



Federal Democratic
Republic of Ethiopia
Ministry of Health

ETHIOPIAN HEALTH ACCOUNTS

HOUSEHOLD HEALTH SERVICE UTILIZATION AND EXPENDITURE SURVEY BRIEF

2015/16

August 2017, Addis Ababa

Ethiopian Health Accounts

Household Health Service Utilization and Expenditure Survey Brief 2015/16

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Additional information about the 2015/2016 Ethiopian Health Accounts Household Health Service utilization and Expenditure Survey may be obtained from the Federal Democratic Republic of Ethiopia Ministry of Health, Resource Mobilization Directorate Lideta Sub City, Addis Ababa Ethiopia. P.O.Box:1234, Telephone: +251115517011/535157; Fax: +251115527033; Email: moh@ethionet.et; website: <http://www.moh.gov.et>

Recommended Citation:

Federal Democratic Republic of Ethiopia Ministry of Health. August 2017. Ethiopian Health Accounts Household Health Service Utilization and Expenditure Survey Brief 2015/2016, Addis Ababa, Ethiopia.

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1. Introduction

This report summarizes the results of Ethiopia's sixth Health Accounts (HA VI) Household Health Service Utilization and Expenditure Survey (HH survey), conducted in mid-2016. The survey explored:

- Health-seeking behavior,
- Use of healthcare services,
- Out-of-pocket health spending,
- Community contribution to health systems strengthening,
- Health insurance coverage of households (HHs).

This survey was conducted through the leadership of the Federal Democratic Republic of Ethiopia (FDRE) Ministry of Health (FMOH). It was funded by The Bill & Melinda Gates Foundation through the Fenot project of the Harvard T.H. Chan School of Public Health, and implemented by Breakthrough International Consultancy PLC (BIC).

The purpose of this sixth round HA household survey was to provide reliable evidence on:

- Health service utilization and expenditure, including on nutrition,
- Household contribution to health systems strengthening in Ethiopia.

2. Objectives

The specific objectives the HA VI HH survey were:

Specific Objective 1: Generate evidence on households spending (both out of pocket and insurance premiums) on health care by level and types of health care services and major diseases, as well as by level of income and other equity features;

Specific Objective 2: Assess health service utilization rates by different socioeconomic characteristics of households and regions;

Specific Objective 3: Generate evidence on specific labor and in-kind community contributions (household level investment of time and other inputs to improve health) to strengthen health systems.

3. Survey Methodology

The study used a cross-sectional analysis of 9,986 sample households to estimate household health expenditures and utilization. The HA VI HH survey sampling used the Central Statistical Agency's (CSA) 2007 population census sampling frame, with a three-stage stratified sample procedure: selecting urban/rural woredas from each region, sampling enumeration areas (EAs) from selected Woredas and finally selecting households from selected EAs. Of the total 86,805 EAs available in the country, this survey randomly selected 400 EAs from 101 woredas (4 EAs per woreda). In each EA, twenty-five households were selected systematically from a fresh list of households in each EA sampled for study. The EAs were selected and provided to the survey team by CSA.

4. Key Findings

4.1. Health service utilization

Reported Illness: Of the total sample, 10% of individuals reported being ill in the 4 weeks preceding the survey, which was higher among females (10.8%) than males (9.3%), and in urban settings (11.1%) than in rural areas (9.9%).

Care seeking among those who were ill: About 53% of individuals who reported being ill, reported visiting a health facility to seek care, a lower figure than what was reported by the NHA5 survey (62.4%), which could be due seasonal differences between the two surveys. Four main reasons reported for not seeking healthcare include: lack of money, considering illness not serious, self-medication at home, and long distance to facility.

Reasons for seeking care: Of those seeking care, half of those individuals mentioned infectious or communicable disease as the reason for seeking care, mainly due to malaria (11.1%), pneumonia (9.3%) and diarrhea (8.7%). Non-communicable diseases (NCDs) were cited as a reason for seeking care by 10% of individuals who sought care.

Variation in care seeking: There was significant variation among regions in seeking care for an illness:

- The lowest rate was observed in Amhara, where 39% of those reporting illness had sought care, and the highest rate was in Harari, where 79.5% of those reporting illnesses had sought care. A relatively low level of seeking care in Amhara was documented by the previous NHA survey and at least one other study.
- Individuals in the lowest wealth quintile were slightly more likely to report experiencing illness, but they were less likely to report having sought care.
- The survey documented a clear positive association between economic status and healthcare seeking behavior, as well as a positive association between age and reported incidence of illness, for both males and females.
- Prevalence of chronic illness: Eleven percent of respondents reported having at least one chronic condition, such as cancer, diabetes, kidney diseases or a mental disorder.

