy HEWs to do the job for a top-up payment.

In SNNP, contributions are collected by the kebele officials. The kebele administration ensures that all cash collected is deposited into the CBHI account opened at Omo Micro Finance and the Commercial Bank of Ethiopia (at the end of the day or at latest on the next day. Even with this additional day, there have been instances of the collected money not being deposited on time; court cases of missing cash were also reported but were not significant or a source of concern.

There are two types of government subsidy: The targeted subsidy covers the entire contribution of people registered as indigents (70% is paid by the region and 30% by the town administration). The other subsidy is known as the general subsidy. It is paid by the Federal government and covers 10% of the contribution collected from members, including indigents. The general subsidy transfer is made only after towns complete contribution collection and secure the targeted subsidy, as verified by bank statement. Once this is produced, the EHIA branch office will deposit the general subsidy directly to the scheme account. The town administration's 30% share of the targeted subsidy also is directly deposited to the CBHI account. But the transfer of the 70% that comes from the regional state is not deposited directly to the CBHI account. Instead, it is deposited in the town finance office account, which is supposed to transfer it on to the CBHI account. According to KIIs with visited schemes in Amhara region, this transfer poses difficulties as the town administration usually uses it for other purposes, and it is time consuming. The KII with the Dessie EHIA branch revealed there are also cases where the town administration withdrew money from the CBHI account to use it for something else. The best solution is to adopt the transfer system of the general subsidy. The regional health bureau, by making the targeted subsidy part of its budget, can transfer it directly to the town health office account, which hosts the CBHI scheme account.

4.4 HEALTH SERVICE

4.4.1 QUALITY OF HEALTH SERVICES

All health centers visited agreed that they are not meeting the standards in regard to required service provision. There are too few health professionals and rooms for the inflow of patients. The major complaints regarding health service quality, however, are about the lack of drugs and diagnostic facilities at both health centers and hospitals (KIIs with CBHI staff, health centers, and EHIA branch office). Patients are referred to private facilities for imaging, chemistry tests, and drugs. Health professionals at health centers recognize this as a problem and in interviews attributed it to the CBHI-related increases in patient flow. The number of people health centers serve is often higher than the set standard which also contributes to poor quality service delivery. One of the visited health centers, in Bure, is providing services for the town's more than 65,759 people; it also serves members of a rural woreda CBHI scheme. The situation is the same in Haik. The Haik health center has a contract with the town CBHI scheme and rural woreda scheme, and people from two nearby woredas also use the health center. Patient file numbers at the one health center have reached six digits. This makes it difficult to provide high-quality services.

The problem with drugs is related to the Ethiopian Pharmaceutical Supply Agency (EPSA). Public health facilities are required to procure drugs from EPSA. According to the head of town scheme D health center:

> EPSA does not have the capacity to provide what is required. The maximum that it can provide is 30% of what is requested. What is even worse is we are not able to purchase drugs from private pharmacies, as EPSA does not authenticate stock-out status as quickly as required in government procurement procedures. The health center is usually procuring drugs from another supplier, which is very expensive. For instance, a box of paracetamol, which the health center used to buy for 400 Birr from EPSA, was bought for 2,000 Birr, five times more expensive, from private supplier. The health center is selling this and adding a 25% profit margin. CBHI members are frequently visiting the health center. It is very common for CBHI members to visit a health center before they finish the prescribed drugs and need further investigation and/or other drugs. There is also a rumor that CBHI members are selling drugs to the private pharmacy.

At FGDs, CBHI members were asked if they had ever not been able to get a needed diagnostic service and/or drugs prescribed by the health professional, and if so, how frequently that happened. Respondents agreed that the shortages of drugs and diagnostic services are less frequent than they were at the beginning of CBHI. But shortages still are a concern. When patients are unable to get prescribed drug in the health center's pharmacy, they are referred to a private facility. This poses two problems: First, the prices there are high and patients may not be able to pay immediately, complicating their health problem. Second, reimbursement for out-of-network purchases is not automatic. It can take months and recently members have not been reimbursed at all (in Finote Selam since August 2020). Furthermore, the new directive being implemented in Amhara region stated that reimbursement is based on the price in a public health facility, which means there is not full reimbursement. Reimbursement has already emerged as an issue in all towns visited in Amhara region, and the new directive will exacerbate this.

Some schemes are trying their best to improve the health services by having contracts with different facilities for drugs and diagnostic facilities. The scheme in Finote Selam, for instance, has contracted with the Red Cross pharmacy for drugs, and this has ameliorated the problem of drug availability. The scheme is also preparing to contract with private diagnostic facilities. This should be scaled up, which has a positive impact on the uptake of the insurance. Bure health center tries to solve the problem of

shortages by borrowing from surrounding health centers. For instance, as we did the interview, the head of the health center was sending two people to bring drugs for children under five from surrounding health centers.

In SNNP, despite CBHI members being frequently referred to private health facilities, there is no reimbursement at all. This situation, which clearly results from the government health facilities not being able to keep an available stock, is a serious complaint of CBHI members. FGD participants stated "we are promised to get the standard services from the contracted health facility and pay nothing other than the membership contribution. Why are members penalized for the government's failure to making services unavailable?" This serious problem is a challenge for the scheme, which wishes to increase coverage and widen the base of the pool.

