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PERFORMANCE REVIEW OF EAST GOJJAM ZONAL COMMUNITY-BASED HEALTH INSURANCE POOL

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USAID Health Financing Improvement Program

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Cover Photo: Community-based health insurance beneficiaries show an insurance card while visiting a health facility in East Gojjam. Photo credit: Ayenew Haileselassie, Abt Associates.

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ACRONYMS

CBHI	Community-Based Health Insurance
EFY	Ethiopian Fiscal Year
EHIA	Ethiopian Health Insurance Agency
EPSA	Ethiopian Pharmaceutical Supply Agency
FGD	Focus Group Discussion
HCF	Heath Care Financing
KII	Key Informant Interview
OOP	Out-of-Pocket
RHB	Regional Health Bureau

1. BACKGROUND

1.1 CONTEXT

The government of Ethiopia has been implementing a range of health care financing (HCF) reforms that have the multiple objectives of improving quality, enhancing efficiency, promoting equity, and providing financial protection to citizens. The implementation of community-based health insurance (CBHI) is one of the health financing reforms introduced in 2011 as a pilot program in 13 woredas of the four big agrarian regions. CBHI implementation has now been scaled up to other regions and city administrations. The number of woredas implementing the program was 851[1] in 2020/21 out of which 827 woredas were fully functional and their members accessing services. About 6.8 million households (38 million people) are provided financial protection through the CBHI program to access modern health services with no payment at the point of service delivery. These beneficiaries are accessing health services at all levels of delivery system, i.e., starting from health center up to tertiary-level hospitals.

Current CBHI design in all regions is limited to establishing schemes at the woreda level. As a result, risk pools are relatively small (average 8,993 households in 2019/20) and cross-subsidization is limited to only the members within a woreda scheme. This limits the risk distribution capacity of these schemes and their financial sustainability. Given the absence of higher-level pooling, these woreda-level CBHI schemes are entering into contract agreements with secondary and tertiary hospitals so that their members can access hospital services. While such contracts allowed for continuity of care for scheme beneficiaries, it has become administratively complex to manage these contracts on both sides: schemes and hospitals.

To address this, the Amhara region decided to establish higher-level pools to minimize fragmentation, improve risk distribution capacity of the CBHI program, ensure continuum of care, and enhance efficiency in purchasing and contracting processes. The Amhara Regional Health Bureau (RHB) is the first to pilot higher-level zonal pooling in East Gojjam zone to learn from the design and operational successes and challenges of establishing and running a higher-level pool. This scheme has been in operation for about two years. The Ethiopian Health Insurance Agency (EHIA), with the support of the USAID Health Financing Improvement Program, assessed the performance of the East Gojjam zonal pool to learn from its successes and challenges in both design and functioning.

1.2 OBJECTIVES

The overall objective of this assessment was to review the design and functioning of the East Gojjam zonal CBHI pool in terms of its relevance, effectiveness, efficiency, and sustainability and draw lessons for its replication in other zones, and for pooling at the regional and higher levels. Specifically, the assessment aimed at:

a) Assessing the revenue and expenditure balance of the zonal pool;

b) Assessing the driving factors for the increase in expenditure of the zonal CBHI pool;

c) Assessing factors affecting risk distribution capacity of the zonal pool;

d) Assessing the structure and staffing of the zonal pool;

e) Estimating the number of patient visits and expenditure of the zonal CBHI pool per woreda;

[1] The total number of CBHI-implementing woredas in the country includes 10 schemes from Addis Ababa, which are established at sub-city level. These 10 schemes cover 40 woredas.

f) Estimating the expenditure of the zonal CBHI pool per patient visit;

g) Outlining the good practices and challenges encountered in the pooling arrangement; and

h) Recommending alternative design options (implementation modalities) for the zonal pool under study and strategic direction for regional higher-level pooling establishment and operation in the region.

1.3 METHODOLOGY

1.3.1 ASSESSMENT FRAMEWORK

The study used the Organization for Economic Co-operation and Development's Development Assistance Committee evaluation criteria of relevance, effectiveness, efficiency, and sustainability to assess the design and performance of the zonal pool. This was complemented by an assessment of the design and implementation processes as well as the documentation of best practices. The relevance of the zonal pool was reviewed in terms of meeting the needs of the beneficiaries to access different levels of care, its achievement in enhancing cross-subsidization among woreda pools to ensure financial sustainability, and in creating opportunities to enhance efficiency in management of purchasing services from secondary and tertiary hospitals and sustainability of the achievements gained. Given that one of the main reasons for the pilot was to draw lessons for establishing a regional pool[2] and to inform the evolution of other higher-level pools in the coming few years, the review framework tries to include both aspects: design and operationality of the East Gojjam Higher pool. Table 1 presents the assessment framework used for the study.

[2] Amhara RHB, Zonal CBHI Pool Implementation Directive 2/2010 EFY, page 1.

Table 1. Zonal Pool Assessment Framework

Themes	Assessment Questions/Issues	Methods/Data Collection Instrument
Design and Implementation	To what extent were the different woreda CBHI schemes and other stakeholders actively involved in the design of the zonal pool?	• Document review (design and performance reports) • Key informant interviews with CBHI schemes and boards members as well as technical assistance providers at the regional and federal levels
	To what extent are the different structures outlined in the guideline in place and functional?	
	To what extent are the different systems (financial management, audit, etc.) in place and functional?	
	To what extent has the zonal pool used its performance successes and challenges to revisit its design?	
	To what extent was hospital-level health services utilization and its financial implication forecasted and used for the design, such as to determine higher-level benefit packages, revenue sharing, and financial risk management?	
Relevance	Was the zonal CBHI pool designed to meet to the needs of CBHI members in accessing secondary and tertiary care? Does it also meet the woreda pool interests? Is it relevant to all members of the pool?	• Focus group discussions with boards and CBHI beneficiaries • Key informant interviews with contracted health facility managers
	Feasibility and scalability of the zonal pool establishment criteria	• Document review (performance reports) • Key informant interviews with officials of woredas and zonal pool schemes as well as RHB
	To what extent did the zonal pool address the concepts of risk sharing and deficit financing among the different woreda pools?	• Desk review of any available data on woreda and zonal pool schemes • Key informant interviews with the different CBHI scheme managers (members and non-members of the zonal pool)
Efficiency	Use of the zonal CBHI pool funds against its intended expenditures	• Review of financial data, including disbursement history
	Exploring factors explaining the utilization of pool budget	• Field visits and interviews
	Linkage and coordination with woreda CBHI pools in managing the different service delivery levels of payment, including reimbursement for out-of-pocket payments made by CBHI members/beneficiaries outside contracted health facilities	• Comparative mapping of facilities that used the zonal pool resources

Themes	Assessment Questions/Issues	Methods/Data Collection Instrument
	Working toward better and accountable purchasing functions with health facilities in terms of: a) Contractual agreement including negotiating the right price b) Clinical audit and reimbursement of payment for health services utilized c) Transaction and other costs saved by the woreda CBHI schemes (per diems and transport costs for contract management and medical auditing with secondary and tertiary hospitals, etc.) d) Transaction cost on providers in engaging different schemes for medical audit and reimbursement of their costs e) Ability of the zonal pool to reduce the total cost of service provision because of strategic purchasing of the zonal pool	• Review of documents (contract documents, audit reports) • Key informant interviews (zonal curative and quality assurance officers/ auditors, facility managers, and scheme coordinators, deputy RHB head and HCF case team) • Focus group discussions with scheme board members and providers
Effectiveness	Extent to which the zonal CBHI pool improved health service utilization at higher levels of care (secondary and tertiary levels)?	• Review of performance reports
	Extent to which the zonal pool reduced risks and enhanced deficit financing among the different CBHI pools: a) Fairness and adequacy of contributions from woreda CBHI pools b) Improvements in the financial status of the woreda pools c) Functionality and inclusivity of the criteria for membership	• Contribution analysis • Analysis of contribution and utilization of services • Performance reports from insolvent schemes • Analysis of the scalability and sustainability
	Extent to which the zonal pool enhancing service delivery with general and specialized (tertiary) hospitals within the region a) Overall trend of members accessing secondary and tertiary hospital services within the zone b) Overall trend of members accessing secondary and tertiary hospital services outside the zone	• Data analysis: data from the zonal pool and from woredas CBHI schemes • Key informant interview (scheme coordinators, zonal pool office, facility managers) • Focus group discussions (CBHI members who have used the service)
	Extent to which the zonal pool enabled members to access services in Addis Ababa tertiary care	• Review of performance reports • Key informant interview (zonal pool office/zonal CBHI and HCF case team) • Focus group discussions with CBHI members that have used the service
	Explore positive and negative unintended consequences of the zonal pool	• Key informant interviews (zonal pool office, zonal curative and quality assurance officers/auditors and facility mangers)

Themes	Assessment Questions/Issues	Methods/Data Collection Instrument
Sustainability	Extent of financial and programmatic sustainability of woreda and zonal CBHI pools: a) Ability of the pool to finance the different levels of care b) Capacity of the pool to reimburse insolvent schemes c) Trends of woreda and zonal pool financial balance d) Revenue and expenditure trend of both woreda and zonal schemes (with and without the pool)	• Data analysis (from the zonal CBHI pool) • Document review (performance and audit reports) • Key informant interviews (scheme managers, zonal pool office, and regional CBHI and HCF case team)
	Do the zonal structures have the legal mandate and financial capacity to be ultimate reinsurer if and when the pool funds are not sufficient to cover the pool expenditures (mobilizing zonal and regional subsidies when necessary)?	
	Existence of adequate structures, systems, and capacity (number and skills of human resources) to run and manage the zonal pool	
	The extent to which contributions by woreda pools are paying both service delivery costs and deficit financing of schemes	
	Any successes and challenges in ensuring sustainability of achievements both at woreda and higher-level pools	
	The efforts made by regional, zonal, and woreda governments to enhance sustainability of risk pooling	
Lessons for the Future	Draw best practices and major lessons to inform improvements for future design, implementation and monitoring of zonal and higher-level CBHI pools	• Analytical review of evidence generated • Document review (performance reports and annual review meeting reports) • Key informant interviews (all stakeholders: regional and zonal CBHI and HCF case teams, zonal curative and quality assurance case team, secondary and tertiary health facility managers, scheme coordinators, CBHI scheme boards and beneficiaries)

1.3.2 DATA COLLECTION METHODS

The assessment team used three methods of data collection and triangulated the data to reach to conclusions and recommendations. These data collection methods were the following:

Document review: The Amhara Regional Zonal Pool Implementation Guideline outlines the purpose, establishment and membership criteria, implementation arrangement with lower-level pools; sources and mechanisms of revenue collection, types of expenditures and mechanisms of purchasing services from secondary and tertiary care providers; management of third-party service provision outside secondary and tertiary public health providers; payment/no payment of subsidies to insolvent lower-level pools; and the structure and management of the zonal pool. The zonal pool directive was reviewed in detail including its design and documented whether the zonal pool was being implemented as per its details: the relevance and effectiveness of the principles outlined in the directive in taking the CBHI pool arrangement toward the intended purposes. The Clinical Audit Directive of the region, the Third-Party Agreements Guideline, and the national CBHI Scale-up Directive, issued in 2015 were also reviewed. The annual reports of the zonal pool was assessed if the required criteria for enrollment in the zonal pool by woreda schemes, and if payment from and to lower-level pools had been undertaken as per the guideline. The necessary documents and secondary data from the zonal pool to assess the effectiveness and efficiency of the zonal pool in collecting revenue from the lower-level pools, paying expenditures to secondary and tertiary hospitals and to third-party providers,[3] and reimbursing beneficiaries for their out-of-pocket (OOP) payments was also reviewed. All the documented stories in performance reports and reviews were used to enrich the findings on the successes and challenges of the zonal pool. The best practices and lessons learned from other countries that have established higher-level pools were reviewed to inform any adjustment of the design and management of the higher-level pool during future scale-up.

Quantitative analysis: The team accessed performance and audit reports from the zonal pool and member and non-member CBHI schemes in the zone. Data were collected on the number of schemes in the zone, number of schemes that are part of the zone pool, pool revenue by source (woreda CBHI scheme), pool expenditure disaggregated by payment for each contracted hospital, reimbursement for members' OOP payments for services and commodities obtained outside of the contracted hospitals, number of patients served by level of health facility (contracted and non-contracted), and the corresponding expenditure and financial position of the pool (see Annex A) for quantitative data analysis tool). The team conducted a review of financial conditions of individual CBHI pools and whether financing scheme deficits is done as per the regional pool directive. Analysis of the quantitative data helped to, among other matters, understand the financial position of the zonal pool, proportion of zonal pool expenditure with contracted and non-contracted contracted health facilities, and total patient visits and expenditure per patient. Further analysis of the financial position of individual pool member CBHI schemes, especially those schemes in deficit, were reviewed, both with and without the higher pool, and whether they got the financing as stated in the directive was assessed.

Key informant interview (KII) guides: The key informant interviewees were those who are directly responsible for managing, leading, coordinating, and providing policy and oversight support to the scaling up of CBHI, establishment of the zonal pool, operating the zonal pool and overseeing its operation, woreda CBHI schemes, and providers (contracted secondary and tertiary health facilities, non-contracted facilities that provide services for beneficiaries). Their selection for this assessment is related to their functions at different levels of the health system. The USAID Health Financing Improvement

[3] Third-party providers in Amhara region are those private health facilities that have signed contracts with a public hospital contracted by the scheme to provide to CBHI members services that are not available in the scheme-contracted hospitals. The region issued Directive No. 01/2011 EFY on the operation of these third-party providers in the region.

Program Amhara regional office and zonal pool coordinator facilitated the program by arranging the interview schedule ahead of the visit. The team performed in-depth interviews with key RHB and Zonal Health Department officials, and health service providers, and implementing partners/stakeholders (USAID Health Financing Improvement Program) to explore their observations and suggestions on the relevance, effectiveness, efficiency, and sustainability of the design and implementation of the zonal pool. An in-depth interview with zonal and woreda CBHI pool teams were carried out to understand the success and challenges of implementing a higher-level pool in the zone. The team explored whether the region, zone, and woreda are providing additional support to strengthen the different levels of pools in the zone. All evidence generated the stories about the success and challenges of zonal pools.

- Zonal CBHI Pool Board (1)
- East Gojjam EHIA branch (1)
- Heads of regional CBHI and HCF case teams (1)
- Zonal curative and quality assurance officers (related to clinical audit) (1)
- USAID Health Financing Improvement Program regional office (1)
- Zonal CBHI and HCF case team (zonal pool office) (1)
- Health facilities (secondary and tertiary hospitals, and sample of non-contracted providers that gave services or health commodities/medicines to beneficiaries)
- Sample schemes' coordinators (4)

The responsible parties for KIIs are included in Annex B and the KII data collection tool is included as Annex C.

Focus group discussions (FGDs) with CBHI members: The assessment team held FGDs with CBHI beneficiaries who access hospitals from woredas located far from the general and tertiary hospital on their perception of the successes and challenges of the zonal pool. The participants were selected randomly from those who were receiving services at the time the assessment team visited the facility. The assessment team conducted FGDs with the zonal and woreda CBHI board members. The team used the FGD guide to generate evidence (Annex D). The FGDs helped to identify the perception of the beneficiaries and health workers on the relevance and effectiveness of the zonal pool to meet beneficiary needs and expectations. It also generated ideas on what should be done to make the zonal pool design and implementation more responsive in future scale-up. The FGDs were carried out with the CBHI boards in each sampled CBHI woreda. The responsible parties for FGDs are listed in Annex B. Six to eight people participated in each FGD.