4.2. Outpatient Care

Service providers: Government healthcare facilities provided the majority of outpatient services (75% of outpatient services nationally, 77% in rural areas, and 63% in urban areas). Government facilities accounted for a lower percentage of outpatient services provided to the richest quintile households (62%) compared with outpatient services provided for individuals living in the poorest quintile households (80%).

Reason for choosing provider: Proximity of a health facility to a patient's home was the main reason for people choosing the outpatient healthcare provider they visited (50%), followed by availability of medicines (8.5%), good counseling by health workers (7.3%), short waiting time (5.5%), qualification of staff (5.3%), and whether the facility accepted patients in the waiver system (5.4%).

Bypassing: The majority (73.4%) of outpatient visits were made to the nearest facility, while the remaining outpatient visitors bypassed the nearest facility. The main reason for bypassing was the perception that quality of care at the nearest health facilities was too low - 50% of individuals who bypassed cited either lack of drugs or qualified staff as the reason for bypassing.

Distance travelled: Patients who sought outpatient care reported traveling an average distance of about 28 kilometers to reach a health facility and return back home. About 70% of the outpatient health service seekers reported obtaining the health services they needed by traveling less than 15 kilometers. The majority of outpatient service users (67.1%) traveled on foot to reach the health facility.

Patient Satisfaction: About 88% of outpatient visitors reported that they were satisfied with the health services they received from the health facilities they visited. The highest rate of satisfaction (92%) was reported for the 'time spent

with the clinician'; while the lowest rate of satisfaction (78%) was cited for 'availability of diagnostic facility'. About 93% of outpatient visitors reported that they had completed their prescribed treatments.

4.3. Inpatient Care

Admission rates: The inpatient admission rate was estimated to be 1.1% of the population in the 12 months preceding the survey, which was higher among females (1.2%) than males (1.0%), for individuals living in urban (1.7%) than those living in rural areas (1.0%), and for patients from the richest households (1.7%) than those living in the poorest households (1.0%).

Reasons for admission: The most common self-reported reasons for inpatient admission were reported to be diarrhea and intestinal worms (11.2%), diseases of the respiratory tract including pneumonia (8.7%), followed by malaria (6.1%), and diabetics (5.5%). Non-communicable diseases including mental illnesses accounted for 13.9% of all causes of inpatient admissions.

Service provider: Government health facilities (government hospitals and health centers) accounted for 80.1% of the total inpatient services, while private health facilities provided 18% of inpatient services, and non-governmental organization NGO health facilities were responsible for the remaining 2%. Individuals living in the richest households were about four times more likely to use private hospitals and about five times less likely to use government health centers or NGO hospitals compared with their counterparts living in the poorest households.

Individuals living in rural areas predominantly use the government hospitals, followed by government health centers and private clinics.

Reason for choosing provider: The main reasons reported for choosing the inpatient health service providers visited were proximity of the facility to one's home (25.7%), availability of medicines (15.3%), provision of exempted services (11.1%), presence of qualified staff (9.8%), and less waiting time (9.1%).

Bypassing: Of those who used inpatient services, 46.3% bypassed the nearest inpatient health facility to their homes to seek health care at another health facility. The main reasons for bypassing the closest inpatient facility was unavailability of medicines (29.0%), lack of bed (19.1%) and lack of qualified staff (18.9%).

Distance travelled: Inpatient health service users traveled longer distances on average to seek care (88.8 kilometers) compared with outpatient health care users (27.8 kilometers). The majority (60.0%) of inpatient health seekers reported traveling over 15 kilometers to access health service providers.

Patient satisfaction: Of the individuals admitted to inpatient health facilities, 88.3% reported that they were satisfied with the inpatient health services received. Overall, each aspect of inpatient care (such as courtesy of staff, availability of drugs, facility cleanness etc.) was rated as 'good' or 'very good' by at least 80% of inpatient service users, with the exception of 'food quality', which was rated as 'good' or 'very good' by about 70% of inpatient users.

4.4. Healthcare Expenditure

Total household contribution to health: The estimated household contribution to health spending was about 21.7 billion Ethiopian birr (ETB) – of which 18.21 billion ETB was in the form of out-of-pocket (OOP) payments, 2.87 billion ETB was in the form of community contribution (see below) to health system strengthening (HDA and malaria control activities), and another 620 million ETB was for premium contributions to insurance.

