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The political economy of health insurance enrolment in Ethiopia: Party, state and the quest for universal health coverage

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Abstract

Many developing countries are considering insurance as a means of pursuing universal health coverage. A key challenge to confront is how to achieve high levels of health insurance enrolment. For voluntary schemes, this entails mass awareness-raising and promotional activity, though as schemes move to compulsory enrolment, monitoring and enforcement is required. This paper focuses on Ethiopia, which is has made state health insurance for the informal sector a central pillar of its universal health coverage strategy. The paper shows that high enrolment requires particular forms of state capacity, captured here by Michael Mann's concept of state 'infrastructural power'. The paper draws on detailed case studies of health insurance implementation in the Tigray and Oromiya regions of Ethiopia to illustrate variation in state infrastructural power and the implications for the promotion of health insurance. The findings suggest that the potential of state health insurance as a means of promoting health access for a broad section of the population may be limited to the minority of countries or regions within countries exhibiting high levels of infrastructural power.

Keywords: health insurance, universal health coverage, Ethiopia, Africa, political economy, state capacity

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Introduction

Universal Health Coverage (UHC) is high on the global development agenda, not least as one of the Sustainable Development Goal targets for 2030. UHC is a situation in which 'all individuals and communities receive the health services they need without suffering financial hardship when paying for them' (Lancet 2016: 2837). Consequently, many see health insurance as an important component of UHC strategies (Lagomarsino et al. 2012), given the potential to limit out-of-pocket spending and the possibility of mobilising revenues to finance healthcare.

Achieving UHC through insurance has, though, proved challenging in practice. In countries where there is a large informal sector – including most countries in the global south – insurance schemes tend to exclude large numbers, either explicitly or because people struggle to pay premiums and mechanisms for collecting contributions are lacking (Lagomarsino et al. 2012, Reich et al. 2016, Harris 2019). Hsiao and Shaw (2007: 77) highlight the 'huge task' of 'enrolling and collecting premiums from nonindigent farmers and informal sector workers'. As a result, other observers consider that funding coverage of the informal sector through general taxation, rather than insurance, is more feasible (Kutzin 2012, Harris 2019).

Nonetheless, some countries have pushed ahead with insurance. This includes Ethiopia, where the government aims to achieve universal coverage through state-administered schemes: Social Health Insurance for the small formal sector and a Community-Based Health Insurance (CBHI) scheme for the remaining 90 percent. CBHI has been rapidly rolling out across the country since 2011. Past research has examined the government's motivations for pursuing health insurance, highlighting the ruling party's strategy of building political legitimacy through the delivery of socioeconomic progress, including health provisioning, and the importance of self-reliance in regime ideology (Lavers 2019). Meanwhile, evaluations of the original pilot schemes have shown largely positive impacts of CBHI on healthcare utilisation and financial hardship (Mebratie et al. 2019). In terms of implementation, studies of the pilot schemes show that individuals who have previously held a state position are more likely to enrol (Mebratie et al. 2015), as are households that receive state distributed social transfers (Shigute et al. 2017).

This paper builds on this existing work. Given the necessity of high enrolment for scheme financial viability, this paper focuses on how the state promotes CBHI enrolment, with a view to better understanding its potential contribution to UHC. To do this, the paper pursues a case-based methodology that draws on detailed field research in four case studies in the Oromiya and Tigray regions, as well as key informant interviews with federal and regional government officials, and official data on the scheme. Governments seeking mass insurance enrolment face a number of significant challenges, including the state of existing health provision and people's ability to pay premiums. However, the mobilisation of large numbers of people to buy health insurance and, where necessary, the enforcement of health insurance mandates, also places great demands on the state's capacity and territorial reach,

conceptualised here as state infrastructural power (Mann 1984). In Ethiopia, as in many other countries, the ability of the state to mobilise its population varies significantly within the country, based on long-run historical factors and more recent political dynamics shaping the relation between the ruling party and the population. The result is that party-state structures which penetrate society in Tigray provide effective mechanisms for implementation of top-down targets, including CBHI enrolment. In contrast, the party-state has long struggled for legitimacy in Oromiya and, in recent years, key administrative structures have collapsed, impeding CBHI promotion.

