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Linking safety net clients with social services.

Possible pathways to increase access to health services by the poor in Ethiopia.

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Background: Ethiopia's National Social Protection Policy

The National Social Protection Policy (Nov 2014)

- A 'sustainable social protection system'
- Integrated service delivery to the poor and vulnerable
- Five focus areas – including promotion of increased access to basic services (among other things)

UNICEF Ethiopia: identify global best practices applicable to Ethiopia which will inform the Social Protection Platform

- How to increase access to basic services by the poorest
- How to promote child protection measures

Background: good practices review

Approaches reviewed include

- Linking safety net clients with complementary services
- Expanding the role of social workers and communities
- Promoting multisectoral collaboration
- The importance of an integrated targeting and monitoring system

Review methodology

- General and country specific literature reviews

This presentation:

- Focus on improving access to basic health services by safety nets clients
- Do the poor access basic health services in Ethiopia ? What are gaps? What was already done? What more can be done?

Do the poor already access adequately basic health services in Ethiopia ?

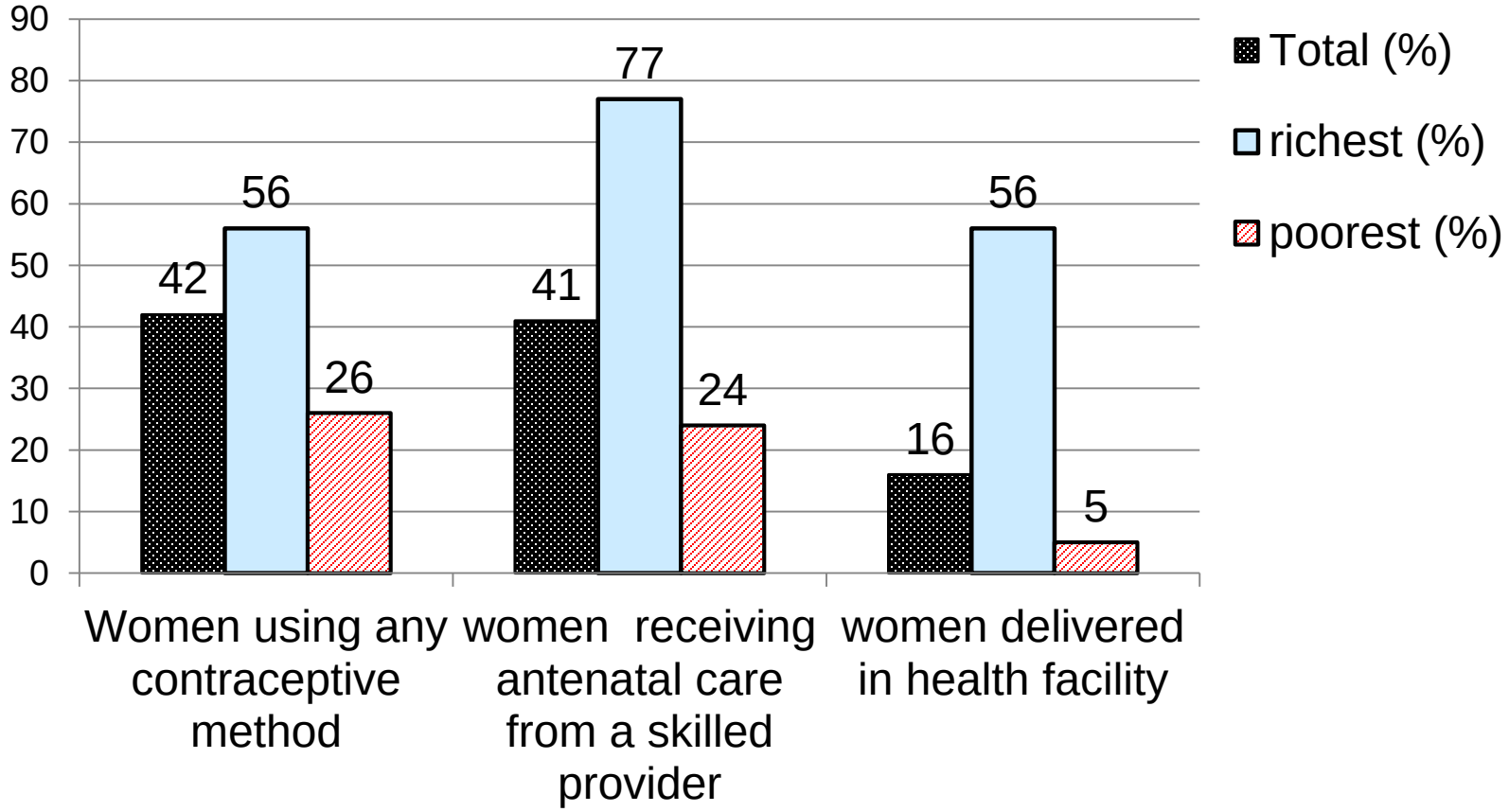
Inequality in access to health services

Promising trends, but concerns remains

- **Outpatient and inpatient service utilization:** reduction in disparity between poor and non-poor (2000-2011)
- **Maternal care:** improved equity in service utilization for antenatal care, contraceptive coverage and skilled birth attendance (2005-2014)
- But…the poorest still continue to use less basic maternal health services than their richer counterparts

ACCESS OF WOMEN TO SOME BASIC HEALTH SERVICES 2014

(TOTAL, RICHEST AND POOREST QUINTILES, EMDHS 2014)



Out-of-pocket expenditures for health

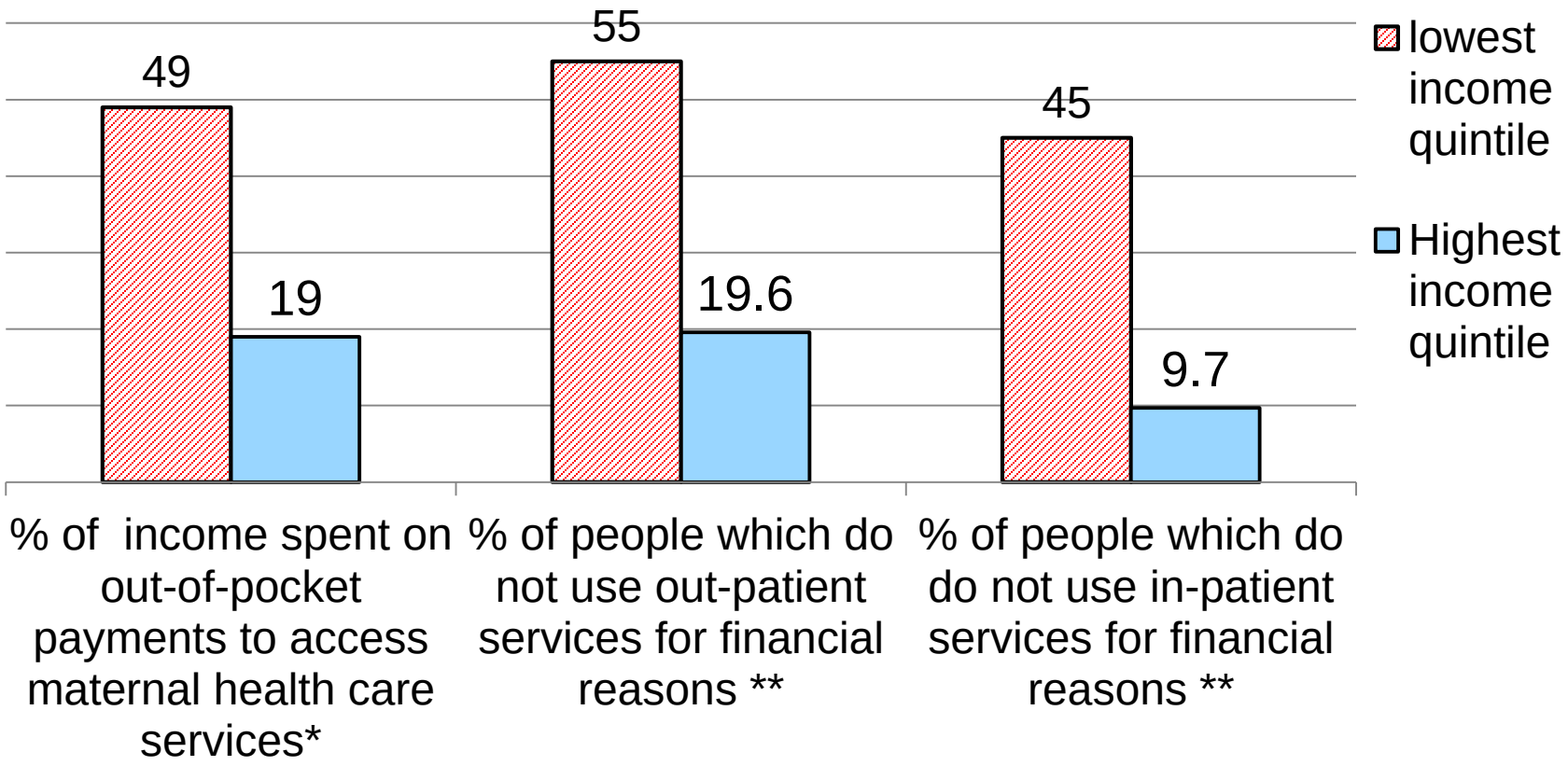
- Out-of-pocket expenditures : may cause people to skip necessary health care – this is more pronounced for the poor