Total out of pocket payment: Of the total OOP payments on health (not including community contributions), 17.5 billion ETB was for outpatient services, and the remaining 711.6 million ETB was for inpatient services.

Per capita out of pocket payment: The total per capita out of pocket spending for health was estimated to be 231 ETB, of which 222 ETB (96%) was for outpatient services, while 9 ETB was for inpatient services. The estimated total OOP spending has increased by about 75% compared with the HA V household survey (2010/11).

Variation in OOP: There is significant variation among regions in the per capita outpatient and inpatient OOP expenditures.

- Oromia and Addis Ababa spent significantly higher than the national average, with 482 ETB and 460 ETB per capita OOP, respectively.
- The average per capita OOP is higher for urban areas (355 ETB) compared to the rural areas (200 ETB).
- An analysis of OOP spending by expenditure quintiles show that average per capita OOPs increase as one goes from lower to higher income quintiles (Q1-162.5 ETB, Q2-227.7 ETB, Q3-236.3 ETB, Q4-161 ETB and Q5-372.7 ETB), with the exception of the fourth richest quintile (Q4).

Expenditure by service: Of total OOP household expenditure, 70% was spent on direct health services (drugs, diagnostics, etc.), while 23% was for other health-related service costs such as transportation and bed/accommodation and food; the remaining 7% of spending was not specified.

- Of the direct health service payments, 45% of the total OOP was incurred for drugs and medical supplies followed by diagnostics and investigation (16%) and consultation costs (9%).
- Treatment for infections and parasitic diseases accounted for 36% of total OOP expenditure, followed by treatment of non-communicable diseases, which accounted for 23% of total OOP expenditure.
- Preventive and promotive services accounted for only 7% of the total household OOP spending, while injuries and nutrition took a share of 3% and 1% of household OOP, respectively. Households were not able to classify 30% of their OOP spending into specific services.

Sources of OOP financing: The survey documented that about 55% of the total OOP health spending was financed through individuals or families own cash on-hand, while 35% of OOP came from assistance from friends/family members, 6% from selling livestock and/or cereals, and another 4% from borrowing from friends and the community.

4.5. Community contribution to health systems strengthening

The success of the Ethiopian health system in meeting some of the global health goals and targets has been explained by the strategy of ensuring that communities produce their own health through the health extension program (HEP) and the associated health development army (HDA). Community members contribute time, labor, and in-kind to strengthen the implementation of the different health extension packages.

- Overall, 90% of households in the survey had at least one member of the household participating in the HDA.
- About 39% of households were involved in Long-Lasting Treated Insecticide Net (LLTIN) distribution, Indoor Residual Spray (IRS) operations, and pond drainage and/or awareness creation about controlling malaria.

Community contribution to health was estimated by converting labor and/or other in-kind contributions into cash using the local input prices.

Monetary value of community contributions to health:

- Total community contribution to health system strengthening was estimated at 2.87 billion ETB for 2015/16, or about 36 ETB per capita. Of this, about 55%, or 19.86 ETB per capita was contributed through the health development army (HDA), while the remaining 45% was contributed through the malaria control program.
- Communities also contributed an estimated 75 million ETB in the form of in-kind contribution of culturally acceptable food to encourage institutional delivery.

Breakdown of community contributions by type:

- When the different components of the HDA are explored, regular meetings among the HDA members account

for about 40% of the HDAs contribution; followed by environmental management activities (excluding malaria), which accounts for 27% of their contribution.

- Community contribution in promoting institutional and safe delivery in the form of mothers' conferences and in-kind food contribution accounted for about 23% of the total community contributions.
- Analysis of how community members spend their time on malaria control activities showed that pond drainage accounted for about 41% of time spent, while awareness creation and distribution of LLTIN took 31% and 20% of the time/money spent, respectively.

4.6. Health Insurance

Insurance coverage and type: This survey documented that 7.4% of the country's population was covered by health insurance in 2015/16. Community based health insurance (CBHI) was the dominant type of health insurance, constituting 96% of the total health insurance coverage. Eighty-six percent of the total insured households were farmers.

Coverage by wealth quintile: The poorest quintile (Q1) and richest quintile (Q5) households have a smaller share of the total population insured, while Q2, Q3 and Q4 wealth quintiles have either proportional or higher shares of the total insured population.

Reported insurance entitlements: Knowledge of the type of services covered in the CBHI scheme seems to vary. Most of the insured population (69%) reported being covered for both outpatient and inpatient health services through their insurance scheme. About 10% of members perceived being covered for only outpatient services through their insurance, while 1.3% reported being covered for only inpatient services through their insurance. The remaining 18% of insured households didn't know the types of health services covered by their insurance, which indicates the need to strengthen communication efforts to increase awareness of insurance coverage.