Table 2. FGD Participants

Sources of FGD Targets' Identification	Targets
Woreda level (FGD with board)	Woreda CBHI board members in all of the four schemes
Secondary and tertiary hospitals	CBHI members who are receiving services at the time of the facility visit (6-8 participants)

1.3.3 SAMPLING FRAME

East Gojjam zone has 21 woredas, 15 of which belong to the zonal pool. Joining the pool is voluntary, and some woredas opted out of joining even though they met the required 60% enrollment rate. Of the 15 woredas that established the pool, one woreda left after a year. The contribution of woredas to the zonal pool was initially decided to be 25% of their revenue but this was increased in the second year of

pool operation to 25-45%, based on the experience in the first year.[4] After review of first-year performance and engagement, three types of contribution to the zonal pool by member CBHI schemes were established. They depended on a scheme's proximity to nearest referral hospital (Debre Markos General Hospital) and availability of a primary hospital in the woreda. These are:

a) Schemes that are far from Debre Markos hospital and have a primary hospital contribute 25% of their annual revenue;

b) Schemes that are near Debre Markos hospital and have a primary hospital contribute 35%; and

c) Schemes that are near Debre Markos hospital and have no primary hospital contribute the highest rate, 45%, as they directly refer from health centers to the hospital.

The sampling considered these three contribution levels as criteria for selection. Accordingly, the team visited two schemes: one with and one without a primary hospital. It also visited one scheme from among the schemes that met the enrollment criteria but refused to join the pool. It also visited another woreda that joined and left the pool after a year. The visit to non-member schemes provided information on the reasons why they declined to join and what should change in terms of design and implementation to motivate them to join.

Table 3. Sampling Frame and Selected Woredas

Sampling Criteria	Total Member Schemes	Number or Samples Selected	Selected Woreda
Contribution rate of Members schemes • 35% • 45%		1 1	Dejen Zuria Debre Elias
Joined and left the pool (25%)		1	Goncha Siso Enesie
Non-member CBHI schemes		1	Enabesie Saremidir

Table 4. KIIs Done at All Levels

Level	Targets
Regional level	RHB top management (bureau head; HCF department head) with head of CBHI and HCF case team USAID Health Financing Improvement Program regional team
East Gojjam zone	CBHI Zonal Pool Board Zonal Health Office (CBHI and HCF case team) EHIA Branch in Debre Markos Curative Care and Quality Assurance officers
Contracted facilities	General manager of Debre Markos hospital
Sample woreda CBHI schemes	4 CBHI scheme coordinators

[4] Zonal CBHI pool performance reports

1.3.4 ETHICAL CONSIDERATIONS

The assessment team obtained informed consent from all participants before starting KIIs and FGDs as shown in the tool guide. Participation was voluntary and participants were informed that they could withdraw at any time if they wished. All data collected were confidential and collected and managed by the assessment team. To maintain confidentiality of information provided by the study subjects, the study findings do not contain the names of interviewees or informants.

The study obtained Ethiopian Public Health Institute ethical clearance before going out to collect information. The Amhara Regional Public Health Research Institute also provided ethical clearance for the study. The study team adhered to the COVID-19 protocol by providing masks and other protection methods during data collection.

1.4 ORGANIZATION OF THE REPORT

Chapter 2 describes the background, objectives, legal and operational framework, and strategies and targets of establishing a zonal CBHI pool. Chapter 3 presents the overall performance of the zonal pool in terms of providing access to the CBHI members, cross-subsidy among different woreda pools, efficiency of the purchasing function, financial status of the zonal pool, and accountability of the zonal pool to its members. Chapter 4 presents the relevance, effectiveness, efficiency, and sustainability of the design and implementation of the zonal pool, documents the lessons learned, and lists the major recommendations for scale-up. Chapter 5 summarize the overall findings, conclusions, and recommendations. The list of the KIIs and FGDs as well as the tools used are enclosed in the annex of this zonal CBHI pool review.

2. DESCRIPTION OF THE ZONAL CBHI POOL

2.1 WHY A ZONAL CBHI POOL?

A woreda CBHI scheme's risk pool is limited to the woreda population. Without cross-subsidization, an individual woreda scheme cannot run a temporary deficit, and it must limit the benefit packages/health services at secondary and tertiary hospitals that the scheme can offer to its members. In addition, this limits scheme capacity to enter into contracts with higher-level hospitals (general and specialized hospitals) that provide services within and outside of the region, including in Addis Ababa. It also limits scheme administrative and technical capacity to do periodic clinical audits in the higher-level hospitals. And it increases the administrative burden on the higher-level (secondary and tertiary) hospitals by forcing them to make a separate contractual agreement with each woreda scheme and to deal with the separate clinical audit of each scheme. Pooling resources at a higher level such as the zone should improve efficiency and thereby enable schemes to purchase higher quantities and types of health services with the same resources. Zonal pooling also will reduce the contracting and clinical audit burden for both the woreda schemes and hospitals. To realize these benefits and serve as a learning ground for establishing region-wide pool in Amhara and scale it up to national level, the RHB established the East Gojjam zonal CBHI pool.

2.2 OBJECTIVES OF ZONAL POOL

As clearly stipulated in the zonal CBHI pool implementation Directive No. 2/2017/2018 issued by the Amhara RHB, the objectives of the zonal pool are to:

a) Establish the system of cross-subsidy among woreda CBHI schemes and ensure the financial sustainability of the schemes;

b) Promote the efficient and cost-effective provision of health services rendered to its members at general and specialized hospitals inside and outside of the region;

c) Introduce the system of coverage of health services rendered at higher hospitals in Addis Ababa by the zonal pool, and ensure the provision of health services in these hospitals is efficient and the reimbursement process for the services rendered is effective and efficient; and

d) Serve as a learning ground to establish regional pool in the region.

2.3 DESIGN, LEGAL, AND OPERATIONAL FRAMEWORKS/DIRECTIVE

The East Gojjam CBHI zonal pool was established based on the regulation for the implementation of CBHI issued by the regional government in October 2017, on Directive No. 1/2017 on the implementation of CBHI issued by the RHB in November 2017, and on Directive No. 2/2018 on the implementation of zonal CBHI pools issued by the RHB in April 2018.

As per the Directive No. 2/2018, a zone can establish a zonal CBHI pool when 80% of the woreda schemes in the zone have at least a 60% enrollment rate. The establishment of the zonal pool will be realized after the approval of the RHB, made at the request of the Zonal CBHI Board. The pool will exist as long as it fulfills the 80% precondition each year. Woreda schemes that are established in the zone can be member of the zonal CBHI pool if they reach enrollment rate of at least 60% and will continue in the pool as long as they maintain this minimum requirement. Woredas schemes are obliged

to contribute 25% of their annual revenue to the zonal CBHI pool.[5] The pool revenue is based mainly on the contributions of member woreda schemes. The directive also allows the pool to generate revenue from other sources as per the decision of the Zonal CBHI Board. Members and beneficiaries of schemes that belong to the zonal pool are entitled to access health services in general and specialized hospitals in the region and in Addis Ababa that have a contractual agreement with the zonal pool. In addition, for services that are not available in the contracted health facilities, upon approval of the contracted facilities, members can access services outside of the contracted facilities and seek reimbursement for any OOP costs they incur. Contracted health facilities get their reimbursement quarterly based on fee-for-service after a clinical audit is conducted by the zonal pool. The zonal CBHI pool agreement has a provision to disburse payment to contracted facilities before they provide services to ease their financial constraint and improve their service delivery. The zonal pool enters into contractual agreements with general and specialized hospitals within the region, while the RHB makes contractual agreements with higher-level facilities in Addis Ababa. Pool expenditure is only for the cost of health services, printing of receipts and vouchers, and banking services. All other costs, including salaries of the zonal pool staff and other operating costs, are covered by the zonal government.

2.4 STRATEGIES AND TARGETS

There is no strategy or roadmap to indicate the activities required to move to establishing a regional pool nor of the time frame to do so. Directive No. 2/2018 on establishing the zonal pool clearly states that one objective of establishing a zonal pool is to generate evidence and to inform the process of establishing a regional pool. A roadmap needs to be drafted, discussed, and approved by the concerned bodies in the region with technical support at the national level as this will help scale-up in other zones, regions, and at the national level.

[5] The Directive allows revising the contribution taking into consideration the financial status of the pool. Accordingly, the contribution of each woreda CBHI scheme has been revised as per the decision of the general assembly to 25%, 35%, and 45% depending on the woreda's access to Debre Markos hospital and the availability of a primary hospital in each member woreda. Services provided at the primary hospitals are not covered by the zonal pool but rather by each woreda scheme.

3. PERFORMANCE OF THE ZONAL CBHI POOL

3.1 ACCESS TO SECONDARY AND TERTIARY SERVICES BY BENEFICIARIES

The establishment of the zonal pool in East Gojjam has provided members of participating woreda CBHI schemes access to higher-level health services, particularly in higher-level health facilities in Addis Ababa, that the limited contractual capacity of individual woreda schemes would not have provided. Providing access to higher-level hospitals in Addis Ababa is difficult for individual schemes as it requires them to execute contractual agreements with the higher-level institutions and to conduct a periodic clinical audit in order to reimburse the facilities for health services provided; such requirements are costly and possibly beyond the capacity of the schemes. As a result of the establishment and operation of zonal pool, beneficiaries of participating schemes have utilized services at Debre Markos hospital, and at Felege Hiwot hospital in Bahir Dar in the first year (2018/19) of pool operation. Patients/participants in the FGD at Debre Markos hospital testified that CBHI has benefited them a lot by allowing them to access health services at different levels of health care. This has been evidenced by the higher number of health service utilization among pool members compared to non-members at secondary and tertiary hospitals level. For example, the number of patients served at higher-level hospitals among pool member woredas in 2019/20 was 4,297, 2,803, and 2,648 in Dejen Zuria, Bibugne, and Enemaye, respectively, while it was only 499, 407, and 419 in the non-pool nearby CBHI schemes of Dejen town, Motta town, and Bichena town, respectively.[6]

During the second year (2019/20) of zonal pool operation, zonal pool contracts with hospitals expanded to include Tibebe Ghion hospital in Bahir Dar and Black Lion hospital in Addis Ababa, and, in the third year (2020/21), St. Paul hospital in Addis Ababa. However, there are challenges to seeking care in these hospitals. Waiting times can be long—a day or two— which is not affordable for patients coming from great distances. In addition, health personnel may refer patients to the private wings of these hospitals, and CBHI schemes do not reimburse beneficiaries for costs they incur in private wings. Such referrals cost the CBHI member and make them lose confidence and interest in CBHI.

The number of patients served at higher-level health facilities contracted by the zonal pool, by each CBHI member scheme, is shown in Table 5. As shown, the total number of patients served by the zonal pool-contracted hospitals was around 95,000 in 2018/19 and 97,000 in 2019/20; it has not increased much since then. The utilization of health services at these facilities varies by woreda scheme. The share of patients of each scheme to total patients served is as high as 15% (2018/19) in Gozamen woreda and 12% (2019/20) in Debre Elias and Machakel woredas, while it was equal to or less than 1% in Sedie, Goncha Siso Enesie (Goncha), and Enabesie Saremidir in 2018/19. The variation is due to the presence of and accessibility to primary and referral hospitals: all four woredas where utilization is highest are near Debre Markos hospital and all lack a primary hospital. This has led to direct referral to Debre Markos hospital and increased scheme member utilization of the hospital. Member woredas that are far from Debre Markos hospital and have primary hospitals referred far fewer patients to Debre Markos. In light of this large disparity in utilization and associated expenditure on health services, the general assembly of the zonal pool, in the presence of woreda schemes that are zonal pool members, revised the schedule for CBHI scheme contributions to the zonal pool in year 2 (2019/20) of the zonal pool operation. Contributions went from 25% to 35% for the woredas that are near Debre Markos hospital

[6] Utilization of health services is affected by many factors including population enrolled in the schemes and other factors. Regardless, the difference in the magnitude of health service utilization shows the degree to which the zonal pool enabled its members to access higher-level hospitals compared to non-zonal pool members.

but also have a primary hospital and to 45% for the woredas that are near Debre Markos hospital and have no primary hospitals in line with their high level of utilization in higher-level hospitals.

Table 5. Number and Percentage of Patients Served at Health Facilities Contracted by the Zonal Pool (2018/19-2019/20)

	Pool Member Schemes	Patients Served at Secondary and Tertiary Care		% Share of Total Utilization	
		2018/19	2019/20	2018/19	2019/20
1	*Aneded*	8075	7293	8.5	7.5
2	*Baso Liben*	10239	9322	10.8	9.6
3	*Sedie*	997	89	1.1	0.1
4	*Goncha Siso Enesie*	2499	70	2.6	0.1
5	*Enabesie Saremidir*	2166	1326	2.3	1.4
6	*Shebel Berenta*	4412	3934	4.7	4.1
7	*Enarge Enawga*	4919	4234	5.2	4.4
8	*Enemaye*	3818	2648	4	2.7
9	*Debaye Telate Gne*	7234	6405	7.6	6.6
10	*Dejene Zuria*	4348	4297	4.6	4.4
11	*Awabele*	5953	5749	6.3	5.9
12	*Gozamen*	14630	14671	15.4	15.2
13	*Debera Eliyase*	10250	11304	10.8	11.7
14	*Machakel*	11575	11322	12.2	11.7
15	*Bibugne*	3711	2803	3.9	2.9
16	*Sinane*	0	11222		11.6
	Totals	**94826**	**96689**	**100**	**100**

Source: East Gojjam Zonal Pool Coordination Office

As KII and FGD participants pointed out, however, there are challenges in seeking services at higher-level hospitals. Like other facilities, drugs, and imaging and lab services in these hospitals are sometimes unavailable. This forces scheme members to pay out of pocket, defeating the purpose of health insurance. It can also jeopardize appropriate care if patients cannot afford any, or a complete course of treatment.

3.2 CROSS-SUBSIDY AND REDUCING DEFICIT OF WOREDA CBHI SCHEMES

One of the objectives of the zonal pool, as stated in the establishment of zonal pool Directive No. 2/2018, is to finance the deficit of participating CBHI schemes when faced with such problem after the evaluation of Zonal CBHI Pool Board and the approval of the general assembly. As shown in Table 6, of the 15 CBHI schemes in the zonal pool, four had a deficit during the last two years of the pool operation. The total deficit of these schemes increased from Birr 3.6 million in 2018/19 to Birr 4.1 million in 2019/2020. At the scheme level, the deficit of two schemes decreased while that of the other two increased. The reason for the deficits requires further investigation, which is beyond the scope of this study. However, as per the directive establishing the zonal pool, the Zonal Pool Board should have undertaken an assessment to identify the reason and then taken the matter to the general assembly for its approval for financing the scheme deficits, assuming the assembly thought the schemes deserved the financing. The board did not do so because it itself is in deficit and so cannot finance the deficits. Zonal pool revenue and expenditure are discussed in Section 3.4 below.