- Estimated per capita OOE spending : 7 USD (2011/12)

- Important inequalities in out-of-pocket spending – this is especially true for maternal health care

OUT OF POCKET EXPENDITURES FOR HEALTH SERVICES

RICHEST AND POOREST QUINTILES



*Sources *Akula 2012 and **WB2015c*

Safety net clients : transfers alone are not enough

PSNP = Ethiopia's largest SN program (7.6 M clients in PSNP3)

- Transfers to chronically food insecure rural HH for 6 months
- Reaches the poor - considered a *well targeted program* (highlands)
- Many good results (reducing food gaps, stabilizing assets, increase HH diet diversity, productive role of public works ...)
- But recent data also show that
  - PSNP clients access less health services then non PSNP clients (EMDHS 2014))
  - PSNP had no significant impact on child nutrition (IFPRI 2014)
  - Nutritional status of children in PSNP HH is worse then in non PSNP rural HH (47% vs 42% for stunting, EMDHS 2014)

➢ Until recently, PSNP had no nutrition objective

What was done so far to promote utilization of basic health services by the poor?

Some highlights

Increasing availability of basic health services

- Expansion of the primary health care units (3,200 HC)
  - Maternal, newborn and child health services
- Expansion of Health Extension Program (16,500 HP)
  - Free preventive, promotive and high impact curative health services at community level - 39,000 HEW
- Improving quality of services
  - Increasing focus on trainings, supervision…
- Monitoring availability and quality of services
  - 2014: almost all HP offer curative care for children, family planning and ante natal care

Increasing incomes of the poor: expansion of safety nets

- **Productive Safety Net** (4th phase – national rural safety net)
  - Started mid 2015
  - Can be expanded in case of shocks (max 10 million clients)
  - Integrated service delivery (transfers, livelihoods, nutrition/health)
  - Increased focus on gender and nutrition sensitivity of interventions

- **The urban productive safety net program (UPSNP)**
  - Launched in 2016
  - Integrated model of support (transfers and livelihood)

Promoting health seeking behavior

Health: Health Development Army (HDA)

- Over 2.3 million networks of “one-to-five HH” operational (Oct 2015)
- Identifies pregnant women and children <5 & links them with HEW

PSNP4 : a platform for promoting health seeking behavior and fostering improved child caring practices

- Participation in monthly BCC sessions = public work (male/female)
- Co- responsibilities for vulnerable clients of PSNP
  - ✓Promote health seeking behaviors for women and children (antenatal care, post natal care, vaccination, regular health and nutritional check up of children, care of malnourished children)
  - ✓*Soft* conditionalties: promotes uptake of services, does not penalize !

