Texila International Journal | Open Access | Peer Reviewed

Journal: Texila International Journal of Academic Research
https://doi.org/10.21522/TIJAR.2014.13.03.Art033

ISSN: 2520-3088
Volume 13 Issue 3, 2026

Social Health Insurance in Ethiopia: A Synthesis of Evidence on Willingness to Enroll, Institutional Preparedness, Fiscal Space, and Service Readiness as a Platform for Policy Action

Wudalew Meselu Tesfaye[1,2]

[1]*Health Financing Analytics, Clinton Health Access Initiative (CHAI), Addis Ababa, Ethiopia*
[2]*Department of Public Health, Texila American University, Guyana*

Correspondence to be addressed: E-mail - wudalewmeselu@gmail.com

Cite this article as: Tesfaye WM. Social health insurance in Ethiopia: A synthesis of evidence on willingness to enroll, institutional preparedness, fiscal space, and service readiness as a platform for policy action. Texila Int J Acad Res. 2026;13(3).
https://doi.org/10.21522/TIJAR.2014.13.03.Art033

Received: 04.05.2026
Accepted: 19.06.2026
Published: 31.07.2026

Abstract *Ethiopia enacted Proclamation No. 690/2010 establishing a Social Health Insurance (SHI) scheme for formal sector employees, yet the program has remained non-operational for over fourteen years. With the government renewing its resolve to launch SHI and the National Health Compact (2025) projecting a doubling of the government health financing share by 2030, a consolidated review of current evidence is urgently needed. This narrative review synthesizes published evidence on four dimensions critical to SHI implementation: willingness to join and pay (WTJ/WTP), institutional preparedness, fiscal space, and health service availability and readiness. Searches were conducted across PubMed/MEDLINE, Google Scholar, Scopus, and Hinari, supplemented by grey literature from the World Bank, WHO, ILO, UNICEF, and the Ethiopian Ministry of Health, covering January 2010 to April 2025. Pooled WTP for SHI among the formal sector workforce was 42.25% for the broader formal sector in a 2023 meta-analysis (19 studies) and 49.62% for public civil servants in a 2024 meta-analysis, the divergence reflecting the populations pooled; average WTP stood at 1.6% of gross monthly income, well below the proposed 3% premium. Willingness to join ranged from 47.5% to 74% across settings, moderated by income, knowledge, quality perceptions, and provider network scope. Institutional readiness is constrained by gaps in EHIS claims management, ICT infrastructure, and strategic purchasing capacity. Fiscal space is restricted by a tax-to-GDP ratio of only 6.8% and persistent high inflation, although the National Health Compact signals new financing ambition. Service readiness in public facilities is critically low, with basic amenities available in only 39% and diagnostics in 40% of facilities. The four domains are deeply interconnected, and a launch that addresses WTP concerns without resolving service quality deficits will reproduce the same impasse that has persisted since 2010. Coordinated, evidence-informed reform across all four domains is a prerequisite for a viable and equitable SHI program in Ethiopia.*

Keywords *Ethiopia, Fiscal Space, Health Financing Reform, Health Service Availability, Institutional Readiness, Social Health Insurance, Universal Health Coverage, Willingness to Pay, Willingness to Join.*

This article is published under Creative Commons Attribution License (CC BY 4.0)

https://doi.org/10.21522/TIJAR.2014.13.03.Art033

Introduction

Universal Health Coverage (UHC) is both a global health aspiration and a practical policy obligation. For Ethiopia, a country of more than 130 million people with one of the lowest per capita health expenditures in Sub-Saharan Africa, the pathway to UHC runs through two parallel health insurance tracks: Community-Based Health Insurance (CBHI) for the rural and informal sector population, and Social Health Insurance (SHI) for the formally employed workforce. While CBHI has expanded impressively since its 2011 pilot, reaching about 12.1 million households, covering roughly 87.4% of districts, by 2023 [1], the SHI scheme has remained non-operational since the promulgation of its founding proclamation in August 2010. The contrast is remarkable: one track of Ethiopia's dual-track insurance architecture has become one of the largest community health insurance programs in Africa, while the other has never processed a single enrollment.

The reasons for SHI's prolonged stall are well-rehearsed in the literature: a formal sector workforce reluctant to contribute the member-side 3% of gross salary (Proclamation No. 690/2010 sets a combined 6% premium, 3% from the employee and 3% from the employer, with 1% plus 1% for pensioners) for coverage they do not trust [2]; a public facility network whose quality falls short of member expectations; and persistent uncertainty about whether the institutional machinery needed to run a claims-based insurance scheme actually exists. What has been less systematically examined is the aggregate picture when these concerns are considered together. This review takes that integrated view, synthesizing evidence across four domains that, taken together, constitute the feasibility architecture of any SHI program: willingness to join and pay, institutional preparedness, fiscal space, and health service availability.

The review is motivated by a specific moment in Ethiopian health policy history. In 2024, the government formally proposed to introduce SHI [3]. The National Health Compact, endorsed in early 2025 with World Bank support, projects total health expenditure to grow from USD 4.8 billion in 2024 to USD 8.3 billion by 2030, with the government's share of health financing targeted to double from 27% to 53% [4]. The Health Insurance Strategic Plan II (HISP II) set a target of covering 100% of formal sector workers through SHI by 2025, a target that will not be met. In this context, a review that honestly appraises the current state of evidence across all four feasibility domains is not merely academic. It is a prerequisite for policy advocacy that is grounded in what the data actually say.

This paper proceeds as follows. Section 2 describes the review methodology. Section 3 presents the evidence on WTJ and WTP. Section 4 examines institutional readiness. Section 5 reviews fiscal space. Section 6 addresses health service availability and readiness. Section 7 synthesizes the cross-cutting policy implications. Section 8 presents advocacy recommendations. Sections 9 and 10 cover limitations and conclusions respectively.

