RESEARCH ARTICLE

Achieving Universal Healthcare Coverage in Ethiopia Through a Healthcare Financing Lens

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ABSTRACT

Since the mid-1970s, Ethiopia has been working towards achieving universal health coverage (UHC) to provide access to high-quality and necessary medical services to its citizens without incurring huge financial burdens on their households. However, questions concerning how financially feasible implementing UHC would be if poverty and health disparities persist throughout the country. This paper focuses on the need for health systems thinking, specifically centering on healthcare financing to improve Ethiopia's delivery of equitable health care services. A systematic review was carried out in which literature revealed that more financing is necessary to achieve UHC in the country.

Additionally, adopting a UHC financing model will address the current inequitable distribution of public spending on health which has the potential to increase the resilience of the healthcare system while improving access to health care and essential medicines. Currently, multiple factors contribute to Ethiopia's low UHC, further exacerbating health inequities already caused by poverty and infectious disease. Therefore, investment in health service financing must be scaled-up for UHC to be achieved. UHC financing will allow for transparent, equitable, and efficient allocation of healthcare resources.

INTRODUCTION

As the second-largest country in Africa, Ethiopia has made multiple attempts to achieve UHC [1]. Beginning in the 1970s, primary healthcare has been at the core of Ethiopia's healthcare approach [2]. However, health indicators suggest that progress has been slow, as Ethiopia's maternal and child mortality rates remain high despite these rates declining elsewhere. The most recent data from 2017 indicated that maternal and child mortality rates were 412 per 100,000 live births and 67 per 1,000, respectively [3].

Additionally, Ethiopia ranks 173rd on the Human Development Index, with a poverty rate of 27%, [6] and health expenditure of only 4.9% of Ethiopia's gross domestic product (GDP), the country falls short of the recommended health expenditure of 6-7% of GDP to achieve a UHC system [7]. Thus, it is evident that critical challenges and gaps in the country's healthcare system need to be addressed if Ethiopia hopes to meet its UHC target by 2030.

Health systems thinking perspective should be employed in efforts to achieve UHC, including focusing on one of the WHO's six building blocks of health systems: healthcare financing, which can be defined as the accumulation and allocation of money to cover health needs [5]. This paper will

focus on Ethiopia's healthcare financing approach to achieving UHC and explore various strategies employed by other countries to recommend policy changes to improve Ethiopia's health service delivery and achieve UHC [4].

METHODOLOGY

A search strategy was developed to identify the relevant literature on Ethiopia's healthcare financing. Search terms included: "healthcare financing" AND "Ethiopia." The search strategy was inputted into three databases: PubMed, Medline (Ovid), and Scopus, and then compiled in Covidence for screening. The PRISMA Framework illustrates the inclusion process for relevant articles. Additional articles were found using Google Scholar and grey literature from trusted organizations.

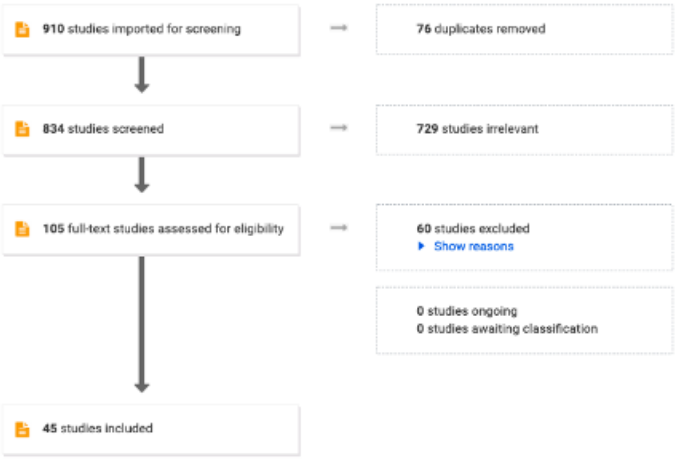

Figure 1: PRISMA Framework for selecting included articles

RESULTS

The healthcare system suffers from limited, inefficient, and inequitable use of resources, contributing to poor UHC [9]. To attain UHC, the Ethiopian government has scaled Community-Based Health Insurance (CBHI) by establishing Social Health Insurance (SHI) for formal sector workers [8]. The goal is to provide essential services to reduce health inequities by expanding health facilities from urban to rural areas. Alongside the SHI and CBHI, the essential health services package (EHSP) was established in 2005 and revised in 2019, to provide basic essential services and expand health facilities in rural areas [10].