Expansion of interventions which reduce out of pocket expenditures for health (1)

- **Fee exemptions** for all basic maternal and child health, HIV and TB services
- **Indigent Health Fee Waiver** for other health services (community targeting - 1.8 million beneficiaries, all regions)
- **The Community-based Health Insurance** (CBHI) – for informal sector employees/rural residents (6.5 million clients)
- **The Social Health Insurance** – for formal employees (not yet fully rolled out)

The Community Based Health Insurance

- **Some experiences :**
  - Has doubled intensity and frequency of health utilization
  - Fast expansion (last year: from 13→200 districts)
  - Mainly financed through member contribution (10USD/HH/year) although general FMOH subsidy
  - Includes a provision of Targeted Subsidies for the poor (community targeting)

- **The strategy :**
  - Following the full roll out of the CBHI, the function of protecting the indigents will be absorbed by health insurance (phasing out of Indigent Health Fee Waiver)

Challenges remain

- **Linking PSNP clients with health services delayed**
  - Issues in multisectoral collaboration and coordination
  - Role of sectors not clear (also at grass root level)
- **Low insurance coverage**
  - Only 1.2% of population insured
  - Low coverage of the poor (CBHI and Indigent fee waiver)
- **Affordability** of the CBHI for HH is an issue
- **Fragmented Social Protection response**
  - Parallel (community) targeting and implementation of PSNP, the Indigent Health Fee Waiver and the Targeted Subsidies under the CBHI;
  - Targeting issues for poor under subsidized insurance

➢ *No integrated service delivery*

What more can be done to link safety net clients with complementary health services ?

Lessons learned from other countries

Linking safety net clients with subsided health insurance schemes (1)

Increasing utilization of health services by the poor – some global evidence

- *Reducing out-of-pocket expenditures*: crucial to make health services affordable and overcome barriers to access of health care of poor

- *Health insurance :* can decrease out-of-the pocket expenditures and promote utilization of health care services by the poor

Linking safety net clients with subsided health insurance schemes (2)

Dual problem also existed in many countries :

- **Safety nets** :
  - Created demand for services through (soft) conditionalities, but sometimes limited progress in health seeking behavior beyond the conditionalities
  - Low uptake of health insurance by safety net clients
- **Health insurance**
  - Include indigent health insurance programs
  - But still faced significant barriers in reaching all the poorest (identification/targeting and affordability issues)

Linking safety net clients with subsidized health insurance schemes (3)

Good practices showed what is possible :

- **Reaching out to SN clients :** subsidized integration of clients of well targeted safety net programs in health insurance scheme allowed for considerable progress in insurance coverage by the poor
- **Data sharing allows for automatic integration of SN clients: i**nteroperational program data systems , unified/single registries and integrated MIS support effective linkages between these programs (targeting, and integrated service delivery and monitoring)
- **Affordability /importance of subsidies** : (soft) conditionality related to health insurance registration of safety net clients without subsidy is hard to implement

Need for formalized collaboration and coordination

- Collaboration among sectors is key when linking SN clients to complementary health services- it will:
  - Ensure availability of services
  - Promote synergies among programs/create effective linkages
- It is possible to coordinate programs even if they evolved separately
- Coordination does not come naturally , it needs:
  - A well defined framework (eg. MoU between sectors…)
  - A strategic vision – importance of the adoption of a national social protection strategy
  - Leadership for social protection coordination
  - A dedicated high level coordinating committee for SP
  - A mutual accountability system/ “who is responsible for what”

Involving more Social Workers & Communities

Targeted support from the community and SW to safety net HH empowers HH to overcome poverty related barriers in access/use of social services

- Communities: identify vulnerable people and refer them to SW,HEW,…
- Support by communities : stronger when paired with SW
- SW can successfully provide full family support to SN HH
- SW can link SN HH with complementary services (health insurance..)
- SW can also play a prominent role in safety nets (targeting, compliance with conditionalities, facilitating access to services …)

➢ **Involvement of SW and communities in PSNP4** : now piloted in an "Integrated Nutrition and Social Cash Transfer pilot" (MOLSA & UNICEF; 2 regions in Ethiopia)

Thank You !

For more information:

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