Table 6. Deficit of Zonal Pool Member CBHI Schemes, 2018/19-2019/20 (Birr)

	Name of Scheme	2018/19		2019/20	
		Total Deficit	Zonal Pool Financing	Total Deficit	Zonal Pool Financing
1	Enabesie Saremidir	1,300,159	0	855,094	0
2	Shebel Berenta	1,027,702	0	400,636	0
3	Bibugne	1,092,742	0	1,253,022	0
4	Sinane	207,719	0	1,577,199	0
	Total Deficit	**3,628,321**		**4,085,951**	

Source: East Gojjam Zonal Pool Coordination Office

3.3 EFFICIENCY IN MANAGEMENT OF PURCHASING FUNCTIONS

One objective of the East Gojjam zonal CBHI pool is to improve efficiency in the provision of health services to beneficiaries of member schemes at the general and specialized hospitals in and outside of the Amhara region. There have been efficiency gains—existence of the pool has saved the time and money it takes for secondary and tertiary hospitals and individual woreda schemes to make contractual agreements because the zonal pool does one agreement. Further, the zonal pool has reduced the transaction costs of schemes, which no longer have to do periodic clinical audits to reimburse the contracted hospitals for the services they render to scheme beneficiaries. This has also benefited the contracted hospitals as they only deal with the zonal pool for the periodic clinical audit. The hospitals and schemes visited in this study confirmed these gains.

These efficiency gains, however, might have been compromised because capacity of the zonal pool to do thorough clinical audits at these hospitals is limited by the number and technical skills of its staff, who are not on par with hospital specialists. Schemes are concerned that these zonal pool deficiencies negate or limit potential efficiency gains.

Further, the absence of third-party agreements[7] has increased the transaction costs of patients who have to find facilities and buy the drugs and other services that are not available at the contracted facilities. Having to process claims and pay reimbursements to scheme members has increased the administrative burden on the schemes and the zonal pool. To maintain the administrative efficiency gains it has made from contractual agreements and clinical audits, the zonal pool should strengthen its clinical audit capacity and implement third-party agreements.

3.4 FINANCIAL STATUS (REVENUE AND EXPENDITURE TRENDS) AND SUSTAINABILITY OF BOTH THE WOREDA AND ZONAL-LEVEL POOLS

As shown in Table 7 below, of the 16 member schemes, four (Enabesie Saremidir, Shebel Berenta, Bibugne, and Sinane) ran a deficit during the first two years of their zonal pool membership (2018/19 and 2019/20). The schemes were not in deficit before they joined the pool in 2017/18. The reasons for such deficit in these schemes warrant further investigation.

[7] A third party agreement is an agreement made between zonal pool contracted hospitals and other health facilities to render services that are not available in the contracted hospitals.

Twelve schemes had a surplus in the first year of the pool operation and 10 did in both years. The surplus in seven of the schemes (Aneded, Enarge Enawga, Enemaye, Dejen Zuria, Awabele, Gozamen, and Debre Elias) increased from 2018/19 to 2019/20 and in three of the schemes (Baso Liben, Sedie, and Machakel) it decreased. The reasons for this decrease might be attributable to the increase of their contribution to the pool (from 25% of revenue to 45% for Machakel woreda scheme and to 35% for Baso Liben; the level of contribution for the Sedie scheme was unchanged).

Table 7. Surplus/Deficit of Zonal Pool Members, 2018/19-2019/2020 (Birr)

	Name of Pool Member Schemes	2017/18	2018/19	2019/2020
1	*Aneded*	997,893.02	837,221.24	1,303,279.31
2	*Baso Liben*	6,468,412.98	6,455,545.70	5,687,409.09
3	*Sedie*	2,258,542.37	2,169,588.54	943,250.34
4	*Goncha Siso Enesie*	5,519,266.90	4,304,696.40	*
5	*Enabesie Saremidir*	11,298.82	-1,300,158.63	-855,093.81
6	*Shebel Berenta*	2,085,633.24	-1,027,701.73	-400,636.04
7	*Enarge Enawga*	2,537,487.93	1,412,046.02	1,659,629.41
8	*Enemaye*	1,112,641.87	1,721,413.66	2,834,055.53
9	*Debaye Telate Gne*	1,849,396.36	446,108.00	
10	*Dejene Zuria*	667,601.96	481965.07	1,754,273.82
11	*Awabele*	1,224,751.51	979,681.60	4,683,291.24
12	*Gozamen*	495,917.49	4,179,253.63	6,441,989.45
13	*Debera Eliyase*	495,917.49	2,360,333.63	2,740,696.67
14	*Machakel*	1,529,374.10	1,694,480.61	1,499,435.89
15	*Bibugne*	927,108.54	-1,092,741.63	-1,253,022.13
16	*Sinane*	366,875.72	-207,718.77	-1,577,198.82

Source: East Gojjam Zonal Pool Coordination Office
* The scheme left the zonal pool during the year.

The zonal pool itself ran a deficit during its first two years of operation. In 2018/19, the deficit was Birr 1.13 million; in 2019/2020, it increased to Birr 1.22 million (Table 8). Reimbursement for OOP payments that scheme members made outside the contracted health facilities is the major driver of the zonal pool deficit, as the prices of outside drugs and services are very high. For example, one tube of sulfur ointment cost Birr 200 in private pharmacies of Enabesie Saremidir whereas its price was less than half that—only Birr 75—in government facilities.[8] Reimbursement for OOP payments increased from 16% of total zonal pool expenditures in 2018/19 to 26% in 2019/2020. Addressing the problem of OOP payments—and ultimately the unavailability of drugs and services in the contracted public health facilities—is crucial for improving the financial status of the zonal pool and the schemes. This could be addressed mainly by availing the drugs at contracted public health facilities at all levels and by implementing third-party agreements to reduce the high prices charged by facilities that are not contracted with the zonal pool. OOP payments not only endanger the financial status of the zonal pool, but also create a barrier to seeking and receiving health services as patients might not be able to pay out of pocket at the time of visit.

There are other possible reasons for the zonal pool deficits. As outlined by key informants from the woreda schemes that are members of the pool and zonal pool office itself, limited clinical audit capacity of the zonal pool, and irresponsible contracted health facilities that push the cost of non-CBHI patients

[8] East Gojjam Health Office (2020). CBHI schemes revenue and expenditure survey report (unpublished).

to the bills of CBHI members also contribute to the zonal pool deficit. Total revenue of the zonal pool and a breakdown of its expenditures are shown in Table 8.

Table 8. Revenue and Expenditure of Zonal Pool, 2018/19-2019/20 (Birr)

	2018/19	2019/2020
# of CBHI households covered in zonal pool	270,983	280,322
Revenue	18,411,868.4	25,950,059
Expenditure (Total)	19,545,208	27,177,649
Hospitals	16,383,464	20,002,519
Reimbursement for OOP	3,161,744	7,175,130
Deficit	(1,133,340)	(1,227,590)

Source: East Gojjam Zonal Pool Coordination Office

Because the zonal pool has been in deficit for two consecutive years, it needs government support as a reinsurer. This was not envisaged in the RHB's Directive No. 2/2018 on the establishment and operation of zonal pools. The directive should have included provisions to enable the financing of the deficit after due evaluation of the cause by a designated authority. The RHB/ Regional Government should provide the deficit financing if after evaluation the deficit is found eligible for financing.

This study also looked at the financial status of woreda schemes that are in the zone but not members of the zonal pool. Generally, there has been a decrease in their surpluses since 2017/18. For example, Dejen town had a surplus of more than Birr 500,000 in 2017/18 but this decreased to Birr 63,422 by 2019/2020 (Table 9). Surpluses also decreased for Bechena town and Debre Markos town schemes. As was discussed above, this trend was not observed among most zonal pool members—more than half grew their surplus. However, care should be taken when looking at such a comparison, because the difference in utilization of health services between pool members and non-members was not taken into account. A counterfactual evaluation would have been possible if zonal pool member and non-members schemes were similar in all aspects except for being a member of the zonal pool or not. But beneficiaries of CBHI schemes that are part of the zonal pool are able—at least in theory—to seek care at higher-level health facilities including in Addis Ababa. This difference alone affects schemes' financial status. Non-participating schemes might be in better financial shape but their beneficiaries health service utilization at higher-level facilities is minimal. Risk pool member schemes might have lower financial status but can allow their beneficiaries use of higher-level health facilities.

Table 9. Financial status/Net Revenue of Non-members, 2017/18-2019/2020 (Birr)

	Non-member Schemes	2017/18	2018/19	2019/2020
1	Hulet Eju Enese	0		611,991.10
2	Debre Markos town	1,611,746.70	1,774,807.35	950,708.89
3	Mota town	1,505,963.18	-	
4	Bechena town	699,261.52	-	103,346.22
5	Dejen town	552,635.59	-	63,422.76

Source: East Gojjam Zonal Pool Coordination Office

3.5 THE ZONAL CBHI POOL MANAGEMENT STRUCTURE AND SYSTEM

Per RHB Directive No. 2/2018 that established the zonal pool, the pool has a general assembly composed of Zonal CBHI Board members, chairpersons of each member CBHI scheme board, and an elected CBHI beneficiary from each member scheme. Under the general assembly, there is Zonal CBHI Pool Board chaired by the East Gojjam Zonal Administrator with members drawn from the zonal offices. The day-to-day function of the zonal pool is managed by the Zonal Pool Coordination Office under the Zonal Health Department. The Zonal Pool Coordination Office is staffed by the zonal HCF and CBHI case team. The office or the HCF and CBHI case team has a coordinator, CBHI officer, health officer, accountant, cashier, and secretary.

Until recently, three curative care and quality assurance officers of the Zonal Health Department with support from the EHIA branch office in Debre Markos performed the clinical audits at contracted facilities, but the health officer was recently recruited to do the audits so that the curative care and quality assurance officers could focus on their regular tasks at the Zonal Health Department. However, KIIs at zonal and woreda scheme revealed that, as the task of the clinical audit at higher-level hospitals requires a level of skill greater than that of a health officer and is too demanding for a single person, it is unlikely that this arrangement will bring better results than did the previous one. In fact, it might weaken the clinical audit process. Hence, this arrangement should be re-examined. The pool should have a general practitioner in addition to the health officer, as suggested by the curative care quality assurance officer; outsource the clinical audit to a university; or let EHIA, which has branch offices in places where the pool has contractual agreements including Addis Ababa, do the audits. These options should be discussed and the optimal one selected.

3.6 ACCOUNTABILITY OF THE ZONAL POOL TO AND PARTICIPATION OF THE LOWER-LEVEL POOLS IN DECISION MAKING

As stated above in Section 3.5, the zonal pool's highest body is the general assembly composed of the Zonal CBHI Pool Board members, chairperson of the board of member CBHI schemes, and representatives of beneficiaries selected in their respective woreda general assembly meetings. The Zonal CBHI Pool Board is chaired by the administrator of the zone and members of the board are drawn from the relevant zonal offices. The woreda schemes and beneficiaries are not part of the zonal board but are part of the general assembly.[9] The board is also accountable to the regional CBHI Board and the RHB in addition to the general assembly of zonal pool. The day-to-day duties of the zonal pool are conducted by the zonal HCF and CBHI case team/Zonal Pool Coordination Office.

These structures were established by Directive No. 2/2018 and are operational. Accordingly, the general assembly had a regular annual meeting in each of the past two years, in which major issues such as the revision of CBHI schemes' contributions to the zonal pool were decided. The zonal board has implemented many—though not all—of the duties assigned to it in the directive. The zonal pool is yet to finance its own deficit and those of the woreda schemes starting with bringing the matter to the attention of the general assembly and the RHB. Nor has the board initiated resource mobilization activities to strengthen the financial position of the zonal pool. As per the zonal-level KIIs, the board also

[9] Woreda schemes as per the Directive No. 2/2018 are not represented in the zonal pool board. This has not elicited any complaint so far as the zonal pool board reports to the general assembly, where the woreda schemes are represented. In addition, major decisions including the contribution amount to the zonal pool by woreda schemes and financing of deficit of woreda schemes are decided at the general assembly level with a recommendation of the zonal board.

has not met quarterly due to competing priorities of its members. This call for the composition of the board to be reconsidered, so that members regularly conduct meetings and address pressing issues in a timely manner.

Generally, the zonal pool is accountable to its member CBHI schemes through the general assembly and this has happened over the past two years. For example, CBHI schemes participated in revising the contribution rate. But the board needs to be strengthened so it can address emerging issues such as sustainability of the zonal pool, including identifying and addressing the causes of the financial deficits at scheme and zonal pool levels. In addition, the RHB, as an authority overseeing the performance of the zonal pool, should play active role in supporting the zonal pool to address its deficit and the challenges related to clinical audits and high OOP reimbursement.

4. RELEVANCE, EFFECTIVENESS, EFFICIENCY AND SUSTAINABILITY OF THE ZONAL POOL DESIGN AND IMPLEMENTATION

4.1 DESIGN PROCESS AND IMPLEMENTATION (SUCCESSES AND GAPS)

The design of the zonal pool was informed by the review of the experiences of other countries, especially Rwanda. During the design process, the two zones that met the established criteria (minimum of 60% enrollment rate) were East Gojjam and North Wollo. The interest and commitment of East Gojjam were additional reasons for it being chosen for the zonal pool. The development of Directive No. 2/2018 on the establishment and operation of the zonal pool was initiated at the regional level and discussed at the zonal level. As per the directive, 18 woredas that met the required enrollment rate of 60% were invited to participate in the general assembly meeting. During the meeting, the contents of the directive were discussed and agreed including the 25% contribution of their annual total revenue including from indigent members to the zonal pool by each scheme. Of the 18 schemes, 16 joined the zonal pool. (Two schemes, Hulet Eju Enese and Motta town, met the minimum enrollment rate but were unable to join as they were in deficit and could not make their contribution during the registration period). This shows the woreda schemes were involved in the design and establishment of the zonal pool as per the directive. As per the directive, the different structure such as the general assembly, zonal board and the structure implementing the zonal pool (HCF and CBHI case team) were also established and now are functional.

The design process had strengths and weaknesses. In terms of strength, all 18 woredas that met the 60% enrollment criterion participated fully in the process, even those that ultimately could not join. The establishment of the general assembly with full representation of pool members and the zonal pool board and its regular and effective functioning will continue to be the main success factors for future scale-up.

The major issues identified in the design process that need to be carefully considered during scale-up are:

- The setting of a flat-rate contribution by woreda schemes did not take into account the woredas' differences in non-medical and transport and accommodation costs associated with accessing care due to distance to the general hospital. Learning from its shortcomings after a year of operation, the zonal pool adopted a three-level contribution schedule with rates of 25%, 35%, and 45%. Some schemes still feel the contribution remains unfair in terms of utilization of health services and contribution rate. The lack of a strategy to link contribution with the utilization of services was raised by some pool members as one of the major drawbacks of the design and this needs to be revisited before zone pooling is scaled up. There is reported unfair distribution of general hospitals which limits accessibility to some woredas pool members. There is clear evidence that the benefits that the pool provides to schemes is much less than their contribution. For instance, the zonal pool financed about 12.5% of the total cost of the Goncha woreda scheme's costs; since this was equivalent to only 50% of its contribution to the zonal pool, Goncha felt that 50% of its contribution was lost while its scheme is in deficit. On the other hand, the zonal pool finances about 50% of the Gozamen scheme's costs, which is more than their contributions. Such a difference is mainly due to the unfair distribution of general hospitals. The exclusion of primary hospitals to be contracted by the pool was rigid and some woredas were favored over others (Gozamen versus Goncha). As a

result, those schemes whose primary hospital is part of the general hospital (like Gozamen) benefits much more than other members, who finance their primary hospitals on their own.

