



Uptake of health insurance and the productive safety net program in rural Ethiopia



Zemzem Shigute ^a, Anagaw D. Mebratie ^a, Robert Sparrow ^{b, c}, Zelalem Yilma ^a, Getnet Alemu ^d, Arjun S. Bedi ^{a, *}

^a International Institute of Social Studies, Erasmus University Rotterdam, The Netherlands

^b Erasmus University Rotterdam, The Netherlands

^c Wageningen University, The Netherlands

^d Addis Ababa University, Ethiopia

ARTICLE INFO

Article history:

Received 24 November 2015

Received in revised form

21 December 2016

Accepted 22 January 2017

Available online 23 January 2017

Keywords:

Ethiopia

Productive safety net program

Community based health insurance

Uptake of health insurance

ABSTRACT

Due to lack of well-developed insurance and credit markets, rural families in Ethiopia are exposed to a range of covariate and idiosyncratic risks. In 2005, to deal with the consequences of covariate risks, the government implemented the Productive Safety Net Program (PSNP), and in 2011, to mitigate the financial consequences of ill-health, the government introduced a pilot Community Based Health Insurance (CBHI) Scheme. This paper explores whether scheme uptake and retention is affected by access to the PSNP. Based on household panel data and qualitative information, the analysis shows that participating in the PSNP increases the probability of CBHI uptake by 24 percentage points and enhances scheme retention by 10 percentage points. A large proportion of this effect may be attributed to explicit and implicit pressure applied by government officials on PSNP beneficiaries. Whether this is a desirable approach is debatable. Nevertheless, the results suggest that membership in existing social protection programs may be leveraged to spread new schemes and potentially accelerate poverty reduction efforts.

© 2017 Elsevier Ltd. All rights reserved.

1. Introduction

Rural households in Ethiopia face substantial covariate and idiosyncratic risks. As in the case of other developing countries, dependence on volatile rain-fed agriculture and absence of well-developed markets for insurance and credit exacerbate the effects of these risks. At the same time, exposure to multiple-risks increases vulnerability (Dercon, 2002; Wagstaff, 2007). For instance, when faced with illnesses, poor households may not be able to afford health care which may impair their health status. Borrowing or selling assets to meet health care expenses may lead to impoverishment which further weakens their ability to withstand non-health related shocks. The potential interplay between different types of shocks suggests that multiple interventions may simultaneously be needed to provide effective social protection for

vulnerable groups (Ranson, 2002; Ssewamala et al., 2010; Wagstaff, 2007). Although there is no dearth of studies which analyse access to and the impact of different types of interventions, research which focuses on potential links between different social protection programs is scarce.

In recent years, a number of developing countries have introduced voluntary community based health insurance schemes to mitigate the potentially impoverishing effects of ill-health. A common problem plaguing such voluntary health insurance schemes is low enrolment and high dropout rates (for a review see Mebratie et al., 2013) and in an attempt to increase demand for insurance, bundling of health insurance with microfinance loans has been suggested as a potential strategy (Banerjee et al., 2014; Dror et al., 2009; Hamid et al., 2011; Ranson, 2002; Ranson et al., 2006). Evidence on the effectiveness of such an approach yields a mixed picture. For instance, Banerjee et al. (2014) analyse the effectiveness of offering health insurance through a microfinance scheme in India. This experiment was unsuccessful as the poor quality of the insurance product led to negative effects which culminated in a withdrawal from the microfinance scheme itself. On a more positive note, Hamid et al. (2011) found that microcredit

* Corresponding author. International Institute of Social Studies, Erasmus University Rotterdam, Kortenaerkade 12, 2518 AX, The Netherlands.

E-mail addresses: shuka@iss.nl (Z. Shigute), mebratie@iss.nl (A.D. Mebratie), robert.sparrow@wur.nl (R. Sparrow), debebe@iss.nl (Z. Yilma), galemu2001@yahoo.com (G. Alemu), bedi@iss.nl (A.S. Bedi).

clients of Grameen Bank in Bangladesh who had access to health insurance offered by Grameen Bank were more likely to be food sufficient as compared to microcredit clients who did not have access to the insurance product. Based on their study of providing health insurance through the Self-Employed Women's Association (SEWA) in India, [Ranson et al. \(2006\)](#) argue that offering health insurance through community-based associations like SEWA is more effective in terms of reaching out to low-income women as compared to stand-alone schemes as insurance offered through existing programs offsets the lack of institutional capacity to run such schemes.

A similar enrolment issue which has been observed in developing countries that have attempted to reach Universal Health Coverage (UHC) through social insurance based programs is the so-called missing-middle problem. The formal sector can be obliged to enrol through typical social insurance designs, with compulsory payroll based contributions. However, such mechanisms are not effective for achieving universal coverage in countries with a large informal economy. The missing-middle problem describes the phenomenon where mandatory enrolment of formal sector workers is combined with subsidized premiums targeted to the poorest, while insurance uptake for the remainder of the informal sector relies to some extent on voluntary enrolment. International experiences suggest that it is extremely difficult to convince informal sector households to enrol voluntarily into health insurance, without providing strong (monetary) incentives to do so ([Capuno et al., 2014](#); [Wagstaff et al., 2014](#)). However, there is no empirical evidence on the effectiveness of policy instruments that leverage insurance uptake for the informal sector by integrating social policies.