Following the health insurance strategy implementation there was evidence of increased healthcare utilization, access to medicines, and quality of service [9]. However, EHSP, CBHI, and SHI relied heavily on health systems financing. Budget allocation for the public health sector was not sustainable, 40% of the revenue depended on donors and 37% came from out-of-pocket household expenses [9]. For example, the per capita drug expenditure from the government was 3.80 USD from 2005 to 2006, yet out-of-pocket household payments made up 47% of the total essential drug expense [9]. Moreover, it is estimated that a per capita of 94 USD would be needed by the SDG timeline of 2030 to implement ESHP effectively [11]. The most significant portion of the estimated health financing projection is cost accounting for 50% to 70% of expenditure, including drugs and commodities [11]. However, the realistic fiscal space to fully fund this portion is only 63 USD per capita. There is a clear gap in funding and resources to reach the next milestone of achieving UHC [11].

Although achieving complete UHC is rare in several African countries, Rwanda and Ghana made significant progress in providing insurance for their populations. The Ghanaian government created national health insurance by deducting 2.5% of the government workers' social security fund every month to cover poor and vulnerable areas [12]. Rwanda's health insurance was widely funded by international aid in which the government imposed new policies to reform a community-based system with individual premium payments [12].

DISCUSSION

Increasing equity in health care utilization, access to medicines, and quality of services

Ethiopia's existing healthcare financing system limits access to high-quality healthcare for populations living within lower-income, rural communities [11]. Less than 4% of spending is attributed to 20% of the lowest income populations in Ethiopia [11]. Therefore, achieving UHC in Ethiopia will increase the population's access to health care and essential medicines while also improving the quality of their care [9]. The downstream impacts of these factors will increase the utilization of health care services by increasing accessibility. Additionally, an increase in the quality of healthcare services will also encourage the population to use healthcare services [9].

Performance and coverage of UHC in Ethiopia

Currently, the UHC service coverage for Ethiopia is extremely low (34.4%) and even lower when compared with other Eastern African countries [17]. Factors contributing to this include prevalent poverty in the region, ongoing war, low literacy rate, and minimal investment in health services. WHO recommends an annual investment of 112 USD per person in low-income countries to achieve their UHC-SDG target [18], and Ethiopia has only invested 28 USD per person [19].

Developing a program that targets primary healthcare, decentralization, and an insurance system has successfully improved Ghana and India's reproductive and child health interventions coverage [13]. Thus, the evidence suggests that a UHC strategy can improve Ethiopia's healthcare systems.

Although there has been considerable progress in services designed to manage infectious and non-communicable diseases and maternal health services in Ethiopia, however coverage for these services is still deficient [14,15]. Ethiopia will benefit from better UHC financing, which involves mobilizing resources, and better monitoring and evaluation processes to ensure equitable allocation of resources.

RECOMMENDATIONS

Investing to improve the quality of healthcare is the cornerstone for achieving UHC in Ethiopia. First, UHC policies should focus to merge the existing social health insurance scheme and the CBHI scheme in Ethiopia. Implementation will be through direct tax deductions from employee payroll. For the population in the informal sector, the government should implement a monthly fee payment program, ensuring UHC is accessible to all. CBHI awareness, family health status, and quality of healthcare institutions are all factors that determine whether households want to enroll in this system.

Furthermore, sustainable awareness programs, premiums based on household financial income, and community solidarity are crucial to creating sustainable enrolment [20]. The financing of CBHI comes from premiums gathered from communities and a 25% subsidy funded by the government. Families provide monthly 0.56 or 0.80 USD, depending on region and income. If they are the poorest 10%, they receive full subsidization [21].

Moreover, the Ministry of Health should consider revising resource allocation strategies between regions. The government must prioritize redistribution of the health workforce, essential services, and access to drugs to rural areas because of increased need [16]. Studies have demonstrated that a more efficient budget structure will reduce the high burden and overreliance on out-of-pocket expenditures.

CONCLUSION

Ethiopia has made efforts to improve its healthcare system in recent years, by working towards UHC; however, significant measures need to be implemented before this goal is realized. This paper outlines recommendations aimed to implement UHC in Ethiopia through the lens of healthcare financing. By incorporating CBHI with the existing social health insurance and reallocating resources to lower-income and rural areas, the proposed recommendations aim to improve Ethiopian health indicators by ensuring equitable access to healthcare.

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