Health centers in each visited town were asked to grade the quality of their services in terms of availability of staff, drugs, diagnostic services, and waiting time. As seen in Table 10, most health centers rated themselves below average. Among the eight health centers, half are poor in waiting time, attitude and motivation of staff, and availability of essential medicines.

Table 10: Health centers' service quality self-grading

Health center	Waiting time	Availability of staff	Attitude and motivation of staff	Availability of diagnostics	Availability of essential medicines	Cleanness of the facility
Finote Selam	Fair	Very good	Fair	Good	Fair	Very good
Bure	Fair	Good	Good	Fair	Fair	Good
Dangila	Very good	Very good	Very good	Good	Very good	Very good
Haik	Fair	Good	Fair	Fair	Fair	Very Good
Sodo	Very good	Very good	Fair	Good	Good	Good
Bodity	Good	Good	Very good	Very good	Good	Very good
Butajira	Fair	Very good	Fair	Very good	Fair	Very good
Worabe	Good	Very good	Very good	Good	Good	Good

Source: Compiled from KIIs.

In almost all visited towns, there is no regular and structured system to monitor the quality of health services.[8] While all health centers visited hold a morning general health education session with clients, very few have a systematic quality monitoring system. Dangila and Haik health centers conduct patient exit interview every quarter on a fairly regular basis. The findings are discussed among the health centers management and board for further actions. Finote Selam and Haik health centers do a quarterly satisfaction survey targeting village representatives and findings are discussed with the board for further action.

Dangila holds a quarterly community provider forum that brings together the board, health professionals, and community (up to 20 representatives from each kebele) to discuss the health services provided by the health center. Dangila health center also makes other efforts to raise its quality services. The health center has a system of client identification that reduces waiting time. Clients are identified by follow-up, emergency, and new visitor. Files (cards) for follow-up clients are pulled a day before their appointment, and when clients arrive at the health center, they immediately are referred to the outpatient department. The health center has three counters: for under-fives, for CBHI members, and for paying clients. Because of this, new patients are served without a long wait. The health center also reviews its drug inventory regularly. Each team/unit (laboratory, outpatient/examination, pharmacy, etc.) evaluates its activity once a week. This tells the health center which drugs were in high demand in the

[8] Clinical audit can be mentioned as a regular quality ensuring system but limited to patient files.

preceding week. Based on this assessment, the health center plans its drug procurement. As can be observed in Table 10, Dangila health center is by far better than the others in its provision of quality services. Dangila has also enjoyed financial support from the town administration. In 2020/21, the town administration provided 450,000 Birr to the health center for procurement of drugs.

4.4.2 HEALTH SERVICE UTILIZATION

All of the key informants interviewed suggested that CBHI members have better health-seeking behavior and a higher service utilization rate than non-members. In fact, CBHI members are often criticized for overutilization of health centers. All contracted health centers experienced an increase in health center visits immediately after CBHI started covering members. Table 11 presents trends in outpatient care utilization at health centers in the two regions. The number of outpatient visits by CBHI members is compared with the number of visits by non-members. Two important differences stand out: One is the speed at which the number of outpatient visits by members increased compared to non-members. The second is that some towns (Worabe, Haik, Bodity) have seen an increasing trend in member utilization whereas non-member utilization has declined. Please note that most health centers are serving non-members from other areas.

In general, health care utilization has increased tremendously for CBHI members and not for non-members. The introduction of CBHI is believed to have increased members' health-seeking behavior, which contributed to the significant increase in utilization. This will undoubtedly increase the revenue of health facilities.

Table 11: Trends in outpatient visits and referrals to hospitals by health centers (2016-2020)

Health center	Year	Outpatient visits CBHI	Outpatient visits non-CBHI	Referrals to hospitals CBHI	Referrals to hospitals non-CBHI
Haik	2017/18	3,676	8,113	300	-
	2018/19	28,694	35,424	1,089	-
	2019/20	38,206	18,504	384	-
Kemise	2017/18	5,620	11,446	448	-
	2018/19	29,672	85,909	2,953	-
	2019/20	16,621	58,945	1,853	-
Finote Selam	2016/17	10,558	70,732	4,866	14,178
	2017/18	10,809	79,185	5,824	13,172
	2018/19	15,306	58,916	8,252	9,001
	2019/20	14,697	55,913	9,561	10,154
Bure	2016/17	2,915	26,780	367	101
	2017/18	5,931	27,000	774	127
	2018/19	13,275	27,810	4,101	143
	2019/20	13,790	30,357	3,919	228
Worabe	2016/17	6,333	59,356	565	1,250
	2017/18	13,921	58,790	2,516	1,893
	2018/19	29,766	32,765	9,268	3,473
	2019/20	42,742	31,254	11,488	3,828
Bodity	2017/18	3,711	27,789	598	38
	2018/19	6,969	26,031	1,766	27
	2019/20	6,296	26,421	2,202	46
Sodo	2017/18	2,415	56,615	212	1,765

Health center	Year	Outpatient visits CBHI	Outpatient visits non-CBHI	Referrals to hospitals CBHI	Referrals to hospitals non-CBHI
	2018/19	3,478	62,690	389	1,900
	2019/20	3,742	86,951	496	2,185
Butajira	2016/17	2,151	28,752	669	4,126
	2017/18	5,867	43,214	1,236	3,189
	2018/19	10,367	108,867	3,213	2,917
	2019/20	18,176	108,005	3,861	2,671