In June 2011, the Ethiopian government introduced a voluntary Community Based Health Insurance (CBHI) in thirteen rural districts of the country. Several of these districts are food insecure and are locations where the Productive Safety Net Program (PSNP), the government's flagship program to deal with covariate risk, also operates. The PSNP program targets food insecure households in chronically food insecure regions. Recognizing the interlinkages between the impoverishing effects of different shocks, an explicit goal is to use the PSNP as a platform to help food insecure households access other social protection programs ([MoARD, 2010](#)). Such an approach is potentially promising in terms of helping the most vulnerable households deal with multiple shocks and at the same time increasing demand for insurance.

Whether the PSNP does enhance access to other social protection programs for food insecure households and more importantly, the channels through which this takes place are open questions. *A priori* it may be expected that food insecure households will be less likely to afford insurance. However, there are a number of reasons why PSNP beneficiaries may be more likely to join the scheme such as a higher chance of obtaining a premium payment waiver or greater information about the benefits of insurance scheme as compared to non-PSNP members. To shed light on such issues, this paper examines the links between the CBHI scheme and the PSNP. In particular, we examine whether being a PSNP beneficiary influences initial enrolment in the CBHI scheme and thereafter whether it influences scheme retention. While the effect of various factors on enrolment and drop-out has been explored by [Mebratie et al. \(2015a\)](#) and [Mebratie et al. \(2015b\)](#), the focus of these papers was not on the role played by the PSNP. This paper's main contribution is that we attempt to identify the channels through which the PSNP may influence uptake and renewal. The study relies on several rounds of focus group discussions and key informant interviews, three rounds of panel data and a health facility survey. It should be noted that the possibility of using existing social protection programs to encourage entry into a new program is of

interest not only to Ethiopia but also to other countries that are using voluntary health insurance schemes to encourage access to health care.

The next section of the paper briefly describes the PSNP and CBHI schemes. Section 3 discusses the data, section 4 lays out the research methods, section 5 contains empirical results and section 6 concludes.

2. A brief overview of PSNP and CBHI in Ethiopia

The PSNP has been designed to deal with covariate risk while the recently piloted CBHI is expected to become the key program to deal with the financial consequences of ill-health.

2.1. The productive safety net program

In 2003, the Ethiopian government initiated discussions with its development partners to replace the existing emergency response of using food aid to fill consumption gaps. These consultations led to the creation of the PSNP which articulated a shift from an emergency relief system to sustainable food security.

Launched in January 2005, the PSNP has three main objectives: to protect food insecure households in food insecure regions by providing resources to smooth consumption during the lean season, protect households by preventing sales of assets and reducing the probability of borrowing and further impoverishment, and finally to promote livelihoods by building community assets with development potential. Program participants are selected through a participatory approach, and households with able-bodied members are expected to undertake public works activities in return for payment either in cash or in kind. The program operates in 319 food insecure districts (40% of the total districts) located in eight regions of the country ([MoARD, 2011](#); [FDRE, 2012](#)). In 2013–14 the program had a cash budget of about \$205 million and access to food resources to the tune of 274,844 metric tonnes and provided social transfers to about 6 million food insecure individuals either through “public works” activities (4.8 million) or as “direct support” (1.2 million) for labor constrained households ([MoA, 2013](#)).

A key objective of the current phase of the PSNP is to forge links between the PSNP and other food security and development programs. As stated in the Program Implementation Manual, PIM ([MoARD, 2010](#): 6):

“The PSNP is not a project but a key element of local development planning. PSNP plans are integrated into wider development plans at *woreda*, zone, region and federal levels.”

2.2. Community based health insurance

In June 2011, the Ethiopian CBHI pilot was launched in 13 districts (for details see [Mebratie et al., 2015a](#)). The introduction of the scheme was driven by the government's aim to enhance access to health care through risk-pooling arrangements and a desire to generate domestic sources to finance and support health care while at the same time reducing reliance on donors. The scheme is government-driven but with community engagement in insurance design, participation, management and supervision. At the design phase, regional governments were involved in determining benefit packages, registration fees, premium payments and co-payments. The role-out phase involved a two-step process, with first the community deciding whether to participate in the scheme and subsequently households could choose whether to enrol or not. The insurance covers households rather than just individuals, in order to reduce adverse selection.

متن کامل مقاله

دریافت فوری ←

ISIArticles

مرجع مقالات تخصصی ایران

- ✓ امکان دانلود نسخه تمام متن مقالات انگلیسی
- ✓ امکان دانلود نسخه ترجمه شده مقالات
- ✓ پذیرش سفارش ترجمه تخصصی
- ✓ امکان جستجو در آرشیو جامعی از صدها موضوع و هزاران مقاله
- ✓ امکان دانلود رایگان ۲ صفحه اول هر مقاله
- ✓ امکان پرداخت اینترنتی با کلیه کارت های عضو شتاب
- ✓ دانلود فوری مقاله پس از پرداخت آنلاین
- ✓ پشتیبانی کامل خرید با بهره مندی از سیستم هوشمند رهگیری سفارشات