



TECHNICAL POLICY BRIEF ON COMMUNITY HEALTH INSURANCE SCHEME

**Based on a learning visit by Members of
Parliament, representatives of the Ministry of
Health and Civil Society Organisations from
Uganda to Ethiopia**

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CEHURD
social justice in health





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1.0 INTRODUCTION AND BACKGROUND

The Parliament of Uganda through the Parliamentary Health Committee has demonstrated sustained commitment and actions towards the realisation of good health and well-being for all people (SDG3), more specifically the attainment of Universal Health Coverage (UHC) with a special focus on those who are most vulnerable. UHC aims to ensure people have access to the high-quality health care that they need, when they need it without suffering financial hardship. Over the last three years, Parliament has made efforts to fast-track the enactment of Uganda's National Health Insurance Scheme Bill into law. This is important for Uganda's progress towards the realisation of UHC and indeed SDGs by 2030.

Uganda is the only country in East Africa that has not passed a national health insurance scheme and has some of the highest out-of-pocket costs for health in the region. In March 2021, the Parliament of Uganda passed the National Health Insurance Bill (NHIB) into law¹. It was passed with a pre-set benefits package that includes a range of

1. National Health Insurance Scheme. http://www.ijhpm.com/article_4281_70bd2a907e68ce3c-c3468a9ae41e63ff.pdf

essential health services including family planning, counselling and services². This was not assented to by the President and was sent back to the Ministry of Health for review. Parliament has since engaged the Ministry of Health on the revision of the Bill which is expected to be back on the floor of Parliament soon.

In preparation for the return of the NHIB on the floor of Parliament, the Parliamentary Committee on Health has made deliberate efforts to visit countries within the East African region to draw lessons from their national health insurance schemes to inform and enrich Uganda's scheme. The members of Parliament had undertaken such visits in Tanzania and Rwanda and were keen to visit another country with a different and unique scheme where sexual and reproductive health would constitute a key focus area for the learning. Ethiopia developed a health insurance implementation strategy which guides the country's social health insurance system for formal sector and community-based health insurance system for informal sector. The country's community health insurance scheme has registered

2. Advance Family Planning. Parliament of Uganda Passes the National Health Insurance Scheme Bill. <https://www.advancefamilyplanning.org/parliament-uganda-passes-national-health-insurance-scheme-bill>

remarkable performance with valuable lessons for implementation of a community health strategy, which is the main reason why Ethiopia was identified to host the learning visit of Members of Parliament, the Ministry of Health, and CEHURD in August 2023.

2.0 THE LEARNING VISIT IN ETHIOPIA, 20TH – 24TH AUGUST 2023

The 3-day learning visit was organized by the Center for Health, Human Rights and Development (CEHURD) with support from PPG and PSI for a delegation of eight officials from Uganda, representing the Parliament, Ministry of Health and Civil Society Organizations. The delegation was led by Hon. Dr Ayume Charles, Chairperson of the Parliamentary Committee on Health. Among the members of Parliament on the visit were: Hon. Kamara Nicholas Thadeus, Hon. Nandagire Christine Ndiwalana, Hon. Rutahigwa and Hon. Ayebare Margaret all from the Parliamentary Committee on Health. The MPs were accompanied by Mr. Atuhairwe Richard, a Clerk of Parliament. Ministry of Health representatives included: Dr Charles Olaro, Director Curative Services and Dr Richard Mugahi, Assistant

Commissioner for Reproductive and Child Health. CEHURD was represented by Mr Peter Eceru, Head of Advocacy. Representation of the line ministry of health in this visit was strategic given their key role in revising and re-tabling the National Health Insurance law on the floor of parliament.

2.1 Aim and Objectives of the learning visit

The learning visit aimed to enable the Ugandan delegation to draw lessons for the inclusion and implementation of a comprehensive SRHR services as part of national health benefits packages in national health insurance schemes. The learning from the visit would enable the members of parliament to give more specific attention to issues of SRHR, especially for young people, when the NHIB is brought back on the floor of parliament. Specific objectives were:

- *To enable Members of Parliament and MoH officials experience and draw lessons for implementation of SRHR policies and laws.*
- *To enable Members of Parliament and MoH officials identify lessons and best practices for the inclusion and*

implementation of SRH services as part of the benefits package in the National Health insurance schemes.