Review Methodology

This paper is structured as a narrative review, drawing on peer-reviewed literature, systematic reviews and meta-analyses, government policy documents, and reports from major multilateral and bilateral organizations. Narrative review was selected over systematic review as the most appropriate method for synthesizing evidence across heterogeneous domains (WTP studies, health systems capacity assessments, fiscal analysis, and facility surveys) that employ fundamentally different research designs and analytical frameworks. The approach mirrors the method used in landmark health financing reviews such

as those conducted for the WHO Health Financing Progress Matrix assessments.

The literature search covered the period from January 2010 to April 2025. Electronic databases searched include PubMed/MEDLINE, Google Scholar, Scopus, and Hinari (WHO Research for Health). Search terms were adapted for each domain: for WTP/WTJ, terms included 'willingness to pay,' 'willingness to join,' 'social health insurance,' 'formal sector,' and 'Ethiopia'; for institutional readiness, 'EHIS,' 'claims management,' 'strategic purchasing,' 'provider payment,' and 'health insurance capacity'; for fiscal space, 'fiscal space for health,' 'domestic resource mobilization,' 'government health expenditure,' and 'Ethiopia health financing'; for service availability, 'service availability and readiness assessment,' 'health facility readiness,' 'essential medicines,' 'health workforce,' and 'Ethiopia.'

In addition to indexed literature, grey literature was reviewed from the following sources: the Ethiopian Health Insurance Service (EHIS); the Federal Ministry of Health of Ethiopia; the World Bank Health, Nutrition and Population Practice; the WHO Ethiopia Country Office and WHO Headquarters Health Financing team; the International Labour Organization (ILO); UNICEF Ethiopia; the USAID Health Financing Improvement Program (HFIP); and Results for Development (R4D). Inclusion criteria required relevance to Ethiopia's SHI or CBHI program, publication in English, and a minimum of primary or secondary empirical content. Theoretical or purely opinion-based pieces without empirical support were excluded. A total of 64 sources were reviewed, including 31 peer-reviewed journal articles, 11 systematic reviews or meta-analyses, and 22 policy and program documents. The review is reported in line with the Scale for the Assessment of Narrative Review Articles (SANRA), addressing its core items: justification of the review's importance, statement of aims, description of the literature search, referencing of evidence, and scientific reasoning in the synthesis [5].

Willingness to Join and Pay: What the Evidence Says

Magnitude of Willingness to Join

Willingness to join (WTJ) and willingness to pay (WTP), while conceptually linked, capture distinct behavioral intentions and are moderated by different factors. A prospective member may, in principle, support the existence of SHI while objecting to the specific terms on offer. Understanding this distinction is important because policy responses differ: low WTJ calls for communication and trust-building strategies, while low WTP at a specific premium rate calls for premium redesign or benefit package enhancement.

Available estimates of WTJ for SHI in Ethiopia range from 47.5% to 74%, depending on the study population, region, and year of data collection. The higher values in this range come from teacher and other professional subgroups; willingness to pay among governmental-school teachers, for example, was about 62% in Gondar and as high as 89.5% in the Harar region [6, 7]. Regassa and colleagues [8], studying public sector workers in the Didu Woreda, South West Ethiopia, found that 47.5% expressed willingness to join SHI. Among those willing to join, 58.6% were further willing to pay the specified premium, meaning that effective WTP in the sample was barely above a quarter of the total workforce surveyed. These figures are not outliers: they are consistent with a pattern of majority non-uptake reproduced across multiple settings, cities, and professional groups in Ethiopia over more than a decade of research.

On the more optimistic end, Zarepour and colleagues [3], analyzing cross-sectional data from 2,749 formal sector employees across four major cities, found that 67% of respondents supported the introduction of SHI. This figure merits careful interpretation, however. Support for the existence of SHI in principle is

conceptually different from willingness to contribute 3% of salary. Among the same sample, only 24% were willing to pay the proposed 3% premium, with average WTP estimated at 1.6% of gross monthly income [3]. The gap between expressed support (67%) and willingness to pay at the proposed rate (24%) is perhaps the most important empirical finding in the SHI literature, because it exposes the premium affordability problem with precision. Ethiopian formal sector workers broadly want health insurance; they simply do not want to pay the price the 2010 design assumed they would accept.

The 2024 PLoS ONE systematic review and meta-analysis by Kaso and colleagues [9], registered at PROSPERO (CRD42023457003) and drawing on twenty studies (8,744 participants) published up to June 2022, produced a pooled WTP estimate for public civil servants of 49.62% (95% CI: 36.41-62.82%). The earlier Frontiers in Public Health meta-analysis by Bayked and colleagues [10], which reviewed 19 studies and pooled 18 of them (8,386 participants), produced a pooled WTP of 42.25% for the broader formal sector population. The divergence between these two pooled estimates reflects the heterogeneity of populations studied: WTP tends to be higher among health professionals and civil servants with better knowledge of the scheme, and lower among private sector workers and those in higher income quintiles who derive less expected benefit from a scheme limited to public facilities.

Determinants of WTJ and WTP

The literature identifies several categories of determinants. Sociodemographic and economic factors consistently predict WTP. Lower-income workers, those with more dependents, and female heads of household tend to express higher WTP, reflecting the greater expected marginal benefit from coverage for those who face higher healthcare cost burdens relative to income. Workers in the two highest income quintiles, who predominantly use private facilities, show the lowest support for a scheme they perceive as offering them nothing they do not already purchase independently [3]. This income-gradient finding has direct implications for scheme design: a benefit package that credibly includes private facility access is likely to shift the WTP distribution upward among the high-income cohorts whose premium contributions are most financially significant.