Source: Contracted health centers in selected towns

4.5 OBSERVED BENEFITS FROM CBHI

All heads of health centers interviewed agreed that the introduction of CBHI has had positive impacts such as i) increased health seeking by the community, ii) increased service utilization by members, iii) increased revenue for health facilities, and iv) increased quality of services at facilities. Contracted health centers have seen their financial resources increase (see Table 12) as a result of increased volume and frequency of CBHI member visits (see Table 11 above, in Section 4.4). Every additional patient visit generates more revenue that the health centers retain. The increased revenue has allowed health facilities to improve the quality of their service provision, as they spend the retained revenues on drugs, laboratory reagents, medical equipment, and facility renovations. The improved quality has in turn led to even more service utilization.

Table 12: Revenue from selected health center by source (2016-2020)

Health center	Year	Budget from gov't (Birr)	Revenue from CBHI patient services (Birr)	Revenue from non-CBHI patient services (Birr)	Revenue from other sources (Birr)	Share from total revenue (in %)			
						Budget from gov't	Revenue from CBHI patient services	Revenue from non-CBHI patient services	Revenue from other sources
Bure	2016/17	2,794,413	194,200	312,412	2,000	84.6	5.9	9.5	0.1
	2017/18	3,561,873	519,719	541,044	2,280	77.0	11.2	11.7	0.0
	2018/19	4,730,975	743,015	359,034	8,636	81.0	12.7	6.1	0.1
	2019/20	5,933,800	982,761	350,730	21,318	81.4	13.5	4.8	0.3
Kemise	2016/17	3,520,488	532,371	1,081,014	13,875	68.4	10.3	21.0	0.3
	2017/18	4,362,870	965,989	583,162	9,510	73.7	16.3	9.8	0.2
	2018/19	4,800,731	1,735,010	407,893	27,210	68.9	24.9	5.9	0.4
	2019/20	5,929,943	958475	671,359	9,683	78.3	12.7	8.9	0.1
Haik	2016/17	4,000,565	853,642	572,520	40,288	73.2	15.6	10.5	0.7
	2017/18	4,559,295	925,998	790,165	51,274	72.1	14.6	12.5	0.8
	2018/19	4,228,867	883,477	1,063,376	84,709	67.5	14.1	17.0	1.4
	2019/20	4,794,052	547,807	117,399	17,604	87.5	10.0	2.1	0.3
Finote Selam	2016/17	3,326,450	287,471	971,458	4,801	72.5	6.3	21.2	0.1
	2017/18	4,380,108	674,047	362,284	19,261	80.6	12.4	6.7	0.4
	2018/19	4,924,596	621,339	377,473	44,252	82.5	10.4	6.3	0.7
	2019/20	5,716,257	836,050	424,027	2,000	81.9	12.0	6.1	
Worabe	2016/17	100,000	7,010	65,435		58.0	4.1	37.9	
	2017/18	120,000	16,719	58,449		61.5	8.6	29.9	
	2018/19	200,000	46,898	31,081		71.9	16.9	11.2	
	2019/20	400,000	54,667	23,395		83.7	11.4	4.9	
Sodo	2017/18	6,893,290	65,654	149,346		97.0	0.9	2.1	
	2018/19	7,186,088	95,176	2,261,324		75.3	1.0	23.7	
	2019/20	11,861,269	186,678	2,599,322		81.0	1.3	17.7	

Health center	Year	Budget from gov't (Birr)	Revenue from CBHI patient services (Birr)	Revenue from non-CBHI patient services (Birr)	Revenue from other sources (Birr)	Share from total revenue (in %)			
						Budget from gov't	Revenue from CBHI patient services	Revenue from non-CBHI patient services	Revenue from other sources
Butajira	2016/17	485,378	123,726	2,267,759		16.9	4.3	78.8	
	2017/18	243,727	297,669	2,475,645		8.1	9.9	82.1	
	2018/19	442,108	761,530	2,759,033		11.2	19.2	69.6	
	2019/20	437,404	1,181,642	2,103,774		11.7	31.7	56.5	

Source: Contracted health centers in selected towns

As can be observed from the table, with the exception of Haik, revenue collected from CBHI for providing services to members has increased much faster than any other source, including the government budget. The share of most health centers' revenue from CBHI member services is consistently increasing while the share of other sources is declining. The increased inflows of CBHI clients (see Table 11 above), with their more demanding behavior than non-members, has created pressure to improve services, and the revenue they bring to health centers has enabled the facilities to make improvements.

Claims for reimbursement by health centers are subjected to a clinical audit, which is based on sample patient files from the claim. The clinical audit checks whether:

a) The patient's medical history is written on their personal file/card;
b) Patients are CBHI members and have renewed their membership;
c) The prescribed medicine written on the prescription slip also is written in the patient's file;
d) The prescribed medicine is relevant to the patient's medical history;
e) The prescribed diagnostics are written in the patient's file; and
f) The health professional signed the patient's file.