- To identify lessons and best practices for the implementation of a community healthy strategy and application of self-care in SRHR.

2.2 Key engagements undertaken

The exchange learning comprised the following specific activities:

- *Engagement with the Ethiopian National Health Insurance Service (ENHIS), a body that is responsible for the oversight of the health insurance scheme.*
- *Visit to USAID, the technical advisor for the implementation of health insurance scheme.*
- *Engagement with the Ministry of Health, specifically the Maternal and Child Health unit.*
- *Visit to a health facility (Abebe Bikila Health Center) implementing community health insurance scheme.*

- *ABT Associates who provide technical and financial support for the implementation of the community health insurance scheme.*

3.0 KEY FINDINGS

3.1 Ethiopia's health insurance history and journey

Ethiopia, just like most Sub-Saharan African countries had found it challenging to raise revenues for financing the delivery of an essential package of health services. In the face of this challenge, there has been growing interest in Social Health Insurance (SHI) and Community-Based Health Insurance (CBHI). SHI and CBHI schemes were launched in Ethiopia, Ghana, Kenya, Lesotho, Nigeria, Rwanda, South Africa, Swaziland, Tanzania, Zambia and Zimbabwe. Ethiopia is one of the countries that spends the least on healthcare services in Africa. In 2016, health expenditure was only 1.4% of gross domestic product (GDP).

Prior to the adoption of the health insurance scheme, the country faced health challenges similar to those Uganda currently faces including;

- *Overall limited resources available for health.*
- *Narrow fiscal space.*
- *High out of pocket expenditure for health services with catastrophic effect of Out-of-Pocket expenditure and high likelihood of impoverishment.*
- *Declining trends for donor funding*

To respond to these, Ethiopia developed a health care financing strategy 1998 (the same was recently revised) which was designed to achieve the following objectives;

- *Increasing resource flow;*
- *Improving efficiency of resource utilization;*
- *Ensuring sustainability of the financing system to improve the coverage and quality of health service;*
- *Ensuring equitable access*

Ethiopia has a tradition of paying for health services, that dates back to the introduction of the modern health service delivery system. Ethiopia like Uganda follows a consolidated revenue collection and budgeting system. All public institutions that are collecting revenue are supposed to channel it to the central treasury

and receive their operational funding in the form of a government budget. Similarly, in the health sector, health facilities were channelling all revenue that they had been generating internally to the treasury. This caused a lack of sense of ownership by health facility staff and health facilities, and the amount of money health facilities had been collecting and channelling to the treasury was rather insignificant. On the other hand, health facilities faced a serious shortage of resources to cover their operational costs, and, in most cases, their non-salary operational budget was being depleted by the end of the first quarter causing inefficient use of scarce resources and poor quality of health care. In response to this problem, the healthcare financing strategy, followed by the respective regional and federal laws, allowed health facilities to retain and use their revenue for health service quality improvements.

The Ethiopian health system is segmented with some services provided free of charge, while others are paid for. Some health services are provided to all citizens free of charge regardless of level of income. This has occurred because of the nature of these services and the need to promote use of certain health care services. Among services that



are provided free are SRH services for young people and this was to respond to teenage pregnancies and the need to keep most young people in school. This partly explains the low levels of teenage pregnancies in Ethiopia at 13%. Although exemption services were more standardized across regions, some services under the health insurance scheme needed standardization by government. Services that were provided free of charge in some public health facilities were not free in others in spite of the fact that they were all public health facilities. In addition, there was no clear.

Demographic Characteristics

In terms of demographics, the Ethiopian age pyramid has remained quite young with 47% of the population being under 15 years and only 4% of the entire population being over 65 years. The average lifetime fertility rate is 4.6 births per woman. The Ethiopian teenage pregnancy rate is relatively low at 13% compared to Uganda at 24%. Ethiopia is the second most populous nation on the African continent with a population of about 155 million people. Most of these live in the rural areas with about 16% of the population in urban areas and only 20% living off the formal economy.