The implication of the paper is that pursuit of UHC through insurance depends on particular forms of state capacity. While boosting health insurance enrolment amongst the informal sector is undoubtedly a major challenge, there are examples where countries have had considerable success based on the power of the state to mobilise its population. Yet, these forms of state infrastructural power are not common and are embedded with long-run historical processes. Ethiopia – frequently acknowledged as unusual in the capacity of the state to implement national initiatives – illustrates the challenge, with state capacity to enrol people in health insurance varying considerably within the country.

Following this introduction, the paper discusses the role of insurance in achieving UHC across a range of countries, providing the rationale for the analytical focus on state infrastructural power. The next section sets out the research design and methodology employed. The analysis of health insurance in Ethiopia begins by introducing the government's plans for health insurance and the progress made so far. Having done this, the paper analyses the historical and recent political dynamics that have shaped the differential development of state infrastructural power within Ethiopia, before turning to the case studies, first Tigray and then Oromiya. The final section concludes by highlighting the variation in state infrastructural power between the regions and the implications for health insurance.

The challenge of universal health coverage through insurance

The first countries to cover broad sections of their populations through health insurance moved gradually from voluntary schemes to compulsory enrolment for certain social groups, with coverage extended over time. Invariably this process took place alongside economic transformation, with the result that the informal sector, and the challenge of enrolling those in it, reduced over time. Germany is the original example, with Bismarck's 1883 reforms that made health insurance compulsory for certain groups often heralded. Yet, these initial reforms only resulted in coverage for 10 percent of the population and it was another 90 years before self-employed farmers were covered (Bärnighausen and Sauerborn 2002). Japan and South Korea followed a similar pattern to Germany, albeit significantly speeded up, with initially voluntary schemes turning to compulsory insurance for certain groups, but self-employed and farmers only included years later (Yang 1991, Ikegami et al. 2011). In

Korea, there was considerable initial resistance from the rural population to enrolment (Yang 1991).

Observers of Germany and Japan have argued that initial voluntary enrolment was important in raising awareness and demonstrating the benefits of insurance, aiding the enforcement of subsequent compulsory schemes (Bärnighausen and Sauerborn 2002, Ikegami et al. 2011). Yet such a gradual approach is clearly problematic for countries formulating a strategy to achieve UHC by 2030. Moreover, the phased expansion in Germany, Japan and Korea depended ultimately on structural transformation and the formalisation of employment. The expectations of modernisation theorists that developing countries would rapidly follow the path of advanced economies to development and formalisation have been dashed. Instead, schemes designed for the formal sector have created vested interests that resist subsequent expansion and pooling with less well-off groups (Kutzin 1997, Reich et al. 2016).

More recently, several middle-income countries where significant numbers in the informal sector remain outside insurance systems have achieved universal coverage by covering contributions from general taxation (Harris 2019). Examples include Thailand following a 2001 reform (Li et al. 2011, Harris 2017) and plans announced by the Philippines government in 2017 (Obermann et al. 2018). This approach bypasses the administrative challenge of collecting premiums from the informal sector. Yet examples largely entail middle-income countries where the uncovered population is approximately 30 percent of the population. How feasible such an approach would be in a low-income country with lower tax revenue and a larger uninsured population is open to debate.