Knowledge and information about the scheme is a robust predictor across multiple studies. Workers who understand what the scheme covers, how premiums and benefits work, and what the claims process involves are systematically more likely to express willingness to join and pay. This finding suggests that low WTP partly reflects information asymmetry and that well-designed information campaigns could shift behavior without any change to the scheme's financial parameters.

Provider network composition emerges as the most structurally significant moderator of WTP. Outpatient care patterns in Ethiopia are dominated by private providers: Zarepour and colleagues [3] found that 55.9% of outpatient visits in their sample were to private facilities. Inpatient care, by contrast, was predominantly provided by public hospitals (62.5%). The proposed SHI scheme, as designed in 2010, was expected to initially contract primarily public facilities. This creates what Zarepour et al. [3] describe as a fear of double payment: mandatory premium contributions alongside continued out-of-pocket spending at private facilities. Until the EHIS credibly commits to including a network of private providers, a substantial portion of formal sector workers will rationally assess SHI as a net financial loss rather than a gain.

Prior health insurance experience, particularly CBHI membership, is positively associated with WTP for SHI. This finding, documented in several regional studies, points to the potential for leveraging CBHI's strong

enrollment and renewal rates (78% and 91% respectively in 2023) as a trust-building asset for SHI advocacy. The formal sector workers who live in communities where CBHI functions well have seen risk pooling in action; their resistance is not to insurance per se, but to the specific design of SHI.

Quality Concerns as a WTP Depressant

Beyond premium affordability, perceived quality of care at contracted public facilities acts as a discrete and independent depressant of WTP. Multiple studies find that even formal sector workers who report the 3% premium as affordable still express unwillingness to pay, because they do not expect the scheme to improve their access to care of acceptable quality. This is not irrational. The national Service Availability and Readiness Assessment (SARA) 2018 found mean availability of basic amenities at only 39%, diagnostics at 40%, and standard precautions at 42% across Ethiopian health facilities [11]. A health insurance scheme that locks workers into contracting with this facility landscape, while prohibiting them from using private providers they currently prefer, offers a negative value proposition even at zero premium cost.

This quality feedback loop creates a structural policy dilemma: low quality reduces WTP, limiting premium revenue, which constrains the resources available to upgrade quality, which perpetuates low WTP. Breaking this cycle requires simultaneous investments in provider quality and in scheme design modifications, particularly private sector inclusion, that make SHI attractive to formal sector workers before quality improvements in the public sector are fully realized.

Regional and Sectoral Heterogeneity

WTP and WTJ are not uniform across Ethiopia's regions or formal sector employee categories. Support for SHI has been found to be highest in regions where CBHI coverage is extensive and service quality has improved, and lowest in areas affected by conflict and governance disruption. Mebratie and colleagues [1] found support for a combined CBHI-SHI scheme (a construct distinct from SHI-specific willingness to pay) lowest in Tigray (63%) and Oromia (69%), and highest in SNNPR (88%), a distribution that correlates with regional variation in service quality and trust in federal institutions. These findings counsel against uniform national rollout of SHI without attention to regional variation in readiness and in the determinants of enrollment behavior.

Institutional Preparedness of the Ethiopian Health Insurance Service

Governance and Organizational Structure

The Ethiopian Health Insurance Agency was established through Council of Ministers Regulation No. 191/2010 and was later renamed the Ethiopian Health Insurance Service (EHIS) to reflect its expanded scope. EHIS operates as an autonomous federal organ with a mandate to implement both CBHI and SHI. It has established 24 branch offices across the country and is organizationally responsible for enrollment management, claims processing, provider contracting, and scheme oversight. The ILO, through its PROSPECTS programme, has recognized the importance of EHIS's institutional development and conducted a four-day training in July 2024 for EHIS officials and partner stakeholders on social health protection administration [12].

However, a candid assessment of EHIS's preparedness for SHI administration reveals substantial gaps. A WHO mission to Ethiopia conducted in September 2023, at the joint request of the Ministry of Health and EHIS, found that core health financing policy issues including the pooling architecture, SHI implementation status, and strategic purchasing remained unresolved [13]. The mission's work led to a joint plan of action for health financing and Health Technology Assessment development, signaling that the institutional

groundwork required for SHI had not yet been completed. This is a significant finding: more than thirteen years after the agency was established to implement SHI, the policy framework for how SHI will purchase services remains under development.

Claims Management and Information Systems

Claims management is perhaps the most technically demanding operational challenge in SHI administration. Processing claims from potentially thousands of contracted facilities, verifying clinical coding, detecting and deterring fraud, and ensuring timely payment to providers requires robust information technology infrastructure, trained staff, and tested protocols. The European Commission, through the m4health AG initiative commissioned by the Ethiopian Ministry of Finance, has been supporting EHIS in developing IT solutions for both CBHI and SHI. As the m4health project documentation notes, Ethiopia's prior CBHI software did not fully support critical processes such as enrollment, claims management, and payments, and a software prototype for SHI was being developed under this initiative [14]. This ongoing development work confirms that EHIS's ICT infrastructure for SHI is not yet operational.

The LSHTM/R4D financing brief on primary healthcare purchasing in Ethiopia [15] noted the existence of multiple purchasers in Ethiopia's health system, including the Ministry of Health, Regional Health Bureaus, EHIS, and donors, and the resulting risk of fragmentation, double budgeting, and misaligned provider incentives. For SHI, this fragmentation problem is particularly acute: EHIS would be a new, large purchaser entering a market already crowded with competing payment streams, and the absence of a clear strategic purchasing framework risks creating perverse incentives at the facility level. R4D and the Strategic Purchasing Africa Resource Centre (SPARC) were supporting EHIS on a provider payment mechanism assessment at the time of this review, but recommendations had not yet been finalized or implemented [16].