Goncha and Enabesie Saremidir CBHI boards' views of the zonal pool

"We have been involved in the design of the zonal pool and was part of the pool for a year. However, the benefits of the zonal pool was not able to compensate the woreda scheme contribution to the zonal pool. The contracted general hospitals were far away and the community prefers to obtain services in closer primary hospitals (Mertule Mariam and Shegaw Motta) that are not part of the zonal pool. This really negatively affected the sustainability of the woreda pool by increasing its deficit" - Goncha Board

"We in principle support the establishment of the pool. We were engaged in the design of the zonal pool process. The major reasons for not joining the pool was (i) lack of resources to pay for zonal contribution due to deficit and (ii) the exclusion of Motta hospital—the major provider for the woreda-as part of the zonal pool contracted facility as it were not upgraded to general hospital." - Hulet Eju Enese CBHI Board

In future scaling up, until conditions are met to establish an integrated single pool, the contribution rate needs to reflect the fact that woredas that do not finance primary hospitals on their own. The woreda pool needs either to pay a higher contribution than other pools or all primary hospitals in the zone need to be part of the zonal pool contract to treat pools more fairly.

- The voluntary decision to join the zonal pool limits universality within the zone. The membership of woreda schemes in the zonal pool could learn from other contributions that are collected in Amhara region. It is reported that of the eight types of contribution collected at the woreda level, only CBHI is voluntary—the other seven are mandatory. There is thus a recommendation to make woreda scheme membership by households and zone pool membership by woreda pools compulsory[10] as long as they meet the membership criteria.
- Another issue raised by woreda schemes that are not zonal pool members is that although they wanted to be members, the timing of pool membership renewal does not fit their capacity to pay. While woreda schemes have resources in February and March after re-enrolling their members, zonal pool membership renewal starts in June, when some schemes, for example, Hulet Eju Enese, do not have the required resources. It is therefore necessary to align the establishment and renewal of zonal and higher-level pools with the time that woreda CBHI schemes mobilize resources from their members, with due consideration of time for resource mobilization and reporting.

4.2 RELEVANCE

The zonal pool is relevant to the push for implementation of the government strategies. Information from the East Gojjam zonal pool is one mechanism that will help translate one of EHIA's 2020/21-2024/25 results, 'financially sustained health insurance schemes,'[11] into practice. One of the major initiatives for the next five years is the design and implementation of higher-level pools.[12] Amhara regional state issued zonal pool implementation Directive No. 2/2018 with the objectives of: (i) enhancing sustainability of insurance and reducing deficits through horizontal risk sharing among woreda schemes; (ii) enhancing the efficiency, cost-effectiveness, and effectiveness of service delivery by general and referral hospitals in the region; (iii) kick start contracting referral hospitals in Addis Ababa for CBHI

[10] When coverage is compulsory or automatic for all population groups/woredas, the pool(s) have a more diverse mix of health risks/areas. People/woredas who have higher risks are just as covered as people who have lower risks. As such, the overall risk profile of the zonal pool will be much more financially sustainable than under voluntary enrollment.
[11] EHIA, 2020, Performance Review of East Gojjam Zonal Community-Based Health Insurance Pool
[12] Ibid.

members; and (iv) generate evidence for future design of the regional CBHI pool.[13] East Gojjam is one of the two[14] zones that currently are helping to test the functionality of zonal pool design to inform the directive establishing the Amhara regional government's zonal pool. This clearly shows that the East Gojjam zonal pool experience is not only relevant to EHIA and regional initiatives but also provides lessons for the functioning of higher-level pooling in Ethiopia to inform future designs for scaling up.

The pool is very relevant to providing additional access to its members to referral hospitals. The establishment of the zonal pool met the interest and need of CBHI members in East Gojjam to access higher-level care from regional referral to national referral hospitals. The zonal pool has covered the care that members seek at general, regional referral, and national referral hospitals and has reimbursed them for the OOP payments they make to non-contracted facilities so they can access care without concern about its cost. For example, as noted above, it has enabled members to access Black Lion hospital in Addis Ababa without financial stress.

The zonal pool design thus responds to the needs of the CBHI members and providers through its following features:

a) Addresses CBHI members' need for continuity of care by enabling them to access higher-level care (general hospitals, secondary hospitals like Debre Markos hospital, and tertiary hospitals like Felege Ghion and Tikur Anbessa hospitals).

b) Reduces the transaction cost of general and regional hospitals by reducing their engagement with woreda pools in terms of clinical audit, financial audit, and reimbursements. Instead, they only engage with the zonal pool.

c) Reduces the transaction cost of woreda CBHI offices, giving them time to manage their own scheme, as audits and payments are made by the zonal pool.

4.3 EFFECTIVENESS

The zonal pool managed to enroll 15 out of 21 woreda schemes (71%) as members of the higher pool (Table 10). Of the total 350,060 CBHI members in the zone, about 80% (280,322) are covered by the zonal pool through their woreda schemes. Of the total 600,000 households in the zone, CBHI enrollment, including in schemes that are not part of the zonal pool, is reported to have reached 74% in 2020/21 (Ethiopian Fiscal Year (EFY) 2013). The withdrawal of the Goncha woreda scheme in 2019/20 reduced household coverage and the coverage rate, as shown in Table 10.

Table 10. Number of CBHI Schemes and Proportion that Joined the Zonal Pool

	2010 EFY (2017/18)	2011 EFY (2018/19)	2012 EFY (2019/20)
Total # of schemes in the zone	21	21	21
Total # of schemes that meet membership criteria to join the pool in the zone	17	18	18
Total # of schemes that are members of the zonal pool	16	15	15
Total # of CBHI member households in the zone	354,284	344,046	350,060
Total # of CBHI member households covered in the zonal pool	294,354	270,983	280,322
% of schemes enrolled in higher pool	76.2%	71.4%	71.4%
% of CBHI members covered by the higher pool	83.1%	78.8%	80.1%

[13] Amhara Regional Health Bureau, 2018, Zonal CBHI Pool Implementation Directive 02/2018.
[14] The review team learned that Awi zone has established a zonal pool.

The effectiveness of the zonal pool was reviewed in terms of realization of its four objectives. The first objective is to enhance financial sustainability of the woreda schemes through risk sharing. The zonal pool has established a system where different woreda pools can share risks by financing zonal hospital and higher-level care. This has helped some woreda pools to reduce their deficits and others to increase their surplus. Four woreda schemes had financial deficits in the two years the zonal pool has been operating and the pool was not able to finance the deficits. Analysis of the four woredas shows that the deficits of Bubugne and Sinane would have increased without the zonal pool whereas the deficit of Enabesie Saremidir and Shebel Berenta would have been marginally reduced, and the surplus of five woreda pools would have been increased marginally without the pool. Overall, risk sharing is working as the reservation on enhancing risk sharing among the woreda pools is observed in only two schemes (see Table 14 below for details).

However, because of the zonal pool's deficit over its first two years (1.13 million in EFY 2011 and 1.5 million in 2012 EFY), it has not been able to finance the deficits of woreda pools, which is one of the major strategies to bring financial sustainability at the woreda level. So, in this regard, the performance of the zonal pool has not been effective. The zonal pool's deficit is largely due to the low level of financial contribution by woreda schemes on the one hand and to the zonal pool's high expenditures, especially for reimbursements of beneficiaries' OOP expenditures on the other. Given the major driver of increasing costs has become the OOP reimbursement, this study tried to capture its significance by showing its share from the total deficits As can be seen in Table 11, reimbursements of OOP payments accounted for 66% and 129% of total zonal and woreda pool deficits in EFY 2011 and 2012, respectively, and increased by 127% in the two years. About 75% of this deficit is from the woreda schemes; the zonal pool accounts for only about 25% of the total deficits in the zone. This clearly shows that reimbursements of OOP payments are driving woreda and zonal pool deficits and that properly managing them, perhaps through accountable third-party arrangements, is one of the main priorities for sustainability of CBHI.

Table 11. Level of Deficits and the Share of OOPs

	2011 EFY (2018/19)	2012 EFY (2019/20)
Woreda pool deficits	3,628,321	4,085,951
Zonal pool deficits	1,133,341	1,468,138
Total deficit	4,761,662	5,554,089
Share of woreda pool deficit from the total deficit	76%	74%
Share of zonal pool deficit from the total deficit	24%	26%
Total reimbursement on OOPs	3,161,744.53	7,175,130.13
OOPs as share of woreda deficit	87%	176%
OOP as a share of total deficit	66%	129%

Another gap is the inadequate commitment and ability of the zonal and regional governments to subsidize the zonal pool as compared to woreda schemes. In 2012 EFY, the total deficit amounted to about Birr 5.5 million, whereas the zonal pool deficits was only Birr 1.5 million. This clearly shows that one of the major objectives of the pool has not been achieved and there is a need to review the overall contribution rates and the level of facility that the zonal pool should finance to make it fairer as well as effective. Given the low contribution by CBHI scheme members at the individual and possibly at the scheme level, financial sustainability is an issue. The experience of Rwanda, one of the countries in Africa

that has been successful in establishing higher pools and financing pool deficits, clearly documented[15] that the national government finances pools at different levels, when they are in deficit. The findings from the zonal pool in Amhara clearly show the need to:

a) Review the contribution of member schemes (higher contribution for schemes that do not pay for primary hospitals) and/or the level of facilities that the zonal pool should finance (all hospitals including primary hospitals) to make the zonal pool fairer and more effective; and

b) Mobilize additional funding at the zonal and regional level to finance the zonal pool deficits and replicate the successes of other countries like Rwanda.

Another objective of establishing a zonal pool was to enhance efficiency, cost-effectiveness, and effectiveness of service delivery in the region's general and referral hospitals. As described above, the zonal pool has enhanced provider efficiency by reducing their transaction costs in terms of contracting, clinical and financial audits, and requesting and receiving payment on time from different schemes. As seen in Table 13, of the total payments for services by different levels of care, 84% was for general hospitals, 12% for regional referral hospitals, and 4% for national referral hospitals. This clearly shows that the zonal pool is effective in using general hospitals for most of its members, the lowest-level service provider that has lower costs for the zonal pool. Although the per patient visit spending differs among the schemes (ranging from Birr 169 in Debre Elias to 4,622 in Sedie), the average per visit spending by zonal pool is about Birr 209. The clinical audit conducted by the zonal pool was also expected to enhance its effectiveness in ensuring patients' high-quality and responsive care. However, the team's discussion with the clinical audit team clearly underlined the fact that the use of clinical audit findings by providers is very weak. The contribution of clinical audits in terms of informing effectiveness of providers' accountability is inadequate. The zonal CBHI case team's recent re-audit of 30 patient cards in five woredas documented that the original audit findings underestimated errors in the facilities' requests for reimbursement, ranging from 59% in Baso Liben to 93% in Enabesie Saremidir (Table 12). The re-audit found that 142 payments should have been denied, but only 39 (27%) actually were. This clearly shows the need to strengthen the quality of the audit process.

Table 12. Number of Payments Denied and Found to Have Been Paid Incorrectly by the Original Audit

	Hulet Eju Enese	Enabesie	Enemaye	Baso Liben	Total
Number of patient cards denied reimbursement by first audit	8	3	10	18	39
Number of cards that should have denied reimbursement, documented by re-audit	24	44	30	44	142
Share of wrongly paid from total audit findings as per re-audit	67%	93%	67%	59%	73%

Source: Zonal CBHI case team assessment report, August 2020

There is thus a need to explore ways to (i) strengthen the capacity of the zonal pool to do clinical audits rather than senior health professionals; and (ii) push forward the EHIA's recently proposed mechanisms of conducting clinical audits of general, comprehensive referral, and national referral hospitals by different EHIA branches in support of the different pools.

[15] In Rwanda, the government was not only able to subsidize CBHI deficits through its direct financing, but also mobilized additional resources from formal sector insurances (Rwanda Medical Scheme and Rwanda Military Insurance) as well as from development partners. It also introduced a co-payment of 10% at higher levels.

Table 13. The Share of Different Levels of Hospitals from Zonal Spending by Scheme Members

	From the Total Pool Spending Share of:			Expenditure per Patient	Share of Patients of Each Member Scheme from Pool-funded Patients	Contribution Rate
	Zonal Hospital	Regional Hospital	Tertiary Hospital			
Aneded	87%	6%	7%	192.4	8%	45
Baso Liben	94%	3%	3%	192.0	10%	35
Sedie	3%	89%	9%	4622.7	0.1%	25
Goncha Siso Enesie	-	30%	-	0	0%	0
Enabesie Saremidir	34%	62%	4%	625.5	1%	35
Shebel Berenta	79%	17%	4%	248.5	4%	25
Enarge Enawga	73%	24%	3%	254.0	4%	25
Enemaye	71%	22%	7%	277.8	3%	25
Debaye Telate Gne	86%	9%	5%	207.3	7%	35
Dejene Zuria	92%	3%	5%	210.2	4%	35
Awabele	95%	2%	3%	195.2	6%	35
Gozamen	91%	7%	2%	190.6	15%	45
Debera Eliyase	93%	4%	3%	169.5	12%	45
Machakel	90%	7%	3%	191.7	12%	45
Bibugne	63%	32%	4%	292.2	3%	35
Sinane	95%	3%	2%	175.2	12%	**45**
Total (share in %)	**84%**	**12%**	**4%**	**209.4**	**100%**	

Patients who were members of CBHI schemes that participated in the zonal pool were able to access tertiary care services from referral hospitals in Addis Ababa in 2012 EFY. The zonal pool spent about Birr 546,000 (4%) of the zonal pool annual expenditure in Addis Ababa. This clearly shows that referral to Addis Ababa is available and the total cost to the zonal pool was negligible, about 4%. The pool is therefore effective in meeting its objective of creating contractual agreements in Addis Ababa tertiary care hospitals to enable its members access to quality tertiary care.

The implementation of the East Gojjam Zone CBHI Pool has effectively realized its fourth objective: generating evidence on the functioning of the zonal pool. It has generated evidence to inform the design and implementation of other zonal and higher-level CBHI pools. The design process needs to be participatory to ensure the engagement and membership of CBHI woreda schemes, as was the case in East Gojjam. The fact that some qualifying woreda schemes remained outside the pool shows there is a gap, either in the pool reaching out or in the schemes' understanding the importance of the zonal pool. It also shows that there might be the need to make zonal pool membership mandatory for schemes that meet certain criteria, such as currently, enrollment more than 60% of eligible households.

The unfairness of the benefits and contributions to woreda schemes was a major issue that was apparent after just one year of implementation and that forced the zonal pool to devise a three-level contribution schedule of 25%, 35%, and 45% of woreda pool revenues. Even with this adjustment, the boards of some schemes still feel the rates are unfair. The Goncha woreda CBHI scheme board's decision to withdraw due to its deficits and high expenditures as part of the pool clearly documented that the design of the pool needs to be fairer in terms of providing equal access to care for all and fair contributions from the woreda schemes. Study findings showed that four woreda schemes (Gozamen, Debre Elias, Machakel, and Sinane) account for 44% of zonal pool patients and 50% of zonal pool expenditures although the schemes contribute only about 33% of zonal pool funding (see Table 14). This shows that design of future higher CBHI pools should consider costs and contribution levels to ensure they are equitable in terms of their members' accessing and utilizing services from primary and general hospitals. Scaling up zonal pools needs to consider options for contracting hospitals, from primary to higher levels, to reduce the 'unintended favor' obtained by some schemes that are accessing both primary and general hospital services in general hospitals. This enhances the principle of insurance by ensuring provision of similar service coverage to members wherever they are.

