



Scaling Community-Based Health Insurance through Health Extension Programme

Ethiopia



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This exemplar explores Ethiopia's use of community-based health insurance through the Health Extension Programme, alongside newer sliding-scale premium reforms. It focuses on how a community delivery platform can support both enrolment and equity in a largely informal economy.

Core exemplar

Community-Based Health Insurance (CBHI) delivered through Ethiopia's Health Extension Programme, with emerging sliding-scale premium reforms.

Why it matters for ALM: It shows how a large community health workforce can act as insurance infrastructure while progressive premium design improves equity and enrolment.

Primary ALM contribution: Equity and financial protection, more money for health through expanded pooling, and governance through community-based delivery systems.

Replicability potential: High for countries with strong community health systems and large informal sectors.

1. Context: Expanding Insurance Coverage in a Large Informal Economy

Ethiopia's health-financing challenge is shaped by its very large informal sector—about 85% of the population—and historically low insurance coverage. The Health Sector Transformation Plan II set ambitious goals for 2025, including 80% CBHI coverage and a drop in out-of-pocket spending from 39% to 20%. The December 2025 National Health Compact then reframed those ambitions in clearer fiscal terms: total health expenditure rising to USD 8.3 billion by 2030, government share increasing from 27% to 53%, and out-of-pocket spending falling to 20% or less through insurance expansion. The Compact also committed Ethiopia to raising domestic pharmaceutical production from 15% to 50% of national demand.

2. Mechanism: Community-Based Insurance and the Health Extension Programme

Ethiopia's CBHI programme was first piloted in 13 woredas in 2010/11 and has since expanded into a nationwide scheme managed by Ethiopian Health Insurance Services. Four features define how it works:

- Flat premium with government subsidy (core scheme): Annual premium of 500 ETB (~USD 10) per household, with reduced fees of 240 ETB (~USD 5) for dependents. Government subsidizes premiums for 1.5 million indigent households.
- Sliding-Scale CBHI (SS-CBHI) pilot (2023–present): In January 2023 the government began piloting income-graduated premiums in 13 districts using an Ubudehe-style socioeconomic classification. A randomized control trial midline evaluation (Dec 2024 – Jan 2025) found 100 % enrolment among low-income/indigent households (premiums waived), with enrolment rising from 33 % to 57 % among high-income households and near-100 % retention among middle-income groups. The scheme is perceived as a "symbol of fairness and social justice."
- Health Extension Programme (HEP) as delivery platform: Ethiopia's 40,000+ Health Extension Workers (HEWs), deployed since 2003, serve as the community-level backbone for CBHI enrolment, health promotion, and service-delivery linkage. A 15-year HEP Optimization Roadmap (2020–2035) guides reform of this workforce.
- Social Health Insurance (SHI) for formal sector: Long-planned but still not implemented. A 2025 survey of 1,919 formal-sector workers found strong solidarity support for CBHI (66 %+) but continued resistance to SHI, due to cost concerns and perceived low quality of public facilities.