Findings are extrapolated to total service delivery. Based on this, health centers might be penalized for discrepancies between their claims and the audit's findings. However, no major gap has been observed so far and the fines the health centers received are not significant. This is mainly because schemes are located in health offices which allows health centers to work closely with schemes. This enables health centers to be aware of clinical audits before they occur and take precautions ahead of time. In hospitals, audits found more serious discrepancies. For instance, the Finote Selam scheme saved 87,000 Birr in 2019//20 claims from Finote Selam hospital and 39,000 Birr in the second quarter of 2020/21 after the audit was conducted and the books reconciled.

Because of the clinical audits, health centers have become proactive in taking quality improvements measures in line with the requirements of the clinical audit manual. All those interviewed agreed that the benefits that health centers have enjoyed due to compliance with the clinical audit far outweigh any penalty related to it, and that the clinical audit has encouraged health professionals to take maximum care in consulting patients and recording their history. This has improved patient files and made follow-up treatment more effective.

4.6 CHALLENGES ARISING FROM CBHI MEMBERS

Most health centers told the assessment team that some CBHI members abuse their privileges: they visit frequently, make return visits before they finish the prescribed drugs, visit just to get a referral letter, and sometimes display aggressive behavior in demanding services. All of this increases the health center's workload (see Table 11 above) and have made health professionals tired of seeing the member patients. One health professional now sees about 70 clients in a day compared to an average of less than 35

patients pre-CBHI. The number of health professional staff has not increased to match the increase in visitors.

As reported in KIIs with health center heads, unnecessary health seeking by CBHI beneficiaries is a problem. When CBHI started, members visited the health center when they had nothing else to do, or if they did not feel better even before they finished their prescribed drugs. The health center and CBHI staff had to educate the community that this behavior is harmful to everyone, because it could complicate their health and will create overcrowding in health centers. Health center staff now monitor overutilization by thoroughly checking patient files; for instance, Dangila checks eight files every week. When they find something inappropriate, they discuss it with the client and try to rectify the behavior. Educating the community and following up abuse found in patients' files have served to deal with the problem of unnecessary visits. This should be recognized as a good practice and scaled up to other schemes.

As noted above, key informants from all health centers visited also reported that CBHI members are visiting health centers just to ask for a referral, because they prefer seeking care in higher-level facilities. This is a serious problem in most health centers.

4.7 FINANCIAL SUSTAINABILITY

The CBHI scheme has three sources of revenue: contributions from paying members, targeted subsidies provided by the town administration and regional states for indigent members, and a general subsidy provided by the Federal government. All schemes retain 100% of the revenue except for Dangila, where 25% is transferred to zonal pool.

The capacity of scheme revenue to finance the health service bill is declining. Among the eight visited schemes, the capacity of four schemes (Bure, Bodity, Sodo, and Butajira) to cover all the claims they receive from contracted health facilities is declining though they can still cover them (see Table 13). The four other schemes (Worabe, Kemise, Haik, and Finote Selam) cannot cover all the claims they receive (see Table 13). This happened with Finote Selam and Haik schemes in 2019/20 and the town administration had to bridge the gap. Finote Selam town administration subsidized close to 800,000 Birr. In Haik, the scheme twice could not settle claims from Dessie hospital and Haik health center. Because of this, Dessie hospital cancelled its contract with the Haik scheme in early July 2019 and took the scheme to court. After few months, Haik health center also stopped providing services for CBHI members in early November 2019; but it was only for four days as frustrated CBHI members demonstrated, and this forced the town administration to intervene and settle the claim. It supported the scheme to the amount of about 3 million Birr and the scheme renewed its contract with the health facility. The scheme still has concerns that it may not be able to cover the claim for the fourth quarter of 2020/21. It should be noted that scheme revenue goes only to paying claims; operational costs like CBHI staff salaries, printing of receipts and ID cards, purchasing and maintenance of office equipment, a motorized bicycle, community mobilization, and general assembly meetings are covered by the town administration and EHIA branch office, and not by the scheme.

Revenue from the scheme and payments to health facilities have increased over time as the coverage of CBHI and frequency of visits increases. But the rate at which payment of health services increases is outpacing growth of scheme revenue. There are schemes in both regions that completely failed to settle claims of health facilities. In the visited towns, half of the schemes are in financial crisis.

The capacity of the contribution to cover members' health service utilization, that is, the ratio of contributions to claims has steadily declined. This needs serious attention before schemes completely collapse. In most schemes revenue is limited by the small size of the eligible population and low level of enrollment.

Table 13: Trends in scheme revenue to claim ratio

Town	Year	Scheme revenue	Scheme expenditure	Revenue to claim (%)
Haik	2017/18	817,552	823,833	99.2
	2018/19	781,757	1,065,194	73.4
	2019/20	1,054,290	1,176,482	89.6
Kemise	2017/18	1,724,636	1,875,676	91.9
	2018/19	1,928,122	2,139,754	90.1
	2019/20	2,497,856	4,395,597	56.8
F. Selam	2016/17	909,322	925,720	98.2
	2017/18	1,790,373	1,216,545	147.2
	2018/19	1,566,296	1,757,817	89.1
	2019/20	1,862,896	2,536,252	73.5
Bure	2016/17	549,258	642,905	85.4
	2017/18	2,171,286	705,549	307.7
	2018/19	1,983,357	1,359,260	145.9
	2019/20	2,861,370	2,060,938	138.8
Worabe	2016/17	435,939	413,008	105.6
	2017/18	1,968,673	1,476,528	133.3
	2018/19	2,398,428	3,693,784	64.9
	2019/20	2,539,817	4,380,840	58
Bodity	2017/18	714,483	202,000	353.7
	2018/19	1,330,633	568,292	234.1
	2019/20	1,208,390	1,020,479	118.4
Sodo	2017/18	2,436,507	295,130	825.6
	2018/19	2,290,668	425,173	538.8
	2019/20	2,802,490	623,075	449.8
Butajira	2016/17	920,569	329,152	279.7
	2017/18	1,905,249	858,003	222.1
	2018/19	1,877,071	1,730,595	108.5
	2019/20	2,619,503	2,463,089	106.4