Summary of performance of the Community Based Health Insurance

So far, the community-based health insurance system has been implemented throughout the country and enrolled more than 12 million households and 56 million population in the current fiscal year. The CBHI has had various successes, including generating additional income for health facilities and promoting cost-sharing between Government and users. Risk-sharing/ social solidarity for the non-predicted illness, providing special assistance mechanisms for those who can not afford to pay, and purchasing healthcare services were also the successes of Ethiopia's health financing. Ethiopia's health financing has significant contributions to healthcare infrastructures, medical supplies, diagnostic capacity, drugs, financial risk protection, and healthcare services. The health insurance scheme frees public resources to strengthen health system strengthening and infrastructure development.

3.2 Community Based Health Insurance (CBHI) management structure

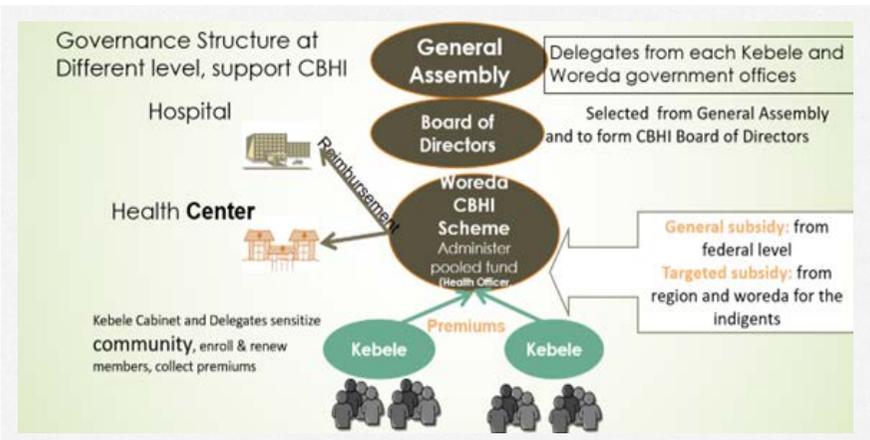
Based on the countries demographic Characteristics as indicated above,

the Ethiopian government adopted a Community Health Insurance System that would cater for the majority of Ethiopians who are outside the formal economy (80% of the population live in an informal economy). At the time of the exchange learning membership of a health insurance scheme was voluntary but amendments to the guidelines had commenced to upgrade to mandatory contributions.

The management structure of the Ethiopian Community Health Insurance prioritizes participation of communities in the management and community mobilization of communities to register for health insurance. The Ethiopian National Health Insurance Service (ENHIS) is responsible for the provision overall technical oversight, quality assurance and capacity building

for the schemes. The General Assembly which is composed of the representatives of each Kebele and Woreda, is the supreme decision-making authority at the Woreda level. A woreda is an equivalent of a district in Uganda while a kabele is an equivalent of a ward. The General Assembly elects a board that is accountable to the General Assembly and exercise oversight over the Woreda CBHI scheme. The Woreda CBHI scheme is responsible for the day-to-day administration of the health insurance scheme operations in the woreda. It should be noted that the leaders of the Kebele are primarily responsible for the sensitization of the community, enrolment of new members and renewals and collection of premiums. At this level the role of the EHIS is to build the capacity of the community structures.

Figure one: Community Based Health Insurance administrative structure



3.3 Community Ownership

The government of Ethiopia has taken Community Based Health Insurance Initiative as a prime intervention to bring health as an agenda of priority both to the public and community. ENHIS and all partners roll out training for key stakeholders, are engaged in advocacy sessions and mobilization events to ensure buy in on the rationale, objective and principles of CBHI to political and community leaders. The principles of Community health Insurance scheme have been popularized through the Health Extension Workers (HEWs), village CBHI coordination councils and local administrative bodies.

To promote the health insurance scheme, emphasis was placed on community mobilization to ensure that there is community ownership. Community mobilization is specifically important because the health insurance is currently voluntary.

The following principles are key for communities;

- *It is a non-profit kind of insurance.*
- *Formed based on the principle of solidarity and cross subsidization.*
- *Community mobilization and advocacy*

- *The benefits of CBHI, eligibility for membership, contribution, benefit package, and membership rights and obligations through direct and indirect community participation in different levels and geographies.*

3.4 Community mobilization for health insurance

The scheme invests in formal media to reach out the wider public and community. On community awareness creation, emphasis is placed on facilitating community conversations on CBHI with community opinion leaders, and faith leaders among others. Community buy-in has been critical given the fact that the health insurance scheme has been voluntary. Even in circumstances where it is mandatory, it will be critical for government to invest in Community mobilization.