The existence of strong and proactive zonal leadership is critical to success in initiating the zonal pool as the zone has one of the highest enrolment rates in the region. The capacity of the zonal pool clinical audit needs to be strengthened: zone auditors need to have the skill, knowledge, and credibility to review the diagnoses and treatments carried out by the medical specialists. There also is a need for strong performance review that ensures the accountability of zonal pool-contracted health providers. Too many providers are not responsive to the findings of the clinical audit functions. This is not properly followed up by the regional government because the purchaser and provider functions are not split. To bridge this gap, there is a need to consider: (i) establishment of a structure with a separate purchasing function that is accountable to the regional government; and (ii) revisit the structure and capacity required to manage zonal CBHI pools in scaling up to other zones. It is also important for the EHIA to explore and draft a strategy to work with regional governments so that it becomes involved in the operation and functioning of the zonal CBHI pools.

Table 14. The Contribution to and Health Expenditure of Woreda Pools from the Zonal Pool

Schemes	Total Scheme Contribution 2011 and 2012	Health Expenditures Paid by the Zonal Pool 2011 and 2012	Total Surplus/ Deficit with Pool for Two Years	Total Surplus/ Deficit without Pool for Two Years	Gain or Loss Due to Pool	Signficiant Negative Impact to Woreda Pool	Postive Effect on Enhances Risk Sharing
Aneded	**2,676,126**	3,096,171	2,140,501	1,720,455	1		
Baso Liben	**3,829,956**	3,881,761	12,142,955	12,091,150	2		
Sedie	**2,088,861**	1,623,093	3,112,839	3,578,607	1	No	
Goncha Siso Enesie	**1,697,604**	1,362,569	0	335,035			
Enabesie Saremidir	**2,978,807**	2,822,757	-2,155,252	-1,999,202	2	Maybe	
Shebel Herenta	**2,735,298**	2,460,822	-1,428,338	-1,153,861	3	Maybe	
Enarge Enawga	**3,178,020**	2,483,853	3,071,675	3,765,843	4	No	
Enemaye	**2,969,245**	2,010,940	4,555,469	5,513,775	5	No	
Debaye Telate Gne	**2,814,045**	3,007,485	446,108	252,668	3		
Dejene Zuria	**2,249,109**	1,960,057	2,236,239	2,525,291	6	No	
Awabele	**3,048,966**	2,510,404	5,662,973	6,201,535	7	No	
Gozamen	**3,766,528**	5,830,223	10,621,243	8,557,548	4		
Debera Eliyas	**3,125,837**	4,081,726	5,101,030	4,145,142	5		
Machakel	**3,427,088**	5,034,893	3,193,917	1,586,111	6		
Bibugne	**2,019,438**	2,299,046	-2,345,764	-2,625,372	7		
Sinane	**1,754,989**	2,497,608	-1,784,918	-2,527,537	8		
Total	**44,361,927**	46,963,407	44,570,677	41,967,187			

Notes:
- Green = evidence of gain
- Red = evidence of loss
- White = no clear evidence

The major efficiency gain of the zonal pool is that it managed to reduce the transaction costs of general and tertiary hospitals and woreda CBHI pools in contracting, undertaking clinical audits, and requesting and making payments. Each woreda scheme that is not a member of the zonal pool should sign contracts with all facilities its members use. It also should send two staff to each provider every quarter to do a clinical audit. The establishment of the zonal pool has saved about Birr 5,000 per woreda scheme per year per signed facility. Also contributing to efficiency, the contracted general and referral hospitals are dealing only with the zonal pool for clinical audit and payment requests rather than with 15 schemes individually. This has reduced the transaction cost of providers and facilitated access to advance payments from the zonal pool to ensure availability of commodities, especially at general hospitals. There is therefore evidence and consensus that the zonal pool has reduced the transaction cost of the woreda schemes and providers.

Some woredas are encouraging more referrals to a general hospital when there are too many patients to be seen at the health center level. This has had a negative effect on cost-effectiveness and efficiency. The per patient zonal pool expenditure on patients who used facilities (general and higher-level hospital services) that are financed by the zonal pool increased from Birr 172.8 in 2011 to Birr 210.2 in 2012, a

22% increase in a year. Referral becomes more complicated when patients are sent from the general and referral hospitals to private pharmacies and diagnostic centers; this has increased the zonal pool's reimbursements of OOP payments.

Most of the zonal expenditures (74% in 2011 and 84% in 2012 EFY) went to the zonal hospital, showing that referral systems are working overall, although this varies from woreda to woreda. Expenditures on national referrals, which started only in 2012 EFY, account for only 4% of the zonal pool expenditure. The FGDs with CBHI members revealed that there have been occasions when CBHI members feel discriminated against because they are not allowed to use hospital's private wings, which offer better hoteling and quicker service, but prohibiting this is the right decision to control zone pool costs.

As this report has discussed repeatedly, the major reason for the increase in the zonal pool's costs is the high rate of reimbursement for scheme members' OOP expenditures. Its share of the total zone pool expenditure went from 16% in 2011 EFY to 26% in 2012 and the average per patient reimbursement went from Birr 519 to 819 (Table 15). This is largely due to the increasing referral of patients to the private sector for diagnosis and medicines and supplies.

Table 15. Level and Share of OOPs from Total Zonal CBHI Spending

	Per Patient OOP		Contribution Rate	Total per Capita Reimbursement	Share of OOPs from Total Zonal Pool Spending	
	2011	2012			2011	2012
Aneded	431.6	730.5	45	922.9	16%	21%
Baso Liben	356.6	3713.2	35	3905.2	14%	20%
Sedie	902.8	977.5	25	5600.3	19%	54%
Goncha Siso Enesie	858.7	-	0	0.0	27%	-
Enabesie Saremidir	840.6	1516.0	35	2141.5	24%	50%
Shebel Berenta	429.1	896.4	25	1144.8	17%	35%
Enarge Enawga	482.2	639.5	25	893.5	6%	31%
Enemaye	668.4	733.5	25	1011.2	21%	35%
Debaye Telate Gne	496.9	560.3	35	767.6	15%	22%
Dejene Zuria	606.0	777.8	35	988.0	16%	21%
Awabele	566.1	773.3	35	968.5	12%	24%
Gozamen	400.6	969.2	45	1159.8	11%	16%
Debera Eliyase	435.2	887.3	45	1056.8	11%	19%
Machakel	408.3	589.1	45	780.8	15%	25%
Bibugne	566.1	791.4	35	1083.7	24%	33%
Sinane	-	569.7	45	745.0	-	21%
Zonal average	**519.3**	**819.5**			**16%**	**26%**

4.4 SUSTAINABILITY

As shown in Chapter 3 and in the effectiveness subsection, the zonal pool is in deficit and is not sustainable. The deficit has many causes: the annual CBHI contribution rate has been Birr 240 per household per year since 2008 EFY even though the cost of care has increased. There is also lack of a threshold to enroll woredas (say, for example, a minimum of 10,000 households) either based on level of contributions or the minimum number of households. Currently it based on enrollment rate. There are also reports of misuse of resources by providers, who use members' medicines for non-members. Medical and clinical audits are weak and inadequate action is taken on their findings.

A major driver of the zonal pool deficit is reimbursement of OOP spending. This is in turn driven by inadequate availability of medicines and supplies—such as painkillers and surgical gloves—in public facilities. As a result, patients are referred to private pharmacies. Availability and supply of medicines through the Ethiopian Pharmaceutical Supply Agency (EPSA) has been a challenge. Some FGD participants in general hospitals informed the review team that "there were cases where patients don't bring money trusting their CBHI membership and were requested to buy the drug outside of the hospital and left without being treated." Although availability of medicines and medical supplies in public institutions is assessed and a review meeting conducted every quarter, availability has not improved significantly. All visited schemes and all levels of boards confirmed that there is abuse by private providers as medicines at private pharmacies are more expensive for CBHI members than non-members, due mainly to moral hazards of the private sector and collusion between beneficiaries and pharmacies. A recent assessment by the zonal pool of the availability of medicines and their prices in five woredas schemes clearly documented that: (i) the percentage of medicines available in facilities as a percentage of the minimum standard is below 50%; (ii) availability of lab tests in primary hospitals is about 80%; (iii) in one week alone, 280 patients from Shegaw Mota, 89 from Jube, 9 from Bichena, and 175 from Metule Mariam primary hospitals were referred to private pharmacies; and (iv) the prices of commodities significantly vary from woreda to woreda and are significantly higher in private pharmacies (see Table 16) than at public providers.

Table 16. Prices of Selected Commodities at Private and Public Providers

Type of Medicines	Prices at Private Pharmacies (Birr)				Prices at Public Providers (Birr)
	Hulet Eju Enese	Enabesie Saremidir	Enemaye	Baso Liben	
Sulphur ointment/1 tube	250	200	85	75	75
Ciprofloxacin 500 mg/7d	79.8	284.9	60.2	-	24.5
Dexamethasone eye drop/1 tube	210	250	100	-	32.5
Augmentin 500 mg/7d	420	649.95	391.9	315	218.4
Chloramphenicol 500 mg/7d	109.8	532	44.8	42	22.4
Ciprofloxacin eye drop/ 1 tube	150	250	45	-	23.75
Chloramphenicol eye drop/1 tube	320	-	60	-	15
Doxycycline 100mg/7d	210	175	35	-	7.7
Terra-Cortril eye drop/1 tube	480	-	180	225	153.3
Dextromethorphan 125/10 ml	-	550	50	-	67.5
Ibuprofen 400 mg/7d	147	-	30.45	25.2	18.9
Coartem/3d	499.92	-	-	-	0
Foley catheter 16/1	450	-	-	-	30
Bisacodyl 5 mg po/7	375.9	-	-	-	15.75

Source: Zonal CBHI case team assessment report, August 2020

The regional government recently issued a guideline to use the government prices for reimbursement of OOP payments, but the woreda schemes still do not know the unit prices of all drugs at higher levels. There is no mechanism to regulate the pricing at private pharmacies. Some CBHI woredas such as Enabesie Saremidir worked with health center managers to reduce referrals to outside public facilities and procurement of medicines from private pharmacies to less than 5%, but they were unable to influence utilization at general and referral hospitals. The regional government has also started working with Ambassel Trading as an alternative supplier for medicines and medical supplies in the region. It is reported that it supplied about 23% of need as compared to 33% by EPSA. This effort needs to be strengthened not only for scaling up the zonal pool but also to increase the quality of services in public facilities.

CBHI is established to share the risk of health care expenditure for Ethiopians in the informal sector, who are largely low income. Key informant interviewees stated that it is indeed difficult to expect CBHI schemes to fully self-finance. While woredas are subsiding woreda pools, this has not been the case for the zonal pool. The experience in other countries clearly documents that even in formal sector insurance schemes, a government contribution is always significant. Currently, except for paying for the staff of the zonal pool and for capacity building, there is little subsidy or direct financing of zonal pool deficits by either the zonal or the regional government. The zonal pool directive (Directive No. 2/2018) is silent about the financing of the deficits. While woredas continue to finance the deficits of their schemes (e.g., Enabesie Saremidir at about Birr 1.456 million and Bibugne at about Birr 500,000), the zonal board has no fiscal space to finance the zonal pool deficit. While efforts and strategies should be explored and implemented to ensure that higher-level pools revenues and expenditures are balanced over the long term, there is a need for the regional government to commit some level of financing when necessary in the short and medium terms to ensure sustainability of CBHI higher pools. Following are the major recommendations on sustainability:

a) Introduce a co-payment for CBHI members—rather than full payment for which they claim reimbursement—who are referred to private pharmacies to reduce the incentive to work with private pharmacies to get more money from the pool. Consider co-financing of the OOP payments between the woreda schemes (e.g., 25%) and zonal pool (75%) to ensure each level becomes more effective and accountable and works harder to reduce referrals and reimbursements.

b) Invest and strengthen alternative suppliers for medicines and medical supplies including the establishment of an EHIA-owned pharmacy at the zonal level;

c) Work toward having a contractual agreement with the private sector with clear pricing and accountability mechanisms;

d) Encourage the RHB to strengthen regulations on private pharmacies to ensure they do not charge CBHI scheme members more than non-members;

e) Undertake a costing exercise and revise the contribution rates to finance at least 50% of the cost of care;

f) Ensure the payment of exempted services is taken up by respective levels of government until the government guidelines are revised; and

g) Develop a strategy and obtain commitment for financing the deficit of higher-level pools by different levels of government.

5. MAJOR CONCLUSIONS AND RECOMMENDATIONS

5.1 MAJOR CONCLUSIONS

The design of the East Gojjam Zonal CBHI Pool was informed by the experiences of other countries, especially Rwanda. It is one of two zonal pool initiatives in the country that will generate evidence and inform design for scale-up of the zonal pool model.

Woreda schemes were involved in the design and establishment of the zonal pool as per Directive No. 2/2018. All woredas in the zone that met the criteria of 60% enrollment (18 woredas) were involved in the design process, even woredas that later chose not to join the zonal pool. The establishment of the General Assembly with full representation of pool members and the zonal pool board and its regular and effective functioning is one lesson learned for scale-up. One aspect of design that some pool members found was a major drawback was the setting of a flat rate contribution of woreda schemes to the zonal pool, because it failed to link the contribution with the utilization of services. The exclusion of primary hospitals in the zonal pool was rigid as member schemes that utilizing primary hospital services as part of the general hospital are now benefiting much more than other schemes. The voluntary nature of joining the zonal pool limited universality within the zone.

The zonal pool is relevant to push for government strategies that expand access of members of CBHI pool schemes to referral hospitals and in reducing the transaction cost for woreda CBHI pools and higher-level providers (general hospital and above).

The zonal pool has enhanced risk sharing among woreda pools, but it has been ineffective in financing the deficits of its woreda members, one of its objectives in enhancing financial sustainability. The commitment of the zonal and regional governments to subsidize the zonal pool is inadequate compared to woreda commitments to subsidize their schemes. However, it is effective in meeting its objective of creating contractual agreements in Addis Ababa tertiary care hospitals to provide its members access to quality tertiary care. By obviating the need to work individually with the different schemes, the zonal pool has enhanced the efficiency of contracted providers by reducing their transaction costs in terms of contracting, clinical and financing audits, and requests and being paid on time. While the zonal pool is effective in using the general hospitals for most of its members, some schemes are benefiting more than others, mainly due to unfair distribution of general hospitals (due to proximity) and some schemes have benefited by not paying for primary hospitals. And, while the zonal pool has streamlined the clinical audit process, the use of audit findings by providers to enhance their effectiveness in providing quality and responsive care to the patients is reportedly very weak. The zonal pool is meeting its fourth objective: generating evidence on the functioning of the zonal pool and on what works and what doesn't. For example, strong and proactive zonal leadership and a strong zonal coordination unit was found to be critical to the successful functioning of the zonal pool.

The East Gojjam zonal pool is not sustainable because it is in deficit due to various factors including low contribution rates, reported misuse of resources of patients by providers to finance non-members, weak claims and clinical audits and inadequate action on audit findings, expansion of health services in hospitals, increased referrals to the private sector and hence increased costs for reimbursement of OOP spending, and fraud by private providers, who overcharge CBHI members, such as charging them for commodities of exempted services like deliveries.