Source: Town scheme

The problems associated with the financial crisis are various. First, health facilities are not delivering the services as per the contract and this exposes CBHI members to go to private facilities by paying out-of-pocket, which later must be reimbursed by the CBHI schemes. Out-of-pocket expenditures have increased much faster than all other expenditures. For instance, in Bure, while out-of-pocket spending increased 6.5 times over the last four years, total expenditure increased by only 3.2 times. In Finote Selam, these numbers are 11.3 times and 2.7 times, and the same is true for other visited towns (see Table 14). The share of out-of-pocket expenditure from total scheme expenditure has increased to 30%, 21%, 22%, and 25% in 2019/20 in Bure, Kemise, Haik, and Finote Selam, respectively.

Table 14: Patterns of scheme expenditure (Birr)

Town	Year	Scheme revenue	Scheme expenditure				
			Health center	Hospital	OOPE*	Total	Other expenditure
Bure	2016/17	549,258	281,900	263,331	97,674	642,905	127,323
	2017/18	2,171,286	332,817	255,014	117,718	705,549	338,906
	2018/19	1,983,357	506,389	669,323	183,548	1,359,260	552,923
	2019/20	2,861,370	654,493	771,120	635,325	2,060,938	593,028
Kemise	2016/17	1,459,581	519,876	353,408	115,000	988,284	154,620

Town	Year	Scheme revenue	Scheme expenditure				
			Health center	Hospital	OOPE*	Total	Other expenditure
	2017/18	1,724,636	943,535	787,141	145,000	1,875,676	159,955
	2018/19	1,928,122	690,743	542,432	906,579	2,139,754	190,200
	2019/20	2,497,856	607,334	2,858,481	929,782	4,395,597	221,608
Haik	2017/18	817,552	339,526	372,393	111,914	823,833	105,756
	2018/19	781,757	318,622	455,709	290,863	1,065,194	84,216
	2019/20	1,054,290	302,191	610,445	263,846	1,176,482	216,036
Finote Selam	2016/17	909,322	325,022	544,492	56,206	925,720	104,932
	2017/18	1,790,373	324,064	785,113	107,368	1,216,545	165,787
	2018/19	1,566,296	431,036	1,150,177	176,604	1,757,817	300,522
	2019/20	1,862,896	485,960	1,414,579	635,713	2,536,252	313,374

*Out-of-pocket expenditures

Source: Towns scheme

Second, the size of each scheme is very small, which limits the pool. In some towns, less than 50% of the eligible population belongs to the scheme and in other towns, it is less than 60% (see Table 7 above, in Section 4.3.1). The recent Directive No. 07/2013 in Amhara stated that schemes should always have 60% net coverage to continue (Art. 7.6). But, as observed in Table 7, only one scheme out of five has a little over 60%. Thirdly, the minimum requirement of eligible population to establish an urban scheme is 5,000 households. In a rural context, most woredas have a population much higher than the minimum requirement. Further study is needed to know if 5,000 households is feasible in the urban context where most residents are expected to be frequent visitors, because geographic access to health facilities is easier, and their health-seeking behavior is relatively better than rural residents. For the same reason, they are also likely to use the referral system more frequently than rural residents. People living in urban areas are more exposed to chronic illness than those living in rural areas, and it is highly likely that those who are chronically ill will enroll in CBHI. These are the observations of KIIs with the CBHI coordinators, heads of health centers, and EHIA branch office.

All the above factors fuel the expenditure side of the scheme. The responsible body should immediately take measures to mitigate the risk they pose to the financial sustainability of the scheme. Possible interventions are the following:

a) Significantly reduce out-of-pocket expenditure by making most services available at the contracted health facility. This will increase members' renewal, encourage new enrollment, and reduce reimbursements of out-of-pocket expenditures.

b) Increase the level of contribution. In this regard, the experience Kemise scheme is encouraging.

c) Significantly increase enrollment of the eligible population. An increase to 75% in the coming two years will solidify the financial position of the scheme. For this to happen, however, there is a need to shift from the existing campaign-type community mobilization to a regular and institutionalized awareness and insurance education. There is still a lack of awareness about health insurance. People think they are healthy and will remain without health problems. This is one of the main challenges for enrollment. For example: A resident of Haik was a CBHI member for two years but did not renew his membership this year because no one in his family had been ill. In June 2021, his wife took seriously ill. When the man visited the scheme to renew his membership, he was rejected.

d) The 5,000 household minimum to establish the scheme at the town level should be significantly revised upward. Towns with a small number of households (for instance, less

than 10,000) can merge with a scheme in a surrounding woreda (Article 7.4 and 56.1 of the new Amhara region directive that allows such mergers). Of immediate concern is that there are several small towns in the process of establishing a CBHI scheme.

e) Thinking should be "out of the box." Currently schemes are established at the town level. An assessment should be done on how to elevate the level (for instance, a zonal-level urban scheme) instead of pooling only a proportion of revenue from each scheme at zone level.