The development of CBHI program in Ethiopia involved many stakeholders who played different roles at different stages including governance, and community ownership. By design, the CBHI in Ethiopia allows for community participation with government focusing on governance and management of the schemes. The policymakers designed the



CBHI to be community-driven with support provided by the government. The participation of communities constitutes a critical component of building trust in CBHI. The government formalized CBHI by establishing the schemes within and making them accountable to existing government structures and allocating budget for their operational expenditures.

The community, represented by three members from each kabele, is part of the General Assembly which convenes once a year to review and approve CBHI scheme plans and budgets, and to listen to scheme performance and audit reports. To ensure more routine participation of the community, three community representatives are elected to the CBHI scheme board, joined by representatives from selected government sector offices.

3.5 Decision to start CBHI and Membership

As per the CBHI directive, the decision to begin a CBHI scheme is made at the kabele level by a collective decision of the residents of the kebele (simple majority). Individual households decide if they would like to enroll in CBHI by paying the membership contribution. The

regional directives indicate that the unit of enrollment is the household to reduce adverse selection of membership. However, to account for differences in family structure in the different communities, discretion was left to Woredas and the community therein on how to include or exclude extended family members. It is important to reflect on the fact that in the current situation, Ethiopian health insurance is a voluntary scheme, and this has an impact in terms of choice to join a health insurance scheme. At the time of the exchange learning, a decision had been taken to make health insurance payments compulsory for all.

3.6 Contribution and collection mechanism

Financing for the health insurance scheme is derived from the payment of premiums by the members of the health insurance scheme and government contributions in the form of subsidies. In the Ethiopian context, subsidies take 2 forms, one by the local government to cater for indigents and then the central government standard subsidy which is 25% of the collected premium. Government contribution of the 25% is a motivation for the local leaders of the health insurance scheme to



creatively mobilize resources for the insurance scheme - the more you can mobilize locally, the more the government will contribute. The Financial, Administration, and Management Systems (FAMS) manual explains how CBHI members are registered, how CBHI contributions are collected, how reimbursements are made to health facilities, and the required management and financial records that must be maintained at a CBHI. The contribution rate was managed by a flat rate determination and family size discretion base once by the regional directive open to upward revision by the GA to secure financial sustainability of each CBHI schemes/basic pools. However, the EHIS is working on how to standardize the determination of the contribution based on sliding scale against income of the CBHI members to make it more equitable, progressive, and sustainable as per the federal council envisioning for a larger unified pool.

The conventional premium collection is made manually as per the clear FAMS adopted by the region. Legal receipt vouchers are distributed to kebele CBHI cashiers then to sub kebele cashiers to facilitate premium collection through door to door or public gatherings of local districts. The members are paying the yearly

stated premium to renew or newly enroll to the CBHI system to the CBHI cashiers and getting an official payment receipt. Kebele cashier is responsible for depositing the cash to banks on the stated CBHI account with the consultation and follow up of the scheme finance officials.

3.7 How cashiers are selected

As indicated above, cashiers are responsible for the collection of premiums from newly enrolled or for renewals. CBHI cashiers are selected by direct community participation, considering key qualities that include; trust by the community members, experience on successful collection and management of community contributions before, basic literacy skills and volunteer to serve the community with no or minimal commission. Regional directives address 2% of the collected amount to be a commission for them with detailed analysis before ensuring the payment.

3.8 Claim Management

The claim management process is based on the health insurance guiding principles which provide for the separation of purchasers from providers. To facilitate the process of managing claims from health



facilities implementing community health insurance, a claims directorate was established with a presence at both national and branch levels. Claims Management is considered the key operation to the success of health insurance implementation. Claim management is based on a request sent from a health care provider to a health insurance system for reimbursement based on services that have been provided to a beneficiary who is eligible for the services covered by the health insurance system.