5.2 RECOMMENDATIONS

The evidence generated by this review documented recommendations for scaling up the zone pool concept to other zones and or a higher-level pool like the region. The recommendations are summarized by main thematic areas of the review:

1) Design and implementation
    a) Review the cost and willingness to pay of members and revise contribution rates.
    b) Revisit the service delivery levels that the pools should finance (woreda pools-health centers and zonal pools from primary hospitals).
    c) Consider revising the zonal pool directive to make membership compulsory for all woreda schemes that fulfill the criteria.
    d) Align the schedule of CBHI scheme contribution payments to zonal and higher-levels pool so payment is due closer to the time that woreda CBHI schemes receive contribution payments from their members; this will help the schemes to join even when they have financial challenges; and
    e) Develop a roadmap (with targets, phased and prioritized strategies, and resource requirements) to guide the scale-up of zonal pools, and the establishment of regional and national pools.
2) Effectiveness
    a) Review the contributions of member schemes and the level of facilities that the zonal pool should finance to make the zonal pool more fair and more effective;
    b) Work to mobilize funding at the zonal and regional level to finance the zonal pool deficits until higher pools can fully self-finance in the long term, by revising contribution rates (households and pools).
    c) Strengthen the capacity to undertake clinical audits by recruiting general practitioners and senior health professionals or outsourcing to teaching hospitals; and/or push forward the proposed mechanisms of conducting a clinical audit of general, comprehensive referral, and national referral hospitals by different EHIA branches.
    d) Revisit the structure and capacity required to manage zonal CBHI pools; and
    e) Have EHIA explore and draft a strategy to work with regional governments to support the operation and functioning of the zonal CBHI pools.
3) Cost-effectiveness and efficiency
    a) Advocate for and work with RHBs/Ministry of Health to improve availability of health services in general and drugs and imaging services in the contracted public health facilities in particular to reduce the cost of reimbursing OOP payments.
    b) Strengthen the clinical audit capacity of the pool either by recruiting a general practitioner to help the health office with the audit, outsourcing the task to teaching hospitals, or delegating the task to EHIA so it can handle it in Addis Ababa through its head office and in the regions through its branch offices.
    c) Create capacity at the zonal pool and woreda scheme office levels to implement a third-party agreement between providers with clear accountability of the private providers; this arrangement will decrease reimbursements of OOP payments which currently do not have any agreed prices for the service provided to the CBHI member.

4) Sustainability
    a) Explore introducing a co-payment:
        i) By CBHI members who are referred to procure medicines from private pharmacies to reduce the incentive to work with private pharmacies and reduce misbehavior by members.
        ii) Between the woreda and zonal pools to ensure each level is more effective and accountable and reduces reimbursements of OOP payments.
    b) Invest and strengthen an alternative supplier for medicines and medical supplies including the establishment of an EHIA-owned pharmacy at the zonal level.
    c) Work toward having a contractual agreement with the private sector.
    d) Have the RHB work to strengthen regulation of the private sector to ensure private pharmacies do not charge CBHI schemes more as compared to non-members patients.
    e) Revise contribution rates in line with the increasing costs of care, to cover at least 50% of the costs of care in the long term; currently the fees charged are much lower than the actual cost.
    f) Ensure the payment of exempted services is taken up by respective levels of government until the government guidelines are revised.
    g) Develop a strategy and commitment for subsidizing higher-level pools by different zonal- and regional-level governments.
    h) Guide and strengthen the capacity of the zonal board to initiate and implement additional income-generating activities to complement member schemes' contribution.

ANNEX A: QUANTITATIVE TOOLS

Table A-1. Percentage of CBHI Schemes Enrolled into the Zonal Pool

	2010	2011	2012
Total # of schemes in the zone			
Total # of schemes that meet membership criteria to join the pool in the zone			
Total # of schemes that are members of the zonal pool			
Total # of CBHI member HHs in the zone			
Total # of CBHI member HHs covered in the zonal pool			

Table A-2. Percentage of Revenue and Contribution Amount to Zonal Pool by Member Scheme

	Name of Member Scheme	% of Revenue Contribution to the pool (25, 35, 45%)	Contribution Amount in Birr	
			2011	2012
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				
13				
14				
	Total Contribution			

Table A-3. Patients Served and Expenditure Incurred for Pool Members by Level of Service and Scheme

		2011				2012 (first six months)			
	Name of the Member Scheme	# of Patients Served	Expenditure at Debre Markos Hospital	Expenditure at Felege Hiwot Hospital	Expenditure at Tertiary Hospital in Addis Ababa	# of Patients Served	Expenditure at Debre Markos Hospital	Expenditure at Felege Hiwot Hospital	Expenditure at Tertiary Hospital in Addis Ababa
1									
2									
3									
4									
5									
6									
7									
8									
9									
10									
11									
12									
13									
14									
	Totals								

Table A-4. OOP Payment by Scheme (in Birr)

	Name of Scheme	2011			2012		
		# of Patients	OOP Reimbursed	Third Party Payment	# of Patients	OOP Reimbursed	Third Party Payment
1							
2							
3							
4							
5							
6							
7							
8							
9							
10							
11							
12							
13							
	Total patients and OOP reimbursed						

Table A-5. Financing Schemes with Deficits

	Name of Scheme	2011		2012	
		Total Deficit	Zonal Pool Financing	Total Deficit	Zonal Pool Financing
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					
11					
12					
13					

Table A-6. Financial Status/Net Revenue of Pool Members and Non-members

	Name of Scheme	2010	2011	2012
I	Pool Member Schemes			
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				
13				
II	Non-member Schemes			
1				
2				
3				
4				
5				
6				
7				
8				

ANNEX B: LIST OF KEY INFORMANT INTERVIEW AND FOCUS GROUP DISCUSSION NAMES AND RESPONSIBLE PARTIES

List of KIIs

Name	Responsibility
Lakachew Abebe	Zonal HCF and CBHI Coordinator
Molla Admasu	Zonal CBHI Officer
Kassahun Seyoum	Zonal CBHI pool Accountant
Talema Genet	Head, Members Affairs, East Gojjam EHIA
Awoke Abebe	Senior officer, Providers' Affairs, East Gojjam EHIA
Dires Dilinesaw	Coordinator, Zonal Curative and Quality Assessment team
Biruk Guday	Quality officer, Zonal Curative and Quality Assessment team
Kidit Mekones	Curative care officer, Zonal Curative and Quality Assessment team
Abebebaw Ademe	NCD officer, Zonal Curative and Quality Assessment team
Endale Alebachew	Gonchan woreda CBHI coordinator
Huluager Tefera	Gonchan woreda CBHI finance officer
Zelalem Tagele	Hulet Eju Enese CBHI coordinator
Abdurahim Yamid	Hulet Eju Enese CBHI health officer
Temesgen Assefa	Dejen Zuria CBHI coordinator
Anyele yeyelachew	Debre Elias CBHI coordinator
Abe Anemut	Debre Elias CBHI resource mobilization officer
Abyiot Hebestu	Debre Elias CBHI Health officer
Dr. Hiwot Debebe	Deputy head of Amhara Regional Health Bureau
Addisu Abebaw	Director, Resource mobilization, Amhara Regional Health Bureau
Ato Genet Anteneh	USAID Health Financing Improvement Program
Ato Abay Akalu	USAID Health Financing Improvement Program
Ato Abebe Dagnaw	USAID Health Financing Improvement Program

List of FGDs

Name	Responsibility
Amanu Melaku	Zonal pool CBHI board member and head of Woreda Finance and Economic Development Office
Taye Berhanu	Zonal pool CBHI board member and head of Woreda Health Office
Shegawm Esubalew	Zonal pool CBHI board member and head of Woreda Communication
Zewde Mulu	Zonal pool CBHI board member and head of Woreda Women and Children Office
Temegen Zewde	Hulet Eju Enese woreda CBHI board member and woreda administrator
Migbar Asrat	Hulet Eju Enese woreda CBHI board member and head of Communication Office
Manaye Nugusie	Hulet Eju Enese woreda CBHI board member and head of Finance and Economic Development Office
Alemu	Hulet Eju Enese woreda CBHI board member and head of Health Office
Abebe Gizachew	Hulet Eju Enese woreda CBHI board member and head of Education Office
Shegaye Dessie	Goncha woreda CBHI board member and Woreda Vice Administrator

Name	Responsibility
Migbar Asrat	Goncha Siso Enese woreda CBHI board member and head of Communication Office
Mekonen Debsu	Goncha woreda CBHI board member and head of Finance and Economic Development Office
Gojam Ayenew	Goncha woreda CBHI board member and head of Women and Children's Office
Yohanis	Goncha woreda CBHI board member and woreda office
Taye Berhanu	Debre Elias CBHI board member and Woreda Vice Administrator
Shegawm Esubalew	Debre Elias woreda CBHI board member and head of Communication Office
Amanu Melaku	Debre Elias woreda CBHI board member and head of Finance and economic development office
	Debre Elias woreda CBHI board member and head of Women and Children's Office
Muleken Admasu	Dejen Zuria CBHI board member and Woreda Vice Administrator
Himanote Kassa	Dejen Zuria CBHI board member and head of Woreda Administration office
ALemayehu Geletu	Dejen Zuria woreda CBHI board member and head of Communication Office
Getachew Eshete	Dejen Zuria woreda CBHI board member and head of Finance and Economic Development Office
Worekneh Ambawe	Members received higher-level care and met at Debre Elias health center
Zegeju Demeke	Members received higher-level care and met at Debre Elias health center
Bantale Fenta	Members received higher-level care and met at Debre Elias health center
Negussu Webearege	Members received higher-level care and met at Debre Elias health center
Gizachew Zewedie	Members received higher-level care and met at Debre Elias health center
Tesema Mitiku	Member from Machakel woreda CBHI receiving higher-level care at Debre Markos General Hospital
Tihun Shegaw	Member from Sinane woreda CBHI receiving higher-level care at Debre Markos General Hospital
Atalay Biadgilign	Member from Enarge Enawga CBHI receiving higher-level care at Debre Markos General Hospital
Etenesh Awoke	Member from Debre Elias CBHI receiving higher-level care at Debre Markos General Hospital
Sileenat Awoke	Member from Debre Elias CBHI receiving higher-level care at Debre Markos General Hospital
Yalganesh Tassew	Member from Debre Markos CBHI receiving higher-level care at Debre Markos General Hospital
Abreham Getinet	Member from Machakel CBHI receiving higher-level care at Debre Markos General Hospital
Kassahun Yaze	Member from Dejen Zuria CBHI receiving higher-level care at Debre Markos General Hospital

ANNEX C: KEY INFORMANT INTERVIEW DATA COLLECTION TOOL

Introduction and obtaining informed consent: Thank you for agreeing to take part in this assessment process; your input is highly valued and appreciated. We are conducting an assessment of the functionality of the zonal CBHI pool in East Gojjam. The purpose of this assessment is to review the relevance, effectiveness, efficiency and sustainability of the zonal CBHI pool. The evidence generated about the strength and gaps of the zonal pool in terms of design and its implementation is expected to inform the design of the current and other zonal and possibly regional CBHI pool in the future. The assessment team has had the opportunity to review necessary documents including the zonal CBHI pool guidelines and other progress reports in order to understand its design and implementation. However, review of the documents alone is not adequate to provide the necessary information and evidence to improve the existing zonal pool design and inform and scale up similar programs in the future. Therefore, we would like to speak with you to hear about your experience and position, in your own words, in order to help us better understand what is working well, what hasn't worked well and what kind of issues need to be looked into and agreed up during future designs.

Confidentiality:

- The information that we will collect will include individuals' names, organizations, and positions. The annex of this report will include a list of key informants, but the findings or statements in the report will not be associated to any particular name of the key informant.
- Quotes from respondents will be included in the report, but there will be no link between the quotes and the names of the individuals who provided the quote. In the event that the team desires to use any personally identifiable information in the report (such as a photograph of the person), the assessment team will first contact the respondent(s) to seek permission to do so.
- The information that we shall collect during this assessment will be used for the sole purpose of this assessment. This information will not be used for any other purpose.
- Your participation in this interview is voluntary and you can refuse to answer any or all questions. However, your participation in this interview will help us gain for a better understanding on the functioning of the zonal CBHI pool and we would greatly appreciate your help.
- Our questions will remain on the program and your knowledge, experience and suggestions about the future of the zonal pool or similar other pools. We will not ask you personal questions and there will not be any sensitive and personally identifiable information about you.

Thank you once again, for taking the time to speak with us today. If you have any questions for us, you can ask now. Would you be willing to participate in this interview?

Interviewee (Name and Title):

_____

_____

Organization: _____

Location: _____

Date: _____

1. Key Informant Interview for Regional CBHI and HCF Case Team

Design and Implementation

Please describe your view on the strengths and gaps in the design and implementation of the zonal pool as well as your recommendations in terms of:

- The extent to which the different woreda CBHI schemes and other stakeholders are actively involved in the design of the zonal pool?
- Were objectives of the pool clear, comprehensive and yet specific enough?
- The extent to which the different structures outlined in the guideline are in place and functional?
- The extent to which the different systems (financial management, audit, etc.) are in place and functional?
- The extent to which the successes and challenges of the zonal pool helped to revisit its design?
- Designing future higher pools at the regional level?
- Existence of mechanisms, processes and dialogue forums to document successes and challenges on zonal pool as well adjusting necessary design issues?

Relevance

To what extent is the zonal CBHI pool meeting CBHI members' higher-level health service needs as well as deficit financing of woreda CBHI schemes?

- What are the strengths and weaknesses of the design of the zonal CBHI pool in terms of its processes and core strategic issues being addressed?
- Was the zonal CBHI pool designed to meet the needs of individual CBHI members in accessing secondary and tertiary care? Is it relevant to all members of the pool?
- Are the zonal pool establishment criteria feasible to scale to other zones and higher-level pools? If not, what needs to be adjusted?
- To what extent does the zonal pool address the concept of risk sharing, and deficit financing of the woreda CBHI schemes? What are the strengths and gaps in this regard?

What are the major characteristics of the zonal CBHI pool that make it more relevant to enhancing acceptability and sustainability of CBHI scheme? Please give examples and evidence for each of the following?

- Addressing CBHI members' needs and priorities in accessing general and specialized hospitals at different levels (zonal, regional and federal level providers) and other non-contracted providers for accessing services and medicines that are not available in contracted health facilities?
- Addressing the financial challenges of woreda CBHI pools that are in deficit?
- Reducing the transaction cost of health providers and households in getting reimbursement for their costs?
- Aligning of the zonal pool's management with the overall zonal health planning, budgeting process to foster resource mobilization in case of deficits?

Effectiveness: To what extent the Zonal CBHI Pool objectives were achieved

To what extent has the zonal CBHI pool improved health service utilization at higher level of care (secondary and tertiary level) and access/use of services and medicines from non-contracted providers when they are not available in contracted providers? Please provide your view on successes and challenges of:

- Opening up opportunities for CBHI members to access zonal and regional hospitals? (please provide evidence)?
- Opening up of the third-party providers for services and medicines that are not available in contracted providers (please provide evidence)?
- Opening up of services to tertiary health facilities outside the regions such as tertiary hospitals in Addis Ababa (please provide evidence)?
- To what extent it enabled to enforce adherence to the referral system (please provide evidence by also comparing with other CBHI schemes beneficiaries and non-CBHI members)?
- Any influence in enhancing enrollment at woreda pools due to access to higher level care?