In African countries, health insurance has often entailed compulsory insurance for a small formal sector, with insurance for the informal sector – where it exists at all – limited to Community-based Health Insurance (CBHI). CBHI schemes tend to be voluntary and community managed. While CBHI may offer some protection against catastrophic health costs for members, critics have argued that with low enrolment and poor management, CBHI has little potential to contribute to UHC (Carrin et al. 2005, Ridde et al. 2018). Yet, there are a few examples in which countries with large informal sectors have achieved high enrolment. China stands out in this regard, having rapidly raised enrolment through three schemes. Of particular note is the New Rural Cooperative Medical System (NRCMS), launched in 2003, which by 2011 covered 97 percent of the rural population, bringing enrolment across the three schemes to 830 million people, according to official statistics (Li et al. 2011, Yu 2015). The state heavily subsidises premiums, yet still requires contributions from households. Existing studies are at pains to stress the voluntary nature of health insurance, apparently making China an exception to the rule that '[n]o country has attained universal population coverage by relying mainly on voluntary contributions to insurance schemes' (Kutzin 2012: 867). However, there is a lack of detailed research on quite how China has managed to buck this trend. Existing findings highlight the inclusion of health insurance enrolment in performance evaluations for provincial and

local government officials, resulting in massive outreach and enrolment campaigns (Yu 2015). It is unclear whether strong state pressure for enrolment challenges the formally voluntary nature of the scheme.

On a very different scale, Rwanda stands out in Africa for mass enrolment in its Mutuelles de Santé scheme. Frequently translated into English as Community-Based Health Insurance, the Mutuelles are 'CBHI in name only' (Ridde et al. 2018). In contrast to the usual voluntary and community-managed CBHI schemes, Rwanda's Mutuelles have become a state-managed, compulsory scheme (Chemouni 2018). Mutuelles were launched in 1999 and a 2006 law required all Rwandans to enrol in health insurance. The result was 90 percent enrolment by the late 2000s between the Mutuelles and a separate scheme for formal sector workers. Key to this expansion was the inclusion of insurance enrolment in the *imihigo* or performance contracts for local government officials and utilisation of the decentralised state administration and network of community health workers for mass mobilisation, monitoring and enforcement (Chemouni 2018). The health insurance law also prescribes fines for failure to enrol and there are reports of arrests and denial of other government services for those that refuse (Chemouni 2018).

As China and Rwanda demonstrate, there is no inherent reason why compulsory insurance cannot be applied to the informal sector. Rather, in most cases, the state lacks the desire and/or capacity to do so. Perhaps one of the few things that China – with the largest population in the world – and Rwanda – among the smallest – share is the enormous power of the state and its capacity to mobilise the population. In contrast, in many developing countries, the state is limited in its capacity to implement policies and ensure compliance with its laws. Ghana is another country that is frequently highlighted in debates on health insurance since enrolment was made a legal requirement in 2003 (Jehu-Appiah et al. 2011). However, in Ghana this has never been more than an aspirational objective and there has been no real attempt to enforce the law. Indeed, it is doubtful as to whether the Ghanaian state would have the capacity to do so, or whether the highly competitive nature of politics would be compatible with the stringent measures taken in Rwanda. The result is that enrolment has stagnated at around 30-40 percent of the population and low enrolment is among the reasons the scheme faces serious challenges with respect to financial sustainability.

Ethiopia's strategy for UHC aims to achieve something like that achieved in Rwanda and China through the mass enrolment of the rural population in subsidised insurance schemes. There are many factors likely to shape the success of this strategy, including the availability and quality of health services, scheme management and people's understanding of health insurance. Building on the discussion above, this paper focuses primarily on the demands that mass enrolment places on state capacity. Different types of policy require quite different forms of state capacity (Centeno et al. 2017). To take two examples of direct relevance, an effective national health insurance system places certain requirements on national administration, namely professional management, actuarial capacity and autonomy

from political influence that might otherwise undermine scheme management. In contrast, the challenge of mass enrolment places quite different burdens on the state. Here a dispersed network of officials that reaches across the national territory is required to mobilise people, raise awareness and, where required, enforce policies and laws. Given the focus on enrolment, it is this latter aspect of state capacity that is the focus of the paper. To do so, the paper draws on Michael Mann's concept of state infrastructural power, namely: 'the capacity of the state actually to penetrate civil society, and to implement logistically political decisions throughout the realm' (Mann 1984: 113). Importantly, infrastructural power emphasises the territorial reach of the state and its relational nature (Soifer and vom Hau 2008).