Household contribution to premium payments: The average household contribution per insured household for insurance was 38.50 ETB per month, and about 86.5% of insured households contribute less than 50 ETB per month. The main source of payment for insurance among the insured was 'household head' (91.6%) followed by 'employer' (4.92%) and 'government' (2.5%) for indigents (the very poor).

OOP among insured population: About 11.7% of households that have insurance coverage reported having made OOP payments for health services that were not covered in their specific health insurance scheme, while 80% of the insured reported not making additional OOP payments for care, implying that these households were financially protected as a result of their insurance status, and were not exposed to catastrophic health expenditure.

Total health expenditure among insured: The total health expenditure among the insured population during the year was 723.3 million ETB. Of this, 620 million ETB (85.8%) was for premium contributions, while the remaining 102 million ETB (14.2%) was spent in the form of OOP payments. However, the share of health insurance expenditure/premiums payments to total national OOP payments was only 3% (i.e. 3% of total OOP health expenditure was spent on insurance premiums); which indicates the need to increase coverage of health insurance, and its share in the total health expenditure, through expanding existing and new pre-payment schemes.

5. Policy implications

Need to Address Inequity

This survey documented the existence of significant inter- and intra-regional as well as income or wealth-related variations in utilization of outpatient and inpatient services. This reconfirms the importance of prioritizing equity as a transformational agenda. Given the variation in healthcare utilization among and within regions and among wealth quintiles, there is a need to explore in detail the drivers of these variations and chart out context-specific actions.

Increasing Non-Communicable Diseases

NCDs have become a significant reason for people to seek health care services, more than reported in the previous survey in 2010/11. It is therefore important to chart out mechanisms of working with the community on how they can protect themselves from this burden by formulating appropriate health promotion and protection interventions. The lessons and best practices of reducing the burden of communicable diseases by the health extension program can be used to chart out how to move forward in this regard.

Investing in Quality and Readiness in Government Facilities

Government health facilities remain not only the major providers of care in Ethiopia (78% of outpatient and 80% of inpatient services), but also the main outlets through which the very poor, by and large, receive health care. Improving and investing in the quality and readiness of these facilities is likely to be a rational investment for reaching the underserved areas/populations and for enhancing equity. Investment in improving the readiness of facilities should continue to be the top priority of the government health system strengthening efforts, as reinforcement of referral systems and reducing bypassing of the closest facilities could reduce the high OOP spending that is incurred by households.

Addressing Stock-outs and HR Qualifications to Reduce Bypassing

The major reason, next to proximity, for choosing/bypassing the nearest facility for utilization was reported to be availability/lack of medicines and qualified personnel. Exploring the gaps and challenges, and planning for rational investments to reduce medicines stock out rates and fill positions with qualified staff is likely to more evenly distribute care seeking across facilities. This would reduce the existing burden on some hospitals, and reduce the cost of care born by households by reducing travel cost and time, as well as opportunity cost of traveling to facilities that are far from their residence.

Expansion of Insurance to Achieve UHC

OOP spending is high and could be one of the major barriers to service utilization. The government's strategy to provide insurance for both formal and informal sectors is likely to help Ethiopia move towards universal health coverage (UHC). However, the expansion of insurance schemes needs close follow up, and regular review of its implementation to ensure that the very poor have adequate protection. The findings of this survey indicate that adequate subsidies to the indigent seem to improve coverage, the effect of which needs to be explored further.

Expanding Evidence Around Community Contributions

Community contribution to health system strengthening in Ethiopia is significant. Given that this is the first attempt to estimate its monetary value, it may be useful to consider introducing a separate/alternative tool and methodology in subsequent household surveys to clearly document community contribution and to countercheck the estimates provided by this survey.

Strengthening Routine Health Finance Information Systems

Finally, Ethiopia has been undertaking such surveys for the last three rounds of the HAs, including this one. This is costly for future HA related activities. Strengthening the routine health finance information system and enabling it to regularly track facility records on OOP spending by public and private facilities would provide more up-to-date data on OOP health spending more frequently. Government and its partners should prioritize investing on strengthening the routine health finance information system.

Reference

More details regarding this brief can be found in the full report of the survey: Federal Democratic Republic of Ethiopia Ministry of Health. August 2017. Ethiopian Health Accounts 2015/2016 Ethiopia's General Household Health Service Utilization and Expenditure Survey, Addis Ababa, Ethiopia.