To what extent has the zonal pool assisted in reducing risks and enhancing deficit financing of the woreda CBHI schemes? Please provide your view on its strength, gaps and what need to be adjusted in terms of:

a) Fairness and adequacy of the different levels of contributions from woreda CBHI pools to sustain the zonal pool?

b) On time financing of the deficits of the woreda pools?

c) Functionality and inclusivity of the criteria for enrolling woreda scheme membership?

d) Affordability of payment by the pool to health providers and third-party providers?

Enhancing cost-effective service delivery by general and specialized hospital within the region

a) Extent to which access of members to secondary and tertiary hospital services within the zone improved?

b) Extent to which access of members to secondary and tertiary hospital services outside the zone improved?

c) Ability of the zonal pool to reduce the total cost of service provision?

Effectiveness of the regional support in the implementation of the zonal pool in terms of:

a) Providing technical assistance and capacity building training?

b) Providing certification when criteria are met and annual renewal of zonal pool certificate?

c) Provision of effective supportive supervision with evidence of improving performance?

d) Follow up of the purchasing agreement with the general and referral hospital, as well as proper service delivery by providers and on time reimbursement of costs by the pool?

e) Support the development of mechanisms of additional income generating mechanisms by the pool?

f) Any successes, challenges and recommendation for future design of zonal pools?

Efficiency

a) From the evidence you have, do you think the woreda CBHI pools are using the leverage of the zonal pool to enforce the implementation of the referral guidelines? Any successes and challenges in this regard?

b) Is the zonal pool getting on time payment of contribution from the woreda pools and also reimburse health providers at general and specialized hospitals on time? Any success and challenges?

c) From your understanding how far do you think health providers are charging fairly the zonal pool? Any successes and lessons learnt from the clinical and financial audit?

d) How efficient are the financial management, clinical and financial audit processes? Please describe the capacity, success and challenges of these systems?

Sustainability

In your view, what are the major innovations, successes, and challenges of zonal pool in ensuring sustainability? Please describe your view, by exploring the following:

a) The extent to which woreda and zonal CBHI pools are financially sustainable (ability of the pool to finance the different levels of care, capacity of the pool to reimburse insolvent schemes, trends of woreda and zonal pool reserves, and revenue and expenditure trend of both woreda and zonal schemes?

b) Existence of adequate zonal structures that have clear mandate and financial capacity to be ultimate reinsurer if and when the pool funds are not sufficient to cover the pool expenditures?

c) Existence of adequate structures, systems (financial management, negotiating with providers, auditing (both financial and clinical) and capacity (number of human resources, skills and motivation) to run and manage the zonal pool?

d) The extent to which contributions are paying both service delivery costs and financing deficits of woreda CBHI schemes)?

e) Any successes and challenges in ensuring sustainability of achievements both at woreda and higher-level pools?

f) The efforts made by regional, zonal and woreda governments to enhance sustainability of risk pooling

g) Implications on the establishment of the higher-level pools?

2. *Key Informant Interviews for Zonal Curative and Quality Assurance Officers*

Design and Implementation

Please describe your view on the strengths and gaps in the design and implementation of the zonal pool as well as your recommendations in terms of:

- The extent to which the different woreda CBHI schemes and other stakeholders are actively involved in the design of the zonal pool?
- The extent to which the different structures outlined in the guideline are in place and functional?

- The extent to which the different systems (financial management, audit, etc.) are in place and functional?
- The extent to which the successes and challenges of the zonal pool helped to revisit its design?

Relevance

To what extent is the zonal CBHI pool meeting the CBHI member higher-level health service needs as well as deficit financing of the woreda CBHI schemes

- What are the strengths and weaknesses of the design of the zonal CBHI pool in terms of processes and core strategic issues being addressed?
- Was the zonal CBHI pool designed to meet to the needs of CBHI individual members in accessing secondary and tertiary care? Is it relevant to all members of the pool?
- Are the zonal pool establishment criteria feasible and scalable to other zones and higher-level pools? If not what needs to be adjusted?
- To what extent the zonal pool addresses the concept of risk sharing, deficit financing of the woreda CBHI schemes? What are the strengths and gaps in this regard?
- What are the major characteristics of the zonal CBHI pool that make it more relevant to government policies, strategies and implementation modalities? Please give examples and evidence for each of the following?
    - Addressing CBHI members' needs and priorities?
    - Addressing the financial challenges of woreda CBHI pools that are in deficit or reduce future insolvency risks?
    - Reducing the transaction cost of health providers and households in getting reimbursement for their costs?
    - Aligning of the zonal pool's management with the overall zonal health planning, budgeting process to foster resource mobilization in case of deficits?
    - Existence of mechanisms, processes and dialogue forums to document successes and challenges on zonal pool as well adjusting necessary design issues?

Effectiveness: To what extent were the Zonal CBHI Pool objectives achieved

To what extent did the zonal CBHI pool improve health service utilization at a higher level of care from contracted referral health providers (secondary and tertiary level) and access to non-contracted providers for services and medicines that are not provided in the contracted health facilities? Please provide your view on successes and challenges of:

- Opening up opportunities for CBHI members to access zonal and regional hospitals? (please provide evidence)?
- Opening up of non-contracted providers for services and medicines that are not provided in the contracted health facilities-the third-party providers (please provide evidence)?
- Opening up of services in tertiary hospitals in Addis Ababa (please provide evidence)?
- Adherence to the referral system (please provide evidence)?
- Any influence in enhancing enrollment at woreda pools due to access to higher-level care?

To what extent has the zonal pool assisted in reducing risks and enhancing deficit financing of the woreda CBHI schemes? Please provide your view on its strengths, gaps and what needs to be adjusted in terms of:

a) Fairness and adequacy of different levels of contributions from woreda CBHI pools to sustain the zonal pool?

b) On time financing of the deficits of the woreda pools?

c) Functionality and inclusivity of the woreda CBHI membership criteria?

d) Fairness and affordability of payment by the pool to health providers and third-party providers?

Enhancing cost-effective service delivery by general and specialized hospital within the region

a) Extent to which access of members to secondary and tertiary hospital services within the zone improved?

b) Extent to which access of members to secondary and tertiary hospital services outside the zone improved?

c) Ability of the zonal pool to reduce the unit cost of service provision?

Effectiveness of the zonal and regional support in the implementation of the zonal pool in terms of:

a) Following up of the quality of service provided by contracted health facilities; identify the gaps, provide recommendation for the ZHD and RHB on how the gaps can be addressed?

b) Following up of proper recording of actual service delivery and their cost and undertaking analysis of requested payment with the contract?

c) Undertaking a clinical audit and providing recommendation for payment for the zonal pool?

d) Support and play actively in the development of an annual plan and budget?

e) Documenting the services provided outside the contracted facilities by third parties for accessing/using services and medicines that are not available/provided in contracted health facilities) and reporting to the zone and region?

Efficiency

a) From the evidence you have, do you think the woreda CBHI pools are using the leverage of the zonal pool to enforce the implementation of the referral guidelines? Any successes and challenges in this regard?

b) Is the zonal pool getting on time payment of contribution from the woreda pools and also reimburse health providers at general and specialized hospitals on time? Any success and challenges?

c) From your understanding, how far do you think health providers are charging fairly the zonal pool? Any successes and lessons learnt from the clinical and financial audit?

d) How efficient are the financial management, clinical and financial audit processes? Please describe the capacity, success and challenges of these systems?

Sustainability

In your view, what are the major innovations, successes, and challenges of zonal pool in ensuring sustainability? Please describe your view, by exploring the following:

a) The extent to which woreda and zonal CBHI pools are financially sustainable (ability of the pool to finance the different levels of care, capacity of the pool to reimburse insolvent schemes, trends of woreda and zonal pool reserves, and revenue and expenditure trend of both woreda and zonal schemes?

b) Existence of adequate zonal structures that have clear mandate and financial capacity to be ultimate reinsurer if and when the pool funds are not sufficient to cover the pool expenditures?

c) Existence of adequate structures, systems (financial management, negotiating with providers, auditing (both financial and clinical) and capacity (number of human resources, skills and motivation) to run and manage the zonal pool?

d) The extent to which contributions are paying both service delivery costs and financing deficits of woreda CBHI schemes?

e) Any successes and challenges in ensuring sustainability of achievements both at woreda and higher - level pools?

f) The efforts made by regional, zonal and woreda governments to enhance sustainability of risk pooling

g) Implications on the establishment of the higher-level pools?

3. *Key Informant Interviews for Zonal CBHI Board*

Design and Implementation

Please describe your view on the strength and gaps in the design and implementation of the zonal pool as well as your recommendations in terms of:

- The extent to which the different woreda CBHI schemes and other stakeholders are actively involved in the design of the zonal pool?
- The extent to which the different structures outlined in the guideline are in place and functional?
- The extent to which the different systems (financial management, audit (financial and clinical), etc.) are in place and functional?
- The extent to which the successes and challenges of the zonal pool helped to revisit its design?

Relevance

To what extent the zonal CBHI pool is meeting the CBHI member higher-level health service needs as well as deficit financing of the woreda CBHI schemes

- What are strengths and weaknesses of the design of the zonal CBHI pool in terms of the processes and core strategic issues being addressed?
- Was the zonal CBHI pool designed to meet to the needs of CBHI members in accessing secondary and tertiary care? Is it relevant to all members of the pool?
- Are the zonal pool establishment criteria feasible and scalable to other zones and higher-level pools? If not, what needs to be adjusted?

- To what extent did the zonal pool address the concept of risk sharing, deficit financing of the woreda CBHI schemes? What are the strengths and gaps in this regard?
- What are the major characteristics of the zonal CBHI pool that makes it more relevant to government policies, strategies and implementation modalities? Please give examples and evidence for each of the following?
    - Addressing CBHI members' needs and priorities?
    - Addressing the financial challenges of woreda CBHI pools when they are in deficit?
    - Reducing the transaction cost of health providers and member households for out-of-pocket payments in non-contracted health facilities in getting reimbursement for their costs?
    - Aligning of the zonal pool's management with the overall zonal health planning, budgeting process to foster resource mobilization in case of deficits?
    - Existence of mechanisms, processes and dialogue forums to document successes and challenges on zonal pool as well adjusting necessary design issues?

Effectiveness: To what extent the Zonal CBHI Pool objectives were achieved

To what extent did the zonal CBHI pool achieve improve the health service utilization at a higher level of care (secondary and tertiary level)? Please provide you view on successes and challenges of:

- Opening up opportunities for CBHI members to access zonal and regional hospitals? (please provide evidence)?
- Opening up of non-contracted providers for services and medicines not available in contracted providers (please provide evidence)?
- Opening up of services and medicines in tertiary hospitals and non-contracted providers in Addis Ababa (please provide evidence)?
- Adherence to the referral system (please provide evidence)?
- Any influence in enhancing enrollment at woreda pools due to access to higher level care?

To what extent the zonal pool assisted in reducing risks and enhancing deficit financing of woreda CBHI schemes? Please provide your view on its strength, gaps and what need to be adjusted in terms of:

a) Fairness and adequacy of contributions from woreda CBHI pools to sustain the zonal pool?

b) On time financing of the deficits of the woreda pools?

c) Functionality and inclusivity of the criteria for membership?

d) Fairness and affordability of payment by the pool to health providers and third-party providers?

Enhancing efficient and cost-effective service delivery by general and specialized hospital within the region

a) Extent to which access of members to secondary and tertiary hospital services within the zone improved?

b) Extent to which access of members to secondary and tertiary hospital services outside the zone improved?

c) Ability of the zonal pool to reduce the unit cost of service provision?

Effectiveness of the board in providing the necessary leadership and management to the zonal pool in terms of:

a) Setting the strategic directions and implement them?

b) Approval of the pools annual plan and budget?

c) Review quarterly progress reports and taking corrective actions when required?

d) Follow up of transfer of resources from members CBHI schemes on time?

e) Follow up of the financial condition of the zonal pool, and look for modalities of additional income generating schemes?

f) Ensuring the zonal pool undertakes annual financial audit (revenue and expenditure)?

g) Presenting the annual performance and audit reports to the general assembly on annual basis?

Sustainability

In your view, what are the major innovations, successes, and challenges of zonal pool in ensuring sustainability? Please describe your view, by exploring the following:

a) The extent to which woreda and zonal CBHI pools are financially sustainable (ability of the pool to finance the different levels of care, capacity of the pool to reimburse insolvent schemes, trends of woreda and zonal pool reserves, and revenue and expenditure trend of both woreda and zonal schemes?

b) Existence of adequate zonal structures that have clear mandate and financial capacity to be ultimate reinsurer if and when the pool funds are not sufficient to cover the pool expenditures?

c) Existence of adequate structures, systems (financial management, negotiating with providers, auditing (both financial and clinical) and capacity (number of human resources, skills and motivation) to run and manage the zonal pool?

d) The extent to which contributions are paying both service delivery costs and financing deficits of woreda CBHI schemes?

e) Any successes and challenges in ensuring sustainability of achievements both at woreda and higher-level pools?

f) The efforts made by regional, zonal and woreda governments to enhance sustainability of risk pooling?

g) Implications on the establishment of the higher-level pools?

4. Key informant Interviews for EHIA Debre Markos Branch

Design and Implementation

Please describe your view on the strength and gaps in the design and implementation of the zonal pool as well as your recommendations in terms of:

- The extent to which the different woreda CBHI schemes and other stakeholders are actively involved in the design of the zonal pool?
- The extent to which the different structures outlined in the guideline are in place and functional?

- The extent to which the different systems (financial management, audit, etc.) are in place and functional?
- The extent to which the successes and challenges of the zonal pool helped to revisit its design?

Relevance

To what extent the zonal CBHI pool is meeting the CBHI member higher-level health service needs as well as deficit financing of the woreda CBHI schemes

- What are strengths and weaknesses of the design of the zonal CBHI pool in terms of its processes and core strategic issues being addressed?
- Was the zonal CBHI pool designed to meet to the needs of CBHI individual members in accessing secondary and tertiary care? Is it relevant to all members of the pool?
- Are the zonal pool establishment criteria feasible and scalable to other zones and higher-level pools? If not, what needs to be adjusted?
- To what extent the zonal pool addresses the concept of risk sharing, and deficit financing of the woreda CBHI schemes? What are the strengths and gaps in this regard?
- What are the major characteristics of the zonal CBHI Pool that makes it more relevant to government policies, strategies and implementation modalities? Please give examples and evidence for each of the following?
    - Addressing CBHI members needs and priorities?
    - Addressing the financial challenges of woreda CBHI pools that are in deficit?
    - Reducing the transaction cost of health providers in getting reimbursement for their costs?
    - Aligning of the zonal pool's management with the overall zonal health planning, budgeting process to foster resource mobilization in case of deficits?
    - Existence of mechanisms, processes and dialogue forums to document successes and challenges on zonal pool as well adjusting necessary design issues?

Effectiveness: To what extent the zonal CBHI pool objectives were achieved

To what extent did the zonal CBHI pool achieve improved the health service utilization at higher level of care (secondary and tertiary level)? Please provide you view on successes and challenges of:

- Opening up opportunities for CBHI members to access zonal and regional hospitals? (please provide evidence)?
- Opening up of the third-party providers (please provide evidence)?
- Opening up of services in Addis Ababa (please provide evidence)?
- Adherence to the referral system (please provide evidence)?
- Any influence in enhancing enrollment at woreda pools due to access to higher-level care?

To what extent the zonal pool assisted in reducing risks and enhancing deficit financing of the woreda CBHI schemes? Please provide your view on strength, gaps and what need to be adjusted in terms of:

a) Fairness and adequacy of contributions from woreda CBHI pools to sustain the zonal pool?

b) On time financing of the deficits of the woreda pools?

c) Functionality and inclusivity of the criteria for woreda scheme membership?

d) Fairness and affordability of payment by the pool to health providers and third-party providers?