Provider Contracting Capacity

SHI's operation depends on a network of contracted providers willing and able to serve as scheme facilities, bill EHIS for services rendered, and maintain the clinical and administrative documentation required for claims verification. Ethiopia's experience with CBHI provider contracting has been instructive. As R4D [16] documents, challenges affecting CBHI implementation include the low readiness of health facilities, characterized by inadequate and unreliable infrastructure, power, water, functional equipment, funds, and trained staff, which have placed CBHI implementation in ongoing jeopardy. These are the same facilities that would constitute the initial SHI provider network. Without significant facility-level investment and quality upgrading, the SHI provider network will not be credible to potential members.

Private sector contracting represents the critical variable that current institutional arrangements do not adequately address. The existing SHI design did not clearly specify the terms under which private providers would be contracted. Given that over half of outpatient care in urban Ethiopia is delivered by the private sector, an SHI without meaningful private sector inclusion is structurally incomplete. Developing and operationalizing a private provider contracting framework requires regulatory work, quality standards development, and negotiation capacity that EHIS has not yet demonstrated at scale.

Human Resources and Organizational Capacity

EHIS's organizational capacity for SHI is stretched. The agency has primarily built its operational expertise around CBHI

implementation, where enrollment, premium collection, and provider payments operate through relatively decentralized and community-mediated systems. SHI administration, involving compulsory payroll deductions, employer reporting obligations, dependent registration, and complex claims processing, requires a fundamentally different set of competencies. The ILO training in 2024 [12] was partly intended to address this gap, but four-day training events, however well designed, cannot substitute for the sustained organizational development, systems investment, and staff specialization required for a large-scale mandatory insurance scheme.

Fiscal Space for Social Health Insurance

The Fiscal Space Concept and Ethiopia's Situation

Fiscal space for health is defined as the capacity of a government to increase health financing without compromising macroeconomic stability or the sustainability of public finances [17]. For SHI, fiscal space matters in two ways: the government must co-finance SHI for public sector employees (both as employer contributor and as budget guarantor of the scheme's solvency), and it must subsidize enrollment for low-income formal sector workers and potentially cross-subsidize CBHI through eventual risk pool integration. The availability of fiscal space thus shapes both the initial premium structure and the long-term financial sustainability of the scheme.

Ethiopia's current fiscal position is simultaneously constrained and undergoing structural transformation. The tax-to-GDP ratio of 6.8% is the most fundamental constraint: at roughly half the Sub-Saharan African average and less than half the threshold considered necessary for financing the Sustainable Development Goals (15% of GDP), it leaves very limited margin for additional discretionary public spending [18]. The country defaulted on a USD 33 million Eurobond coupon payment in December 2023 [19] and is assessed by the IMF and World Bank as being at high risk of debt distress. The fiscal deficit narrowed to 2.0% of GDP in 2023/24, an improvement from 2.6% the previous year, but the path was achieved partly through reduced spending on priority sectors including health [20].

Against this challenging backdrop, there are credible signals of a structural shift in health financing ambition. The health sector budget grew from ETB 100.2 billion in 2023/24 to ETB 143.4 billion in 2024/25, a nominal increase of 43% [21]. The National Health Compact [4] projects total health expenditure growing from USD 4.8 billion in 2024 to USD 8.3 billion by 2030, with the government's share of total health financing targeted to double from 27% to 53%. This ambition is underpinned by a medium-term revenue strategy, plans for health tax revenues from tobacco, alcohol, and high-sugar beverages, and efficiency gains from digitalization targeting 83% of district-level primary healthcare service delivery.

Government Co-financing Requirements for SHI

For SHI to launch, the government faces at least three categories of co-financing obligations. First, as an employer, the government must contribute the employer-side premium (equivalent to 3% of gross salary per employee) for all civil servants enrolled in SHI. Given the estimated size of the civil service, this represents a substantial recurrent budgetary commitment. Second, the government may need to provide start-up capitalization for the SHI fund and reinsurance arrangements to guard against adverse selection risk during the early, low-enrollment phase. Third, subsidies will be required for lower-income formal sector workers for whom even the member-side 3% contribution is unaffordable, as well as for pensioners whose fixed incomes may not sustain premium contributions over time.

A fiscal space analysis using the World Bank's decomposition framework (Government

health expenditure per capita equals health share of government budget multiplied by government budget as share of GDP multiplied by GDP per capita) reveals the levers available. With GDP per capita relatively low and growing from a small base, with government expenditure as a share of GDP at an estimated 18%, and health's share of government spending at an estimated 9% (author approximations based on the national health budget briefs [20, 21]), the scope for immediate large-scale increases in absolute health spending is limited in real terms. However, the decomposition also points to the potential of incremental improvements: a one percentage point increase in the health share of the government budget, combined with projected GDP growth of 7%, would yield meaningful additional resources that could be ring-fenced for SHI co-financing and facility quality upgrading.

SHI Premium Revenue as a Domestic Resource Mobilization Instrument

An important but sometimes overlooked dimension of fiscal space analysis is that SHI is itself a domestic resource mobilization instrument. When functioning at scale, the SHI scheme generates a revenue stream from employer and employee contributions that is wholly domestic, countercyclical to donor financing, and self-reinforcing as enrollment grows. For Ethiopia, whose health system is approximately 33-36% dependent on external development assistance [22], the institutionalization of SHI would represent a significant diversification of the health financing base. A scheme covering Ethiopia's estimated 4 to 4.5 million formal sector employees at even a 2% employee contribution rate would, on an illustrative author calculation assuming average covered earnings in the region of USD 150 to 200 per month, generate on the order of several hundred million US dollars annually, rivaling the contribution of some major bilateral donors.