To facilitate the claim process, a clinical audit manual was established, and this enabled the National Health Insurance Service to discharge its activities as per the agreement and standard of care. Claim audit involves a process of validating claims submitted by health care providers through systematically examining the beneficiary, services, and costs. It encompasses pre-payment, beneficiary, and post-payment audit. The mandate of the claim's directorate includes, among others;

- *To strengthen the practice of timely, accurate and efficient reimbursements of claim data set, through ensuring claim batches are paid on time, and minimum health insurance*

resources are engaged.

- *To prevent, detect and mitigate claim data set fraud. This is done through prevention measures, minimize improper claims affected by fraud and moral hazards on the part of service provider and beneficiaries, ensure quality by validating submitted claims against standards of care and contractual agreement and finally, application of health insurance adjudication measures or billing.*

The Claims directorate is also critical in the provision of synthesized information for strategic decision-making and ensuring that claimed costs are correctly calculated according to cost of the services, payment modality and benefit package. This process further helps in health service cost projections and approaches to ensure financial sustainability.

The directorate also serves the purpose of;

- *Validation of provider quality assurance: It determines the quality of the services provided by comparing them to the contract and standard clinical*

guidelines. For example, do the services provided match the diagnosis, the detection of stock-outs, etc.

- *Validation of beneficiary: It confirms whether the beneficiary received the entitled services under the health insurance system. This further shows beneficiaries' confidence in the health insurance program.*

3.9 Benefit Package

Currently, Community Based Insurance Service caters for the following service package;

- *Outpatient care;*
- *Inpatient care;*
- *Delivery services;*
- *Surgical services;*
- *Diagnostic tests and generic drugs included in the drug list of the Agency and prescribed by medical practitioners.*

The Ethiopian Health Insurance benefit package broadly sets out a list of general services. The list excludes many services as compared to those that are provided by the scheme. There is a lack of evidence regarding the cost effectiveness of the interventions since there is no defined list of services and therefore,

it is difficult to cost in the current benefits package. It is difficult to hold providers accountable for service delivery due to lack of a common understanding of services that need to be available. To respond to these challenges EHIS is currently redesigning an explicit Benefit Package.

While health service delivery in Ethiopia is generally paid for, government has maintained a category of service as free for all. These include services that relate to child and adolescent health. This is in line with government commitment to further reduce teenage pregnancy across the country.

3.10 Sexual and reproductive health services

The country has also successfully implemented evidence-driven actions for better management of high-risk unwanted pregnancies, resulting into reduced maternal deaths. They have important lessons on the inclusion or exclusion of maternal and child health services in health benefits packages. Over the last 2 decades, through a series of concerted, policies, programs and commitments, Ethiopia has made notable advances in improving the



reproductive health of its population, including expanding Family Planning information and services to larger segments of its population. The national health extension program and the accelerated expansion of primary health care services to increase both availability and accelerated expansion of primary health care services to increase both availability and accessibility of essential services have both proven pivotal to expanding Family planning access, most notably among the country's rural population. In the Adolescent and Youth health strategy, Ethiopia commits to reduce teenage pregnancies from 13% to 7% by 2025. The new strategy emphasizes multi sectoral approach in the provision of Adolescent and youth service including the review of the training curriculum of health workers with the view of strengthening health workers competencies in the provision of youth friendly services.

Concerning cost barriers for adolescent and youth service utilization, the government prioritizes the use of cost waivers, health insurance, and subsidized fees. Considering adolescent and youth financial limitations the government promotes community health insurance to make sure cost barriers

are addressed. To take services closer to the communities, Ethiopia has incorporated adolescent and young people's SRHR in their primary health care system.

With a goal of reducing maternal mortality and morbidity, Ethiopia liberalized its abortion law in 2005, making it one of the early champions in Africa of expanding access to safe and legal abortion services. Ethiopia expanded its abortion law, which had previously allowed the procedure only to save a life of a woman or protect her physical health. The amendment expanded the circumstance under which abortion can be done to include; cases of rape, incest or fetal impairment, if she has physical or mental disabilities or if she is a minor who is physically or mentally unprepared for childbirth.