4.8 GOVERNANCE STRUCTURE AND LEADERSHIP[9]

The legal governance structure of CBHI has four levels: general assembly, board, health office, and the scheme under the health office. Other structures also have duties and responsibilities for the CBHI activity: the regional coordinating committee in SNNP and regional CBHI board in Amhara, zone CBHI committee in SNNP and zonal CBHI board in Amhara, as well as the regional health bureaus and zonal health departments.

The CBHI design offers a structure at kebele level. In reality, there is no such structure. Kebele officials are actively involved during renewal time and village volunteers do community mobilization at that time.

Leadership at the higher level only issues directives; their involvement in other areas is not apparent. For instance, the health bureau is responsible for examining the manpower requirements of schemes and for submitting a proposal for human development to the civil service commission of the region for approval. But most schemes are suffering from lack of manpower, particularly for the data-related activities. This is serious in Amhara region. It is very common that data are not readily available, securely stored, and regularly updated. In many cases, data are held at a personal level and usually are not backed up. This is related to scheme implementation and management. Most schemes have failed to use the systems that were designed for data-related activities.

The general assembly and particularly the board at town level are somewhat active although they do not conduct regular meetings. The general assembly, which consists of sectors heads and representatives from each kebele, is mandated to approve all bylaws, and annual plans, budgets, and audit reports. It elects and appoints CBHI members from the general assembly to the town's CBHI board. This CBHI board is responsible for providing general leadership to the schemes. It presents the annual plan and budget to the general assembly for approval; monitors the implementation of plans and budgets; and periodically evaluates the performance of the scheme. The board is mandated to approve the list of indigents prepared by the kebeles and to allocate the targeted subsidy budgets. The board is responsible for the financial audit of the schemes in collaboration with the town finance office. The board is the main vehicle for community mobilization during CBHI membership registration and renewals (see Article 53 of Directive 07/2020 (Amhara) and art. 21 of Directive 005/2019 (SNNP). It mobilizes opinion leaders, elders, health development army, and town cabinet members to carry out sensitization and awareness creation tasks and monitors and evaluates their performance by including CBHI as one of the cabinet members' evaluation checklist. All of the key informants agreed the board performs these tasks very effectively.

While CBHI members are represented in the general assembly and board, they are not represented on health facility boards. The boards do include representation from the general community. But as the percentage of CBHI members from the community increases, it will be fair and meaningful to allot spaces to them. All CBHI coordinators interviewed agreed this should be addressed.

The visited schemes have very strong relationships with the health office, the scheme owner, and with the health centers and town administration. Relationships with the zonal/regional CBHI structure are

[9] This discussion is largely drawn from the Directives of both regions.

more tenuous. The most interesting observation was that schemes have a strong relationship with the EHIA branch office. The EHIA branch offices provide training, support the scheme during the clinical audit and during community mobilization, and provide office equipment and transport facilities, financial support for community mobilization and the general assembly meeting, etc. Although the legal relationship of the scheme with the EHIA branch office is not clear to anyone we interviewed, the functional relationship, as reported by key informants, is very strong.

Another observation is on the staff of the scheme. Most visited schemes in Amhara region do not have a secretary or database expert. Data for this study were collected by staff of the USAID Health Financing Improvement Program and of the scheme. It took appreciable time, and in the end, we found that the quality of data and the disaggregation level was inadequate. What is surprising is that the zonal health department has up to four staff responsible for collecting reports from the CBHI schemes, but their assistance was not visible. The main responsibility of these people, as reported by town CBHI scheme staff, is collecting reports from the scheme. In KIIs, scheme coordinators claimed the zone is not closely monitoring or supporting the scheme. CBHI staff at the town level suggested that some of these staff should work at scheme level or their duties and responsibilities be redefined so that they work closely with the scheme.

There are two concerns about the organizational structure: the relationship between the CBHI scheme and health office and the CBHI section at the kebele level. The scheme and health centers are under the health office. The town health office is a regulator and at the same time leader/owner of the health service providers. The current practices show that the health office is also the provider of health services and at the same time is the purchaser of health services. In addition, the health office through its health centers provides health services, regulates health service provision, and has a role in contracting h health centers on behalf of CBHI members, since the scheme is accountable to the health office and the scheme coordinator is a health office employee. This means the regulator of health services is also the provider and buyer of the services. CBHI, as an insurance organization, should be legally separated from the provider and autonomously buy health services for its members with full decision-making capacity resting in its hands. Currently, CBHI and the health office work together amicably, but this might not be so in the future. The EHIA needs to strategically think before problems arise, and consider how and when these two institutions should be separated or be made independent.

The other concern is the CBHI structure at the kebele level, which is not functioning as promulgated in the directive. Many of its CBHI activities are carried out by volunteers whose work is critical to the success of the CBHI program, yet their role is not institutionalized. They have neither a legal nor an administrative contract and are paid on an ad hoc basis. We do not see a replacement system in the near future, so the ad hoc nature of their engagement is an issue to be dealt with promptly.