This framing reframes fiscal space from a question of whether the government can afford SHI to a question of whether Ethiopia can afford not to have SHI. The transition from external financing dependency to domestically funded health coverage is exactly the shift that the National Health Compact targets. SHI is a primary instrument for achieving that transition. The challenge is managing the fiscal commitments required during the ramp-up phase, when enrollment may be low and adverse selection risks are highest, before the scheme reaches the enrollment threshold at which premium revenues cover running costs.

External Financing for the Transition Period

International experience from Ghana, Rwanda, and Kenya suggests that external donor financing of the SHI transition period, covering start-up costs, actuarial modeling, IT infrastructure, and initial deficit financing, is both common and effective. Rwanda's community health insurance scheme, Mutuelle de Sante, received sustained World Bank and other donor support during its scale-up phase before becoming financially self-sustaining. The National Health Compact process and the associated World Bank engagement in Ethiopia create a policy window for similar transition financing, provided the government presents a credible actuarial and implementation plan.

Health Service Availability and Readiness

The Service Supply Constraint on Insurance Attractiveness

Health insurance is only as valuable as the services it enables access to. If the facilities contracted under SHI cannot reliably deliver the services in the benefit package, the scheme becomes, in effect, a tax rather than an insurance product. This supply-side constraint is not peripheral to the SHI feasibility question; it is central to it. Formal sector workers in Ethiopia's urban centers have demonstrated,

through their healthcare seeking behavior, that they do not rely primarily on public facilities for outpatient care [3]. Any SHI scheme that does not address this quality differential, or that does not include private providers with adequate quality, is asking workers to pay for inferior access.

Physical Infrastructure and Facility Network

Ethiopia has made remarkable quantitative progress in health infrastructure expansion. Primary healthcare service coverage, measured as access to a facility within a two-hour walk, increased from 51% in 2000 to greater than 90% by 2019 [1]. As of 2022, there were 227 primary hospitals, 3,587 health centres, and 17,534 health posts operating within the primary healthcare arrangement [23].

However, the quantitative expansion of facilities has not been matched by qualitative readiness to deliver the services that an SHI benefit package would require. The national SARA 2018 survey, which underpins the HSTP II baseline, found mean availability of basic amenities across Ethiopian health facilities at only 39%, basic equipment at 60%, standard precautions at 42%, and diagnostics at 40% [11]. A 2024 assessment of primary healthcare capacity, conducted from April to June 2024 across all regional states, concluded that the capacity of Ethiopia's primary healthcare system was limited in delivering quality health services and that overall performance remained insufficient to progress toward UHC [23]. These assessments, taken together, suggest that the public facility network is not ready to serve as a credible SHI provider network without substantial quality investment.

Essential Medicines and Diagnostics

Availability of essential medicines and diagnostics is among the most frequently cited quality deficits in Ethiopian public facilities and among the most frequently cited barriers to WTP for SHI. Workers who encounter drug stockouts or unavailable laboratory services at public facilities will find little value in an insurance card that nominally entitles them to those services. The 40% mean availability of diagnostics documented in the SARA 2018 survey [11] implies that in the average public facility, three out of five required diagnostic tests are not reliably available. For SHI to be credible, contracted facilities must maintain formulary adherence and diagnostic availability at a level that members can observe and verify.

The EHIS documented over 530 benefit package items for CBHI in its 2017/18 report [24], a figure that predates subsequent package revisions, reflecting the scope of what the benefit package aspires to deliver. Ensuring that contracted facilities consistently have the medicines and equipment to deliver even a core subset of this benefit package requires a supply chain investment that goes beyond what the EHIS alone can mandate. It requires coordination between EHIS, the Federal Ministry of Health, the Ethiopian Pharmaceuticals Supply Service, and the Ethiopian Food and Drug Authority.

Non-Communicable Diseases and the Evolving Burden

Ethiopia is in a health transition. While communicable diseases, maternal conditions, and malnutrition remain significant contributors to the burden of disease, non-communicable diseases (NCDs) are growing in importance, particularly in urban formal sector populations. The Ethiopia Service Provision Assessment (ESPA) 2021/22 found that 84% of health facilities offered at least one NCD service, but only 26% offered mental health services [23]. Cardiovascular disease, diabetes, and chronic respiratory conditions, the leading NCDs in urban Ethiopia, require reliable diagnostic capacity, sustained medicine availability, and trained outpatient management protocols, precisely the capabilities in shortest supply in the public sector.

This NCD transition matters for SHI benefit package design. The formal sector workforce skews urban, middle-aged, and sedentary, making it a population with above-average NCD risk. A benefit package that does not cover NCD management will be seen as inadequate by the very demographic it targets. At the same time, including NCD management without corresponding supply-side investment in diagnostic and pharmacological capacity would result in nominal coverage without effective access, damaging trust in the scheme.

Human Resources for Health

Ethiopia's physician density remains critically low, estimated at 0.1 physicians per 1,000 population by the World Bank [21]. Health center staffing is predominantly at the level of nurses, health officers, and midwives, with limited specialist coverage below the hospital tier. While task-shifting has been used strategically to expand primary care, the staffing gaps at health centers and primary hospitals mean that contracted facilities under SHI may face workload surges, particularly in outpatient departments, without the human resource capacity to sustain quality. Provider payment mechanisms must therefore be designed with workforce sustainability in mind, including incentives for health worker retention and appropriate remuneration, rather than purely on cost-containment principles.

Synthesis: The Four Domains as an Integrated Policy System

Interdependencies and Feedback Loops

A central contribution of this review is to show that the four domains are not independent barriers to SHI launch but are components of a single, interconnected policy system. Low WTP is not simply a financing problem solvable by reducing the premium rate; it is substantially driven by rational assessments of service quality and provider network scope, which are supply-side problems. Low institutional readiness is not simply an administrative problem; it is partly a consequence of fiscal constraints that limit EHIS's ability to invest in IT infrastructure and human capacity. Fiscal space constraints are not simply a macroeconomic problem; they are partly addressable through the premium revenue that SHI itself would generate once enrollment reaches scale. And service quality deficits are not simply a supply-side problem; they are partly addressable through the strategic purchasing leverage that a well-capitalized SHI fund would possess.