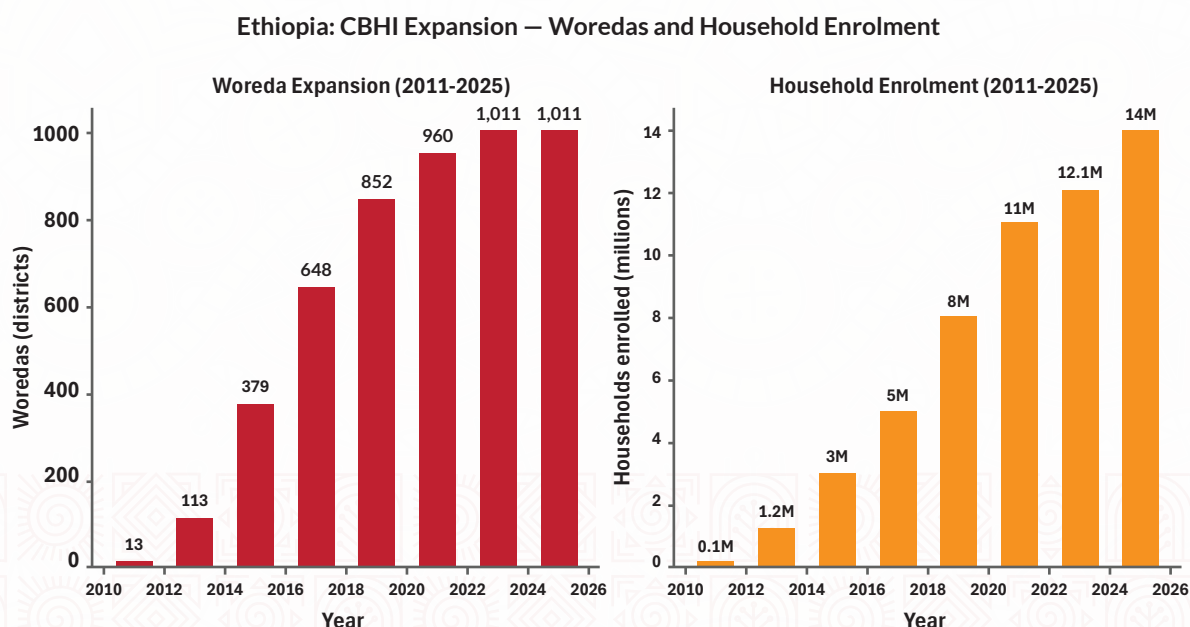


Figure ET-1. Ethiopia: CBHI Expansion — Woredas and Household Enrolment (2011–2025). From 13 woredas piloted in 2010/11 to 1,011 woredas (89 % of districts) by 2023, reaching over 55 million beneficiaries through Health Extension Workers.

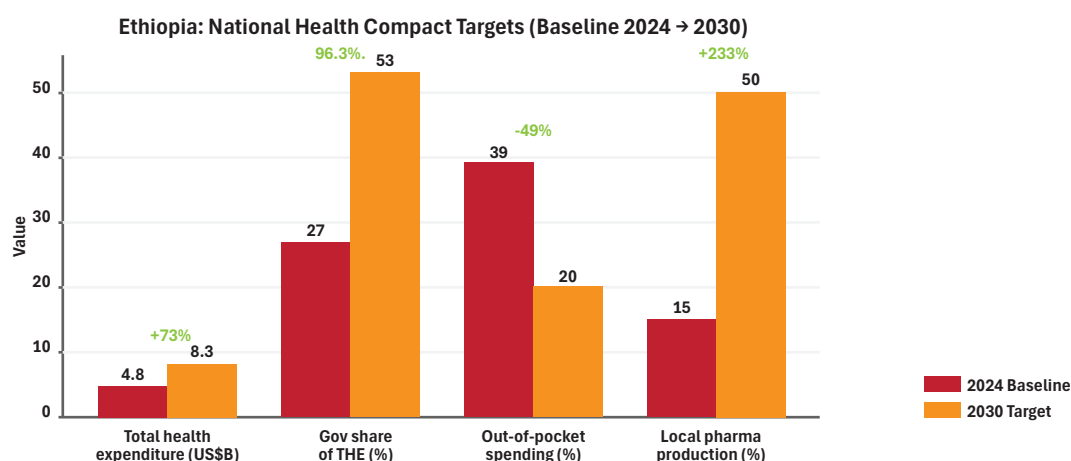


Figure ET-2. Ethiopia: National Health Compact Targets (2024 Baseline → 2030). Tokyo December 2025 Compact commits to +72 % total health expenditure, doubling of government share, halving of out-of-pocket, and tripling of domestic pharmaceutical production.

3. Outcomes: Nationwide Expansion of CBHI and Coverage Growth

CBHI has now expanded to 1,011 woredas, covering about 89% of administrative districts and reaching roughly 81% of eligible households. In total, more than 55 million people benefit from the scheme. New consultations by CBHI members rose by more than 200% between 2015 and 2020. The 2025 Compact adds another layer by setting targets for digitalizing 83% of PHC service delivery, generating at least 20% efficiency gains through public financial management reform, and using sin taxes to subsidize low-income and vulnerable households while raising coverage from 50% to 75% by 2030.

Ethiopia is currently operating under the Health Sector Medium-Term Development and Investment Plan (HSDIP, 2023–2026), which succeeded HSTP II and targets a 26% reduction in maternal mortality and a 19% reduction in neonatal mortality. Out-of-pocket spending has already fallen from about 39% to about 31%, largely because CBHI has expanded so significantly.

Key Vulnerability

- **What is at risk:** A coherent national insurance architecture—because Ethiopia’s formal sector Social Health Insurance (SHI) remains unimplemented.
- **Why it matters (evidence):** With SHI still pending, the two pillars of Ethiopia’s planned insurance system have not been integrated. Operational frictions—drug stockouts, reimbursement delays, and uneven performance—undermine confidence in CBHI. Regional disparities are visible: support for CBHI is lowest in Tigray (63%) and highest in SNNPR (88%). A “two-speed” pattern is emerging: rural enrolment is high but often administratively driven, while urban enrolment is lower but more deliberate. The system also faces a 21–32% financing gap (as acknowledged in the Compact), and the 2025 US foreign assistance freeze adds additional pressure.
- **What would reduce the risk:** A credible pathway to implement and integrate SHI, paired with practical fixes that improve the member experience (reliable medicines, timely reimbursements) and targeted measures to reduce regional disparities—so expansion does not come at the expense of trust and quality.