There are CBHI focal persons in the health center and hospital, but this structure has never been utilized effectively. As employees of the health facility, they are not introduced to CBHI members and do not report directly to the scheme. There is no coordination between the scheme and health facilities, particularly at the hospital level.

The scheme has a regular reporting system both horizontally and vertically. The scheme prepares monthly, quarterly, and annual reports and shares them with the health office, mayor's office, zonal health department, and EHIA branch office.

4.9 RISK MITIGATION

The risks related to finances are minimal. According to key informants, the financial management system in use from the time contributions are collected to when they are deposited in the banks are different from the way CBHI was designed. The design allows two weeks to deposit the money collected, but what is being practiced allows very few days.

The kebele officials and ketana/block representatives collect contributions from members, deposit them in the bank, and handover the bank slips and receipts to CBHI staff the same day or the next morning at the latest. The scheme and town finance staff reconcile the totals of the receipts and the bank deposit slips. This happens on a regular basis, at least twice a week. These controls leave very little opportunity for fraud. The maximum number of days that collected money can sit with the collectors is two days and this is not very common.

5. CONCLUSION AND RECOMMENDATIONS

By way of conclusion, the following evaluation matrix summarizes CBHI design against what actually happens, with challenges and recommendations for each design feature in the urban context.

Table 15: Evaluation of design features against implementation and urban context

Design feature	Existing design	Practice/ implementation	Challenge	Recommendation
Community mobilization system	The following are responsible for community mobilization: • Zone health department • Zone CBHI board/zone CBHI coordination committee, town health office/CBHI scheme • Town cabinet members • Kebele cabinet members • HEWs and village-level volunteers and development groups in the village	• Scheme staff, town health office, town cabinet members, kebele cabinet members, HEWs, and village volunteers and development groups are active and carry much of the responsibility for community mobilization. • Social groups/organizations including religious leaders, famous individuals, community organizations, and heads of associations are used to create awareness and mobilize. • Health centers are engaged in community mobilization by using the health center client meetings conducted mainly for health education purposes. • EHIA branch offices support financially community mobilization activities.	• There is no regular budget for mobilization activities. Mobilization activities are always covered by asking various stakeholders • Ketana/block level volunteers who shoulder the main burden of community mobilization usually are not paid and, when they are, payment is very small and irregular.	• Make the budget for community mobilization part of the annual plan of the town health office since the scheme coordinator is accountable to the health office. • Revisit the incentive system from two perspective: first, whether it is really meaningful; and second, whether all those involved in the activity are benefitting from the incentive.
Membership	• Done at kebele level • If kebele decides to join the scheme, all households in the kebele should enroll	• Membership decisions are made by households.	• The regulation stipulates that membership decisions are made by majority vote of the kebele. However, it does not say once the kebele decides, it will be mandatory for households to join.	• Revisit the directive and clarify the enforcement mechanism. • Consider making CBHI mandatory. Doing so should be based on evidence from a study on which households can/has

Design feature	Existing design	Practice/ implementation	Challenge	Recommendation
				capacity to pay once and who can pay in installments or connecting community members as there will always be some households who face challenges to pay contributions all at once
Defining and identifying eligible households: • Paying • Indigent	• Paying members are those engaged in the informal sector. • Town and kebele cabinet members and village volunteers are responsible for identifying paying members. • Indigents are the poorest of the poor. • Town/Kebele cabinet members and village volunteers are responsible for identifying the poorest of the poor.	• Any resident of a town except government employees and government pensioners are eligible to become paying CBHI members. • The definition of informal sector is not applicable in practice. • Anyone who cannot afford to pay the annual contribution as determined by the kebele is included in the list. • Kebele officials and village volunteers are responsible for identification, and the town administration approves a final indigents list.	• Defining the informal sector and identifying who is in the informal sector is difficult. There is no guideline that defines it or that identifies who is in it. • Making civil service retirees ineligible for CBHI membership raises issues of fairness. • Some relatively well-off individuals have managed to get onto the list of indigents. In Sodo town, they are encouraged to enroll in CBHI even if they are not indigents. • There is no clear guideline for the selection of indigents, leaving the issue open to abuse. • Selection of indigents is not transparent in SNNP. • Too many very poor people are not covered as indigents. • Significant number of individuals who used to benefit from the old system (free care in public health facilities based on letter from kebele) are cut off from the indigent category because of the quota given to towns.	• Studying the nature of the informal sector and defining who is in it is one solution. But given the nature of the economic engagement of urban households, clear classification into one group will remain a challenge. • Perhaps provision of an exhaustive list of the ineligible would be a better solution. For instance, all public servants, pensioners, NGO employees, employees of bilateral and multilateral organizations, and employees of private enterprises whose staff is greater than 10 would be ineligible. All other residents of the town would be eligible. • Community review of indigents has to be practiced and be more transparent. • Explore possibilities to cover all those below the poverty line as indigents.