This systems view has important policy implications. Interventions targeted at only one domain in isolation are unlikely to succeed. A premium rate reduction without private sector inclusion will not substantially shift WTP among higher-income workers. Institutional capacity building without a credible provider quality improvement agenda will not build member trust. Fiscal space analysis without SHI revenue projections will underestimate the scheme's self-financing potential. And facility quality upgrading without a concomitant enrollment drive that generates demand and revenue will not be sustained. Successful SHI launch in Ethiopia requires coordinated, sequenced action across all four domains.

Comparative Lessons from the Region

Rwanda's experience with Mutuelle de Sante demonstrates that community and social health insurance can achieve high enrollment and financial protection in low-income settings, provided certain design features are in place: income-tiered premium contributions, government subsidization of the poorest quintile, sustained investment in facility quality, and credible claims management. Rwanda now has among the highest health insurance enrollment rates in Africa, with the published literature associating the scheme with reductions in out-of-pocket expenditure. Ghana's National Health Insurance Scheme (NHIS), despite well-documented financial sustainability challenges, has shown that formal

sector integration into a broader national health insurance pool can significantly expand coverage, provided actuarial discipline is maintained and exemption categories are clearly defined. Kenya's National Hospital Insurance Fund, replaced from October 2024 by the Social Health Insurance Fund (SHIF) under the newly established Social Health Authority (Social Health Insurance Act, 2023), provides a cautionary example [25] of what happens when claims management capacity, provider payment timeliness, and benefit package scope are not adequately resourced at launch.

From these regional comparisons, three consistent lessons emerge. First, income-tiered or sliding-scale premium structures consistently produce higher enrollment and greater equity than flat-rate schemes. Ethiopia's January 2024 adoption of a sliding-scale contribution model for CBHI, approved by the national CBHI council, represents a promising innovation that should be analyzed for applicability to SHI. Second, private sector inclusion in the provider network is associated with higher uptake, particularly among upper-income formal sector workers. Third, a trusted and transparent administrative agency is a necessary precondition for enrollment: schemes perceived as poorly managed or financially unsound consistently experience enrollment resistance regardless of premium level.

The CBHI-SHI Integration Opportunity

CBHI's strong enrollment and renewal performance provides an institutional asset that Ethiopian policymakers should leverage more deliberately for SHI. By 2023, CBHI's enrollment rate was 78% and renewal was 91% [1]. The scheme reached 12.1 million households across 1,011 districts, covering more than half of Ethiopia's population. Formal sector workers who live in communities with functioning CBHI, who have seen insurance work, and who understand risk pooling through direct household experience, are demonstrably more receptive to SHI. A communication strategy for SHI that builds on the CBHI narrative, rather than treating the two schemes as entirely separate policy objects, could leverage this familiarity to reduce the information gap that partly accounts for low WTP.

In the longer term, the convergence of SHI and CBHI into a single national health financing pool, as envisioned by the EHIS ten-year strategic plan [26], would represent the most significant structural advance toward UHC. A unified pool would allow cross-subsidization from higher-income formal sector members to lower-income CBHI members, improving the financial sustainability of both schemes and deepening Ethiopia's social solidarity in health financing. The design of that convergence, however, requires the four domains analyzed in this review to be adequately addressed within each scheme before integration is attempted.

Policy Implications and Advocacy Recommendations

Redesign the Premium Structure Based on Updated Evidence

The most immediate implication of the WTP evidence is that the 3% flat-rate premium, calibrated to 2010 salary data, is not viable as currently designed. The average WTP of 1.6% of gross salary documented by Zarepour and colleagues [3] suggests that an initial contribution rate of 1.5% to 2%, with a pathway to 3% as scheme performance improves and member trust builds, is more consistent with the revealed preferences of the target population. This inference should be treated with caution, as the underlying estimates derive from contingent-valuation surveys of stated willingness, which may overstate actual contribution behavior; the proposed rate therefore warrants validation against enrolment data once the scheme is piloted. This rate adjustment should be accompanied by a comprehensive actuarial reassessment using current salary distributions and cost-of-care

data, to determine the benefit package scope that is financeable at lower contribution rates with government co-financing bridging the gap.

Mandate Private Provider Inclusion from Day One

No single design change is more likely to shift the WTP distribution among formal sector workers than credible private provider inclusion in the SHI network. The fear of double payment, which depresses WTP even among workers who find the 3% premium affordable [3], is only resolved when the SHI card provides access to the facilities workers actually use. The government and EHIS should move urgently to develop a private provider contracting framework, with minimum quality standards, a tiered fee schedule, and anti-fraud safeguards, that can enable a meaningful cohort of accredited private facilities to participate in SHI from its inception.

Invest in Provider Quality as a Prerequisite, Not a Parallel Track

The supply-side evidence reviewed in Section 6 makes clear that facility quality upgrading is not an optional complementary investment to SHI: it is a prerequisite for SHI to deliver value. The low availability of basic amenities (39%), diagnostics (40%), and essential medicines documented across Ethiopian public facilities [11] must be addressed at contracted facilities before, or at minimum in parallel with, SHI enrollment. A phased launch strategy, starting with facilities that already meet defined quality thresholds and expanding as additional facilities achieve those standards, would be more credible than a blanket rollout across an unprepared provider network.

