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**An assessment of Community Based Health Insurance Scheme in rural Ethiopia**

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This study aims to provide policy relevant knowledge regarding the performance of the Ethiopian pilot CBHI scheme. The study, particularly, focuses on understating factors driving the scheme initial enrollment, drop out and re-enrollment decisions. It also looks at the effectiveness of this intervention in terms of creating access to care and providing financial protections. Unlike the existing studies, it relies on a rich longitudinal household survey which includes baseline information and three follow up surveys which allow to assess trends in the CBHI uptake and the dynamic effect of the scheme on the outcomes of interest. The baseline survey covers 1632 randomly selected households from pilot and non-pilot woredas. Health facility survey collected in 2011 before the introduction of the scheme is also used in the analysis. Moreover, it uses qualitative information gathered through key informant interviews and focus group discussions.

It is found that the uptake of the scheme has been 41% of the target households in 2012 and this has increased to 58% in 2015. Membership renewal is more than 80% of the initially enrolled households. The Ethiopian scheme enrollment and retention rates are impressive as compared to the experiences of other African countries. In terms of uptake, there are substantial differences across the pilot regions. It is found that Amhara is the best preforming region with coverage rate of 68% while Tigray is the lowest one with 49% uptake rate. Variations in the extent of ownership and commitment from local administration bodies to concerted mobilization effort during the defined renewal time frame, waiting time, renewal timing, and allocation of targeted subsidies for indigent groups contributed to the differences in the coverage of the scheme across the pilot regions.

The results from multivariate analysis show that, similar to the experience of many countries, the poorest households are more likely to be excluded from the scheme mainly because the poor are unable to afford membership contribution. However, participation in productive safety net program which targets food insecure households increases the incidence of being member of the scheme by at least 13 percentage points. This is attributed to better access to CBHI knowledge and some sort of enforcement mechanisms. An increase in household size boosts the scheme uptake since the premium level is constant pre core household members regardless of family size.

Overall, this study demonstrates that the Ethiopian scheme can play a crucial role to achieve the goals of universal health coverage. However, there are a number of implementation challenges which need the attention of the concerned bodies. These include limited political commitment to mobilize the target households, lack of quality health care services, and shortage of drugs in the facilities, health workers attitude for insured patients, moral hazard behavior in services utilization, low financial capacity and difficulty to settle reimbursement claims to the contracted heath facilities, and limited knowledge about the detail of the scheme design feature