4. Ethiopia on the ALM Scorecard

Ethiopia's ALM scorecard shows strong forward momentum, with seven commitments rated On Track and three rated Partial. The strongest areas include domestic mobilization, operational undertakings, the large-scale CBHI platform supported by the Health Extension Programme, and the December 2025 Tokyo National Health Compact, which ties financing, coverage, efficiency, and domestic manufacturing targets into a single reform framework. Three Partial ratings relate to private-sector engagement, the accountability framework and the hosting role, where progress is evident but not yet fully developed. Overall, the scorecard is consistent with a country that has built an impressive community-level reform platform while still broadening the partnerships needed for the next phase.

ALM Scorecard Heat-Map	
Country	Ethiopia
Political Agenda	Green
Leverage Partners	Green
Domestic Mobilization	Green
Private Sector	Amber
PMPA Harmonization	Green
Operational Undertakings	Green
Monitoring & Reporting	Green
Accountability Framework	Amber
Hosting Role	Amber
Leveraging AU Support	Green

Legend:

- Green = On Track
- Amber = Partial
- Red = Off Track

5. Key Lessons and Policy Implications

- **HEWs as insurance infrastructure.** The 40,000-strong community health workforce provides a pre-existing enrolment and delivery network that dramatically reduces the cost of insurance expansion. Countries with established CHW programmes (Rwanda, Kenya, Mozambique, Malawi) can replicate this model.
- **Sliding-scale as equity tool.** The SS-CBHI pilot's midline data — 100 % low-income enrolment when premiums are waived and 57 % high-income enrolment when graduated premiums are introduced — demonstrates that income-graduated premiums can achieve near-universal enrolment among the poorest while building a pathway to higher contributions from wealthier households.
- **Woreda-level pooling limits.** Pooling at district level creates small, fragile risk pools. Ethiopia is working toward regional-level pooling — a reform directly applicable across decentralized African health systems.
- **Compact as macroeconomic integration.** The 2025 Compact frames health as a human-capital investment tied to HGER 2.0 (industrialization and productivity) — a more politically resilient framing than the "health as social cost" narrative and explicitly aligned with ALM's economic logic.
- **Manufacturing leap 15 → 50 %.** Ethiopia's Compact commitment to triple domestic pharmaceutical production share in five years is among the most ambitious on the continent and — if delivered — would position Ethiopia as a major PMPA-compliant producer, relieving continental reliance on South Africa, Egypt, and Morocco.

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ALM score card sources: Ethiopia (7/10 On Track, 3 Partial)

C1: Political agenda — On Track Indicators: Tokyo Compact Dec 2025 (THE +72% to \$8.3B by 2030); HSDIP 2023-2026; HGER 2.0 Sources: Ethiopia Tokyo Compact; HSDIP 2023-26 (moh.gov.et); WB press release Dec 2025

C2: Leverage partners — On Track Indicators: WB Tokyo MDTF; Global Fund; Gavi; BMGF; PEPFAR (pre-freeze); EU; Sweden Sources: Ethiopia Tokyo Compact donor architecture

C3: Domestic mobilisation — On Track Indicators: Govt share 27%→53% target; OOP 39%→20%; pharma 15%→50%; expanded sin taxes Sources: Ethiopia Compact commitments; Capital Ethiopia Jan 2026

C4: Private sector — Partial Indicators: Compact targets \$250M private investment by 2030; Kilinto pharma park; base level low Sources: Ethiopia Investment Commission; Tokyo Compact

C5: PMPA — On Track Indicators: EFDA regulator; Kilinto Industrial Park; tripling pharma production target; AU AMA Sources: EFDA (efda.gov.et); Kilinto documentation; AU AMA Treaty

C6: Operational — On Track Indicators: CBHI 1,011 woredas (89%); HSDIP active; SWAp; NHA; 55M+ CBHI beneficiaries Sources: EHIS Annual Report 2023/24 (ehis.gov.et); P4H Ethiopia (p4h.world)

C7: Monitoring — On Track Indicators: DHIS2 nationwide; SS-CBHI RCT midline (PEP-Net 2025); Annual Joint Sector Review Sources: PEP-Net SS-CBHI RCT (pep-net.org/ethiopia-sscbhi-rct)

C8: Accountability — Partial Indicators: Compact 2030 milestones; stalled SHI bill; Tigray CBHI disparities Sources: Ethiopia SHI legislative timeline; Parliamentary Health Committee

C9: Hosting role — Partial Indicators: Addis hosted ALM 2019; AU HQ; Africa CDC HQ; no subsequent ALM convening Sources: AU Assembly/AU/Decl.4(XXXII) venue

C10: Leveraging AU — On Track Indicators: Compact references AU Vision 2040; AVMA eligibility; PIFAH alignment Sources: Ethiopia Compact; AU Vision 2040; Gavi AVMA

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