Prioritize EHIS Institutional Capacity Building as a Critical Path Item

SHI cannot be launched without a functioning claims management system, a trained cadre of medical auditors, an operationalized provider payment mechanism, and an ICT infrastructure capable of processing enrollment, claims, and payments at scale. The EC-funded m4health digitalization initiative [14] is laying groundwork, and the WHO [13], ILO [12], and USAID HFIP [27] are providing technical assistance. But these efforts need to be explicitly framed as critical path items with non-negotiable completion milestones that condition the launch date. EHIS should publish and regularly update an institutional readiness scorecard against which donors, the government, and civil society can track progress.

Use the National Health Compact Framework to Mobilize SHI Co-Financing

The National Health Compact, endorsed in 2025 [4], is the most significant high-level policy commitment to transforming Ethiopian health financing since the original SHI proclamation. Its target of doubling the government's share of health financing from 27% to 53% by 2030, and its projection of total health expenditure reaching USD 8.3 billion, provide the fiscal ambition framework within which SHI co-financing commitments should be explicitly nested. The government should table a SHI co-financing budget line, representing the employer contribution for civil servants and a subsidy allocation for vulnerable workers, in the Medium-Term Expenditure Framework, making SHI financing a committed and trackable item in the federal budget.

Conduct a Comprehensive Feasibility Reassessment Before Launch

The synthesis of evidence across the four domains reviewed in this paper points consistently to one conclusion: the evidence base generated in 2010/11 is no longer adequate to support a sound launch decision. Macroeconomic conditions, the labor market, the facility landscape, institutional capacity, and the political economy have all changed substantially. A comprehensive feasibility

reassessment, covering updated actuarial projections, WTP at revised premium scenarios, provider readiness, EHIS institutional capacity, and fiscal space, is the most risk-reducing investment the government and its development partners can make before a launch decision. This call is consistent with recommendations from the WHO September 2023 mission to Ethiopia [13] and with the direction of travel in the National Health Compact [4].

Limitations of This Review

This review has several limitations that should be acknowledged. First, as a narrative review, it does not apply systematic eligibility criteria to the selection and weighting of evidence, potentially introducing selection bias. Second, the WTP literature is dominated by contingent valuation methods, which can produce aspirational rather than behaviorally predictive estimates. Stated WTP in survey contexts may differ from revealed WTP in actual enrollment decisions. Third, the service readiness evidence draws heavily on the SARA 2018 survey and the ESPA 2021/22, which predate the most recent period of post-conflict reconstruction and may not fully capture current facility status in previously conflict-affected regions. Fourth, fiscal space projections are inherently uncertain in a rapidly changing macroeconomic environment, and the National Health Compact targets, while ambitious, are aspirational rather than contractually committed. These limitations do not invalidate the review's conclusions, but they reinforce the argument for updated primary research before SHI launch decisions are finalized.

Conclusion

Ethiopia's Social Health Insurance program has waited too long to be designed on the basis of old evidence. The formal sector workforce, the macroeconomic environment, the healthcare delivery landscape, and the institutional capacity of the EHIS are all materially different in 2025 from what they were in 2010. This review has shown that the four domains critical to SHI feasibility, namely willingness to join and pay, institutional preparedness, fiscal space, and service availability, are individually constrained and mutually reinforcing in ways that require policy responses calibrated to their interactions.

WTP at the proposed 3% premium is well below the threshold needed for financial sustainability, and it will remain so until the provider network credibly includes private facilities and until public facility quality is demonstrably improved. EHIS's institutional capacity, while growing, has critical gaps in claims management, strategic purchasing, and provider contracting that must be resolved before the scheme can operate. Fiscal space is tight but not prohibitive, and SHI's own premium revenue has the potential to become a major domestic financing instrument if the scheme is designed to reach and sustain high enrollment. And service readiness, particularly for outpatient diagnostics and essential medicines, is the most fundamental constraint of all, because a health insurance scheme that cannot reliably deliver the services it promises will erode trust faster than any communication campaign can rebuild it.

The policy window for getting SHI right in Ethiopia is open. The National Health Compact, the renewed government commitment to launch, and the sustained engagement of major development partners all point in the same direction. What is needed now is the disciplined commitment to update the evidence base, redesign the scheme parameters that the evidence identifies as inadequate, and build the institutional machinery that a credible SHI requires. The cost of doing this work is a fraction of the cost of a failed launch. The obligation to the millions of Ethiopian workers and families who stand to benefit from a functioning scheme is to get it right.

Author Contributions

Wudalew Meselu Tesfaye conceptualized the study, designed the review framework, conducted the literature search and screening, performed the narrative synthesis, and drafted the full manuscript. The author read and approved the final version submitted for publication.

Conflict of Interest

The author declares no conflict of interest, financial or otherwise, in relation to the research, authorship, and publication of this article. The views expressed are those of the author alone and do not represent the official position of any affiliated organization.

Ethical Approval

This article is a secondary narrative review of previously published literature and publicly available policy documents. No primary data collection involving human participants was conducted. Accordingly, formal ethical approval was not required. All cited sources are appropriately acknowledged in accordance with standard academic practice.

Data Availability

This review is based entirely on publicly available published literature and open-access policy documents. No primary datasets were generated or analyzed. All sources are cited in the reference list and can be accessed through the URLs and DOIs provided.

Funding

This research received no specific grant from any funding agency in the public, commercial, or not-for-profit sectors. The work was conducted independently by the author.

Acknowledgements

The author gratefully acknowledges the contributions of researchers and policymakers whose published work formed the evidence base for this review. Special recognition is given to the Ethiopian Health Insurance Service (EHIS) and the Federal Ministry of Health of Ethiopia for their sustained engagement in advancing the social health insurance reform agenda. No direct financial or logistical support was received from any institution in the preparation of this manuscript.