Enhancing cost-effective service delivery by general and specialized hospital within the region

a) Extent to which access of members to secondary and tertiary hospital services within the zone improved?

b) Extent to which access of members to secondary and tertiary hospital services outside the zone improved?

c) Ability of the zonal pool to reduce the unit cost of service provision?

Efficiency

a) From the evidence you have, do you think the woreda CBHI pools are using the leverage of the zonal pool to enforce the implementation of the referral guidelines? Any successes and challenges in this regard?

b) Is the zonal pool getting on time payment of contribution from the woreda pools and also reimburse health providers at general and specialized hospitals on time? Any success and challenges?

c) From your understanding how far do you think health providers are charging fairly the zonal pool? Any successes and lessons learnt from the clinical and financial audit?

d) How efficient are the financial management, clinical and financial audit processes? Please describe the capacity, success and challenges of these systems?

Sustainability

In your view, what are the major innovations, successes, and challenges of zonal pool in ensuring sustainability? Please describe your view, by exploring the following:

a) The extent to which woreda and zonal CBHI pools are financially sustainable (ability of the pool to finance the different levels of care, capacity of the pool to reimburse insolvent schemes, trends of woreda and zonal pool reserves, and revenue and expenditure trend of both woreda and zonal schemes?

b) Existence of adequate zonal structures that have clear mandate and financial capacity to be ultimate reinsurer if and when the pool funds are not sufficient to cover the pool expenditures?

c) Existence of adequate structures, systems (financial management, negotiating with providers, auditing (both financial and clinical) and capacity (number of human resources, skills and motivation) to run and manage the zonal pool?

d) The extent to which contributions are paying both service delivery costs and financing deficits of woreda CBHI schemes?

e) Any successes and challenges in ensuring sustainability of achievements both at woreda and higher - level pools?

f) The efforts made by regional, zonal and woreda governments to enhance sustainability of risk pooling?

g) Implications on the establishment of the higher-level pools?

5. KII for East Gojjam Zone Health Department Head with CBHI and HCF Case Team (East Gojjam Zone Pool Office)

a) Why some schemes that fulfil the criteria did not join the zonal pool?

b) Are there schemes that have not renewed their membership? How many and who are they? What are their reasons for not renewing their membership?

c) What were the reason and the basis for the variation of the contribution among schemes to the pool during the second year of operation?

d) Did the decision on variation of the contribution among schemes follow the procedures outlined by the directive on the region's zonal pool directive and involved the schemes?

e) What were the reasons for the deficit/surplus for the first year of operation by both the member CBHI schemes and the zonal pool?

f) What are the major achievements of the pool compared to the situation before the zonal pool was established?

g) What are the major challenges to run and sustain the zonal pool in both the first and second year of operation?

h) What do you recommend to improve the operation of the zonal pool?

i) What is your opinion on the establishment of regional pool and what conditions should be fulfilled to establish regional pool?

j) Any other suggestions for the operation of the zonal pool and beyond?

6. KII for Contracted Health Facilities (Debre Markos and Felege Hiwot hospitals)

a) When did you have contractual agreement with the zonal pool?

b) Do you have focal person which facilitate the service and receive any complaints from zonal pool CBHI members? If no, why?

c) Please describe the mechanisms to address the issues raised (complaints) by zonal pool CBHI member patients?

d) How frequent are the clinical audits conducted to get the reimbursement for the patients you served? Any issue with regard to the clinical audit?

e) Do you get advance payment from the zonal pool to improve the service delivery? If yes, how frequent it was?

f) What are the benefits of having contractual agreement with the zonal pool compared to contractual agreements made with each of the woreda schemes? Did it save your time and reduced any administrative burden?

g) Did you have any contractual agreement with third party to provide services and avail essential medicines to CBHI beneficiaries that are not available in the hospital?

h) If yes, which services and what medicines were contracted and why were they not available at the hospital?

i) How did you establish the price for services and medicines offered by the third party (drugs and other services mainly diagnostic services)? How do you ensure such prices are in line with the guideline of the zonal pool?

j) What are the major achievements of having contractual agreement with the zonal pool?

k) What are the major challenges to provide services to the zonal pool CBHI members?

l) What do you recommend to improve the services of the hospital to zonal pool members and to other patients?

7. KII to Schemes (Both member and non-members of the Zonal pool)

III.1 For Zonal Pool Member Schemes (CBHI coordinators)

a) When did you start to be a member of the zonal pool? During the first year or second year of the operation of the zonal pool?

b) What percentage of your revenue do you contribute? How was the contribution amount determined? Were you involved? Do you think the contribution is fair? If no, please describe why it is not fair?

c) What are the benefits of the zonal pool?

d) Has the zonal pool improved efficiency in contracting with higher level service delivery and clinical audit?

e) What are disadvantages of being a member of the zonal pool?

f) What are the challenges in the implementation of the zonal pool?

g) What do you recommend to improve the benefits and services of the zonal pool?

h) Do you have any feedback from your scheme members that have used the zonal pool for accessing services at zonal pool?

   i. What are the general comments?

   ii. Are your members satisfied or not satisfied from the services?

   iii. Do you have members that access services and/or obtained medicines from non-zonal pool contracted providers? How satisfied or dissatisfied were they?

   iv. How easy and efficient is reimbursement to your members for OOPs that they effected to non-contracted providers?

III.2 For Non-members Schemes (CBHI Coordinators)

a) Why you are not member of zonal pool when you have fulfilled the criteria of 60% enrollment rate to be a member?

b) Do you have contractual agreement with higher-level hospitals (secondary and tertiary)? If no, why? If yes, what are the major successes and challenges in managing the agreement and also the clinical audit on both sides?

c) If you have contractual agreement at secondary and tertiary hospitals, what was the number of patient visits and expenditure last year?

d) What is your financial status? Do you cover all your annual expenditure and have some reserve?

e) Do you have a plan to join the pool? If no, what improvements do you expect to be part of the pool?

f) What do you hear and how do you assess performance of the zonal pool?

8. Key Informant Interviews Health Financing Improvement Program Regional Office

Design and Implementation

Please describe your view on the strength and gaps in the design and implementation of the zonal pool as well your recommendations in terms of:

- The extent to which the different woreda CBHI schemes and other stakeholders actively involved in the design of the zonal pool?
- The extent to which the different structures outlined in the guideline are in place and functional?
- The extent to which the different systems (financial management, audit, etc.) are in place and functional?
- The extent to which the successes and challenges of the zonal pool helped to revisit its design?

Relevance

To what extent the zonal CBHI pool to the meeting the CBHI member higher-level health service needs as well as equalization of the risks among the woreda CBHI schemes

- What are strengths and weaknesses of the design of the zonal CBHI pool in terms of its processes and core strategic issues being addressed?
- Was the zonal CBHI pool designed to meet to the needs of CBHI members in accessing secondary and tertiary care? Is it relevant to all members of the pool?
- Are the zonal pool establishment criteria feasible and scalable to other zones and higher-level pools? If not what needs to be adjusted?
- To what extent the zonal pool addresses the concept of risk sharing, risk equalization among the different woreda pools? What are the strengths and gaps in this regard?

What are the major characteristics of the zonal CBHI pool that make it more relevant to government policies, strategies and implementation modalities? Please give examples and evidence for each of the following?

- Addressing CBHI members' needs and priorities?
- Addressing the financial challenges of woreda CBHI pools that are in deficit?
- Reducing the transaction cost of health providers in getting reimbursement for their costs?
- Aligning of the zonal pool's management with the overall zonal health planning, budgeting process to foster resource mobilization in case of deficits?
- Existence of mechanisms, processes and dialogue forums to document successes and challenges on zonal pool as well adjusting necessary design issues?

Effectiveness: To what extent the Zonal CBHI Pool objectives were achieved

To what extent did the zonal CBHI pool achieve improved the health service utilization at higher level of care (secondary and tertiary level)? Please provide you view on successes and challenges of:

- Opening up opportunities for CBHI members to access zonal and regional hospitals? (please provide evidence)?
- Opening up of the third-party providers (please provide evidence)?
- Opening up of services in Addis Ababa (please provide evidence)?
- Adherence to the referral system (please provide evidence)?
- Any influence in enhancing enrollment at woreda pools due to access to higher-level care?

To what extent the zonal pool assisted in reducing risks and enhancing risk equalization among the different CBHI pools? Please provide your view on strength, gaps and what need to be adjusted in terms of:

a) Fairness and adequacy of contributions from woreda CBHI pools to sustain the zonal pool?

b) On time financing of the deficits of the woreda pools?

c) Functionality and inclusivity of the criteria for membership?

d) Fairness and affordability of payment by the pool to health providers and third-party providers?

Enhancing cost-effective service delivery by general and specialized hospital within the region

a) Extent to which access of members to secondary and tertiary hospital services within the zone improved?

b) Extent to which access of members to secondary and tertiary hospital services outside the zone improved?

c) Ability of the zonal pool to reduce the unit cost of service provision?

Sustainability

In your view, what are the major innovations, successes, and challenges of zonal pool in ensuring sustainability? Please describe your view, by exploring the following:

a) The extent to which woreda and zonal CBHI pools are financially sustainable (ability of the pool to finance the different levels of care, capacity of the pool to reimburse insolvent schemes, trends of woreda and zonal pool reserves, and revenue and expenditure trend of both woreda and zonal schemes?

b) Existence of adequate zonal structures that have clear mandate and financial capacity to be ultimate reinsurer if and when the pool funds are not sufficient to cover the pool expenditures?

c) Existence of adequate structures, systems (financial management, negotiating with providers, auditing (both financial and clinical) and capacity (number of human resources, skills and motivation) to run and manage the zonal pool?

d) The extent to which contributions are paying both service delivery costs and risk equalization expenditures (financing deficits of woreda CBHI pools)?

e) Any successes and challenges in ensuring sustainability of achievements both at woreda and higher-level pools?

f) The efforts made by regional, zonal and woreda governments to enhance sustainability of risk pooling?

g) Implications on the establishment of the higher-level pools?

Thank you for your collaboration.

ANNEX D: FOCUS GROUP DISCUSSION GUIDES

Instructions: At the beginning of each focus group discussion with participants, we will introduce our team and explain the purpose, confidentiality and ethics context of the assessment as stated below.

Introduction and obtaining informed consent: Good morning/afternoon! Thank you for taking the time today to speak with us; your input is highly valued and appreciated. We are conducting an assessment of the functionality of the zonal CBHI pool in East Gojjam. The purpose of this assessment is to review relevance, effectiveness, efficiency and sustainability of the zonal CBHI pool. The evidence generated about the strength and gaps of the zonal pool in terms of design and its implementation is expected to inform and improve the scheme as well as to use the evidence for the design of other zonal and possibly regional CBHI pool in the future. The assessment team has had the opportunity to review necessary guidelines and other progress reports to have a good understanding of its design and implementation. However, review of the documents alone is not adequate to provide the necessary information and evidence to improve the existing zonal pool design and inform and scale up similar programs in the future. Therefore, we would like to speak with you to hear about your experience, in your own words, in order to help us better understand what is working well, what hasn't worked well and what kind of issues need to be looked into and agreed up on during future designs.

Confidentiality:

- The information that we will collect will include individuals' names and sex of the FGD participants. The annex of the assessment report will include a list of FGD participants, but the findings or statements in the report will not be associated to any particular name of the key informant.
- Quotes from respondents will be included in the assessment report, but there will be no link between the quotes and the names of the individuals who provided the quote. In the event that the team desires to use any personally identifiable information in the report (such as a photograph of the person), the evaluators will first seek and get the permission of the FGD participants to do so.
- The information that we shall collect during this assessment will be used for the sole purpose of this evaluation. This information will not be used for any other purpose.
- Your participation in this interview is voluntary. If you do not feel comfortable answering any particular question, please let us know and we will simply go on to the next question.
- Thank you once again, for taking the time to speak with us today. If you have any questions for us, you can ask now. Would you be willing to participate in this Focus Group Discussion?

Names and titles of FGD participants:

Name	Title	Sex: M/F

Date: _____

Focus Group Discussion Guide

1. CBHI Members

Guide to the Assessment Team

This document is meant to be used as a general guide to conduct focused group discussions with members of CBHI schemes that are/have accessing/accessed general and specialized hospital services through the zonal pool. The assessment team will start by explaining briefly the purpose of the discussion, the assessment process, confidentiality, request for their consent and thank them for coming to the meeting as outlined in the preceding section.

Woreda CBHI Scheme/Name of health facility: _____

FGD No: _____

Composition of FGD Participants (5-10 people):

1. Number of males: _____
2. Number of females: _____
3. Number of youth: _____
4. Number of adults: _____

Date: _____

1. As a member of a CBHI scheme, would your briefly describe for us the major benefits you got so far from the CBHI scheme?
2. How do you get access to this general and specialized hospital referral service?
3. And what do you think are the major successes/challenges that the zonal pool brings to your benefits?
4. What is your perception about the quality of care you have received from general and specialized hospitals after the establishment of the zonal pool CBHI contracted facility in terms of:
    a. On time and use of appropriate referral system?
    b. Accessing care without having too much waiting time?
    c. Quality of services in terms of
        i. Availability, attitude, motivation and better qualified of staff?
        ii. Availability of diagnostic facilities?
        iii. Availability of essential medicines?
5. What were the benefits of the zonal pool in reducing your out-of-pocket spending? (please provide evidence?) What are the major costs you have to still pay from by your own when you access this general and specialized hospitals?
6. Any suggestions on improving the services provided by general and tertiary hospitals?
7. Any suggestion for the zonal pool to ensure you get the maximum benefits?

2. CBHI Woreda Scheme Board members

Guide to the Assessment Team

This document is meant to be used as a general guide to conduct focused group discussions with members of CBHI board members within the zonal pool. The assessment team will start by explaining briefly the purpose of the discussion, the assessment process, confidentiality, request for their consent and thank them for coming to the meeting as outlined in the preceding section.

Name of Woreda CBHI Scheme/: _____

FGD No: _____

Composition of FGD Participants (3-5 members):

1. Number of males: _____
2. Number of females: _____
3. Number of youth: _____
4. Number of adults: _____

Date: _____

1. As a board, why have your decided to be a member or not a member of the zonal pool? Please describe for us what you have considered in reaching to the decision you made?
2. As member of zonal CBHI pool, would your briefly describe for us the major benefits you got so far and the major challenges in terms of:
    a. Creating access to higher levels of care for your members?
    b. Reducing the out-of-pocket spending of your members?
    c. Financing the deficit of your scheme, if the scheme is in financial difficulty?
3. Please explain to us what works well and what doesn't in in the management of the zonal pool and its relationship with your woreda CBHI scheme in terms of:
    a. Deciding the contribution rates of woreda CBHI schemes and their fairness among different schemes?
    b. Contracting of tertiary care facilities as well as third-party providers on time?
    c. Adequately carrying out clinical and financial audit?
    d. Timely supporting your scheme when you are in financial difficulty?
    e. Functionality of the zonal board and the general assembly?
4. As a non-member of the zonal pool, what were the major factors that deter you from being a member and what do you think should be adjusted in the design and management of the zonal pool to attract your and other schemes to be a member?
5. Please provide for us any suggestions that needs to be improved in the design and management of the zonal pools as other zones start establishing such pools?