Design feature	Existing design	Practice/ implementation	Challenge	Recommendation
				• In the short run, revisit the fiscal space at town level to increase targeted subsidy. • In the long run, link premium payment for indigents with social protection programs.
Contribution: • Amount • Setting of contribution • Collection system	• Regional CBHI coordination committee/board sets the amount of contribution based on cost of health services, willingness to pay, and affordability study. • Communities do not participate in the setting of the amount. • Sub-kebele CBHI team collects money from members and deposits it into the CBHI account with two weeks.	• Premium is set at the regional level, by the health bureau. We could not find any study used to determine the amount. • Contribution varies by region and scheme. Schemes are not obliged to charge what the regional health bureau sets. • Contribution is collected by house-to-house visits by kebele officials and other public servants, and village volunteers. • Collected money is deposited in the CBHI account no later than the next day. • Village volunteers carry out most activities for which there is no defined incentive. • Contribution in SNNP is not based on size of household. The amount varies from town to town, based on the level of the town. In Amhara, it is based on household size irrespective of town level.	• Most key informants stated that the amount of contribution is small relative to the cost of health care. • Ketana/block volunteers work without a contract, remuneration, and in most cases, without incentives although they carry out most of the activity. This reduces their motivation and has an adverse impact on contribution collection. • Cash collection is time consuming; one may have to visit the same house more than twice. • Amount of contribution is very small relative to the benefit package. Because of this, a significant number of urban schemes have a financial deficit.	• SNNP needs to consider introducing different levels of contribution depending on members' income. Learn from the new CBHI implementation Directive No. 07/2020 issued by the Amhara Health Bureau for 2020/21. • Systematize contribution collection and formalize the 2% payment for all involved in collection. • In the long run, link annual contribution with mobile money. For those who use this, reduce premium by a certain percent.
Health service utilization: • Mechanisms in-placed to contain overutilization	• Create a waiting time of at least one month before a new member can access services.	• The only town with a one-month waiting time is Butajira. • The clinical audit done by town and zonal CBHI coordinating committees, and occasionally EHIA	• Unnecessary demand for referrals from members. • Some CBHI members visit facilities simply because they are	• Regular health education will reduce requests for unnecessary referrals and frequent visits, particularly by CBHI members who

Design feature	Existing design	Practice/ implementation	Challenge	Recommendation
• Health service delivery	• Town health office/CBHI contract with heath facilities.	branch offices, is the main vehicle to mitigate any possible overutilization; audits check for improper service provision and recommend amelioration strategy including fining the health facility or its staff.	insured, putting an unnecessary workload on the facilities. • Very poor services particularly with drugs and diagnostic facilities. Members are exposed to out-of-pocket expenditure for which they are not reimbursed in SNNP and only partially reimbursed in Amhara.	return to the facility before they finish the prescribed drugs. • There is a need to revise drug procurement procedures/policy. The current practice is not efficient and made drug unavailability common in most health centers and hospitals. This is a serious challenge for renewal.
Health service fee-setting mechanisms and EHIA/CBHI level of engagement	• Health bureau is responsible.	• Health bureau sets the health service fee. EHIA and CBHI are not involved. • Fees for drugs and some lab tests are set based on the purchase price plus 15-25% to cover administrative cost. • Health facility management is responsible for preparing a fee rate proposal for drugs and the board makes the final decision.	•	• In principle, EHIA and CBHI schemes as buyer of health services should have a role in setting health service fees. For instance, during the contract year, the health bureau may change the fee without consulting EHIA/CBHI schemes and the schemes are forced to pay the new rate. This is not fair and the scheme should be one of the major stakeholders setting the fee.
CBHI structure and staffing pattern: • Governance structure • Town staff in terms of number and professions	• At the top is the region, down to zone, town, and kebele. • Town general assembly meets once a year. • Town board, accountable to zone CBHI and general assembly, meets quarterly.	• Town general assembly meets once in a year. • Town board is accountable to zone CBHI and general assembly. • Schemes have three or four staff persons. Most have a coordinator, health officer, accountant, and, in a few cases, cashier. Most do not have a data/IT related expert or secretary.	• The responsibility of each body is defined by the directives but the vertical and horizontal relationship between and among different responsible bodies for clear and effective implementation is not yet clear. • Schemes are suffering from lack of data experts. Most information is kept in the	• Getting reliable, time series, and disaggregated data about schemes is very difficult. Most schemes visited have no readily available data. There is a strong need for a data specialist and strong monitoring by higher-level bodies.

Design feature	Existing design	Practice/ implementation	Challenge	Recommendation
	• Town CBHI scheme is under health office. • Scheme staff comprises coordinator, health officer, accountant, data manager, and secretary.	• Kebele CBHI does not exist.	personal notebook of scheme coordinators.	
Risk mitigation mechanisms • Fraud management • Period to deposit collected contributions in CBHI bank account	• Town finance office conducts audit. • Town CBHI scheme checks receipts from kebeles and whether the money collected is deposited every two weeks. • Town CBHI scheme conducts clinical audit of health facilities.	• Town finance office conducts audit • Town CBHI scheme checks receipts from kebeles and whether the money collected is deposited every day. • Town CBHI scheme conducts clinical audit of health facilities supported by EHIA branch office.	• Clinical audit is practiced on a sample basis; sampling 10%- 30% of patient files. This sampling approach seems unscientific and hence may not be representative or detect all errors.	• Increase the sample size to at least to 50% with the aim of checking all files over a two-year timeframe.

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