References

[1]. Mebratie AD, Shamebo D, Alemu G, Shigute Z, Bedi AS. Willingness of urban formal sector workers to support a community-based health insurance scheme in Ethiopia. Clinicoecon Outcomes Res. 2025;17. Available from: https://doi.org/10.2147/CEOR.S533996

[2]. Federal Democratic Republic of Ethiopia. Social Health Insurance Proclamation No. 690/2010. Addis Ababa: Federal Negarit Gazeta; 2010.

[3]. Zarepour Z, Mebratie A, Shamebo D, Shigute Z, Alemu G, Bedi AS. Social health insurance and healthcare seeking behavior in urban Ethiopia. Ann Glob Health. 2023;89(1). Available from: https://doi.org/10.5334/aogh.4240

[4]. World Bank, Government of Ethiopia. National Health Compact: Ethiopia [Internet]. World Bank; 2025. Available from: https://thedocs.worldbank.org/en/doc/0273f33ab6ee48c5d842108b9b55c789-0140022025/original/National-Health-Compact-Ethiopia.pdf

[5]. Baethge C, Goldbeck-Wood S, Mertens S. SANRA-a scale for the quality assessment of narrative review articles. Res Integr Peer Rev. 2019;4:5. Available from: https://doi.org/10.1186/s41073-019-0064-8

[6]. Setegn A, Andargie G, Amare G, Debie A. Willingness to pay for social health insurance among teachers at governmental schools in Gondar Town, Northwest Ethiopia. Risk Manag Healthc Policy. 2021;14:861-868. Available from: https://doi.org/10.2147/RMHP.S299119

[7]. Girma S, Abebe G, Tamire A, Fekredin H, Taye B. Teachers' willingness to pay for social health insurance and its determinant factors at Harar Region, Ethiopia, 2021. Clinicoecon Outcomes Res. 2023;15:181-193. Available from: https://doi.org/10.2147/CEOR.S397766

[8]. Regassa Z, Negera E, Silashi T, Kaba Z, Mosisa G. Willingness to join and pay social health insurance and associated factors among public sector workers in Didu Woreda, South West Ethiopia, 2018. SAGE Open Med. 2022;10. Available from: https://doi.org/10.1177/22799036221123957

[9]. Kaso AW, Obsie GW, Debela BG, Tololu AK, Mohammed E, Hareru HE, et al. Willingness to pay for social health insurance and associated factors among public civil servants in Ethiopia: A systematic review and meta-analysis. PLoS One. 2024;19(2). Available from: https://doi.org/10.1371/journal.pone.0293513

[10]. Bayked EM, Toleha HN, Chekole BB, Workneh BD, Kahissay MH. Willingness to pay for social health insurance in Ethiopia: A systematic review and meta-analysis. Front Public Health. 2023;11. Available from: https://doi.org/10.3389/fpubh.2023.1089019

[11]. Federal Ministry of Health, Ethiopia. Health Sector Transformation Plan II (HSTP II): 2020/21-2024/25. Addis Ababa: FMoH; 2020.

[12]. International Labour Organization (ILO). ILO trains social health protection actors in Ethiopia [Internet]. ILO PROSPECTS Programme; 2024. Available from: https://www.ilo.org/resource/news/ilo-trains-social-health-protection-actors-ethiopia

[13]. P4H Network. Strengthening health financing and HTA institutionalization: WHO mission to Ethiopia [Internet]. P4H Network; 2024. Available from: https://p4h.world/en/news/strengthening-health-financing-and-hta-institutionalization/

[14]. m4health AG. Digitalising Ethiopia's health insurance systems [Internet]. m4health AG; 2024. Available from: https://m4health.pro/project/digitalisation-of-health-insurance-services-in-ethiopia/

[15]. London School of Hygiene and Tropical Medicine, Results for Development. Financing primary healthcare in Ethiopia: Overview of briefs. London: LSHTM; 2022.

[16]. Results for Development (R4D). Three challenges affecting community-based health insurance in Ethiopia [Internet]. R4D; 2024. Available from: https://r4d.org/blog/3-challenges-affecting-community-based-health-insurance-in-ethiopia/

[17]. Heller PS. The prospects of creating fiscal space for the health sector. Health Policy Plan. 2006;21(2). Available from: https://doi.org/10.1093/heapol/czj013

[18]. African Development Bank. Ethiopia economic outlook 2023/24 [Internet]. African Development Bank Group; 2024. Available from: https://www.afdb.org/en/countries/east-africa/ethiopia/ethiopia-economic-outlook

[19]. Reuters. Ethiopia becomes Africa's latest sovereign default after missing bond payment. London: Reuters; 26 December 2023.

[20]. UNICEF Ethiopia. National health budget brief 2023/24. Addis Ababa: UNICEF; 2024.

[21]. UNICEF Ethiopia. National health budget brief 2024/25. Addis Ababa: UNICEF; 2025.

[22]. Federal Ministry of Health, Ethiopia. Ethiopia National Health Accounts VII. Addis Ababa: FMoH; 2017.

[23]. Aschalew AY, Kelkay JM, Teshale G, Demissie KA, Baykemagn ND, Tadele A, et al. Availability and readiness of health facilities for non-communicable disease services in Ethiopia: Evidence from the nationally representative health facility survey 2022. PLoS One. 2025;20(12). Available from: https://doi.org/10.1371/journal.pone.0336675

[24]. Ethiopian Health Insurance Service (EHIS). Annual Performance Report 2017/18. Addis Ababa: EHIS; 2018.

[25]. Republic of Kenya. Social Health Insurance Act, No. 16 of 2023. Nairobi: Government Printer; 2023.

[26]. Ethiopian Health Insurance Service (EHIS). Health insurance ten years strategic plan (2020/21-2029/30). Addis Ababa: EHIS; 2022.

[27]. USAID Health Financing Improvement Program (HFIP). HFIP newsletter: Highlights from Ethiopia's health insurance program [Internet]. Abt Associates; 2023. Available from: https://www.hfip-newsletter.com/