LESSONS LEARNT

1. From the start of a health insurance scheme there must be clear distinction on what health insurance premiums will be used for and what will be catered for by the public health financing. This should be determined by national policy priority issues. In case of Uganda for example, since the priority is on controlling teenage pregnancies, investment would be toward improving responsiveness of service delivery to the health needs of young people.
2. The existence of public health insurance does not mean available services have to be provided under the scheme. Services like SRH for young people and maternal health services should be provided free of charge. While the services are provided free of charge, resources from health insurance should be used to supplement government budgetary allocation especially for SRH commodities. This reduces overreliance on external sources for SRH services and commodities.
3. Community ownership and confidence in the public health insurance scheme is critical for the successful implementation of health insurance. Where there is public confidence, contributions are voluntary. This can be achieved through media engagement and involvement of community gate keepers including political leaders, religious leaders among others.
4. Success of a public health system is rooted in a transparent and accountable system. This comes along with anti-fraud systems that bolster public confidence in a public health insurance scheme. These should ensure that service providers are able to receive reimbursements in a short time and service recipients are guaranteed quality services.
5. It is important to allow health insurance schemes to grow organically over time. This enables the country to learn through the implementation process. It is evident that over time Ethiopia has consistently modified its guidelines to reflect the growth in health insurance.
- 6.

4.0 KEY CHALLENGES

Whereas the Community Based Health Insurance scheme has registered a number of achievements, there are several challenges it continues to face. These challenges can be instrumental in informing Uganda's path to a public health insurance scheme;

- 1. The entire community health insurance scheme is manual, making it less efficient and difficult to manage. Right from admission, collection of premiums, renewals, and processes at the health service provision point are manual. These delays in claim handling processes lead to delays in reimbursement to health facilities. This results in negative impacts on quality-of-service delivery. Computerization would allow scheme staff more time to spend on quality assurance and engaging membership.*
- 2. Drug stock out continues to be a major challenge. Part of the component of the health insurance includes access to medicines and supplies, how in most cases, health facilities and the medicines supply agency do not have medicines, and this negatively affects public confidence in the health insurance scheme.*
- 3. Financing challenges due to delay in reimbursements and this has an impact on availability of drugs and supplies and quality of service. This ultimately jeopardizes members confidence/trust in the entire insurance system, degrading the enrollment performance of schemes and their potential to generate revenue.*

5.0 RECOMMENDATIONS FOR UGANDA

1. Uganda should clearly set out services for which access will not require a health insurance system. Since Uganda has adopted universal access to primary health care, it is important to ensure that young people's SRHR will continue to be free. Even those who are incapable of paying for health insurance should be able to access free services of the same quality as those on health insurance.
2. Strengthening Antifraud mechanism: Health insurance is prone to fraud, and this affects the quality-of-service provision. The currency for insurance generally and health insurance is the trust of the communities that their money is safe and that they receive the quality of service that they deserve.
3. Strengthening the quality of health service delivered: When citizens contribute towards health insurance, they should be assured of a certain standard of care in the public health system. The claim reimbursement process should therefore audit not just the service provided but also investigate the quality of service provided to the recipient.
4. Community Mobilization: since communities are the primary contributors of insurance premium, community mobilization is a critical aspect in successful management of the fund. The Ethiopian experience has demonstrated the important role of the political leadership at all levels in community mobilization.
5. Cost effectiveness of the health insurance scheme: The management of the health insurance system must remain cost effective. To achieve this, there is a need for tapping into existing structures to ensure cost effectiveness of the management of the health insurance scheme.
6. Build a self-accounting system with internal checks and balances. To ensure this is done, we need to distinguish between



the administrator of the fund and the service provider. This will enable the administrator of the fund to exercise effective oversight over the service provider, ensure quality of service, and avoid fraud.

7. Currently, Regional Referral hospitals in Uganda run private wings in their hospitals. These private wings remit all collections to the treasury and only await budgetary disbursements to the health facilities. This is a disincentive to health facilities which collect this money especially as they continue to grapple with challenges consumables, water, and electricity, among others. The government of Uganda needs to take a learning from the Ethiopian health system and give a waiver to use resources locally collected by especially regional and national referral hospitals.

6.0 CONCLUSION

The lessons from the Ethiopian experience indicate that it is critical to allow health insurance ecosystem to grow organically and keep reviewing the law and regulations as this growth takes root. What is key is to ensure that fraud is dealt with from the onset, mechanisms must be established for detection and investigation of fraud.

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