Mann (1984) uses the concept of infrastructural power to examine how changes in transportation, technology and the organisation of the state have shaped the rise and fall of civilisations. Drawing on recent engagement with Mann's work (Soifer and vom Hau 2008, Soifer 2015), this paper focuses on three key aspects of state infrastructural power relevant to the analysis of health insurance enrolment. First, is the availability and training of state officials on which any attempt at implementation must rest. Second, however, the concept of infrastructural power highlights the importance of the state's relations with society. State infrastructural power is enhanced where the state is able to mobilise societal organisations in the pursuit of its objectives, and constrained where it faces opposition from society. Moreover, where the state and its laws are seen as legitimate by society, compliance is likely to be stronger than where the legitimacy of the state and its laws are questioned, placing a greater burden on costly enforcement. A third key aspect of state infrastructural power is the relations between state agencies (Soifer 2015). Vitally, to achieve its objectives, the central state must be able to influence the activities of lower-level state officials, whether through performance evaluations, discursive narratives or coercion. Vitally, the existing literature on the state in Africa (Mamdani 1996, Boone 2003) and elsewhere clearly highlights wide variation in each of these aspects of state infrastructural power. As discussed below, Ethiopia is no exception.

Research design and methodology

This paper pursues a comparative process tracing methodology. Process tracing is a method for within-case analysis focused on developing our understanding of the causal process leading to particular outcomes (George and Bennett 2004). Used in a comparative setting, the aim is to select cases that vary with respect to key factors of interest, in order to highlight the causal processes at work. The analysis of health insurance in Ethiopia provides a useful setting in this regard. One challenge with international comparisons is that variations in scheme design raise questions about the comparability of different country cases. In Ethiopia there is currently a massive push to expand health insurance coverage across the country. Since 2016 this has been based on a standardised CBHI model. As discussed below, however, key factors of interests, namely state infrastructural power, vary markedly within Ethiopia, providing the possibility of using comparative analysis to examine the impact of infrastructural power on the promotion of health insurance.

The approach to case selection was to choose cases from two regions with varying performance in enrolment, with a view to highlighting factors shaping divergent trends. As discussed in the next section, the cases selected are Oromiya and Tigray. Within each region, two wereda (district) sub-cases were selected, one of which was among the first wereda where CBHI was established and which by the time of fieldwork had been operational for approximately seven years, while CBHI in the other site was in the second year of operation. The intention was to explore whether the challenges facing schemes differed in the early and later phases of implementation. Clearly, selecting just two districts from large regions means that the sub-cases cannot be representative of the regions of which they are a part or of the country as a whole. Instead, the cases are selected to illustrate challenges faced in CBHI implementation. Nonetheless, where two independent sub-cases within a region share clear commonalities and these differ from another region, this may be an indication of a more general pattern.

There are limits to the comparability of these two regions that must be acknowledged, however. First, Tigray is a much smaller region than Oromiya, both in terms of territory and population. Undoubtedly the challenge of expanding health insurance enrolment is higher in Oromiya. Secondly, however, Tigray is a poorer region than Oromiya. While most of Tigray is classified by the government as chronically food insecure, Oromiya is home to some of the most economically productive areas of the country. In acknowledgement of this, case selection in both regions focused on districts classified as chronically food insecure and thereby eligible for support from the Productive Safety Net Programme (PSNP), a state-implemented social transfer programme.

The case studies draw on a range of data sources, which are used to build up a picture of the processes being examined. These include administrative data from relevant agencies from the federal government to the local administration within each sub-case. However, the main sources are qualitative, in each sub-case approximately 25-30 key informant interviews were conducted with government officials from the wereda, kebele and sub-kebele administrations,[1] social elites in the community and individual residents, as well as four focus group discussions with participants and non-participants.

An important limitation of the study is the influence of social desirability bias. In a context in which the party-state attempts to regulate economic, social and political life, and to shape norms regarding 'good' behaviour, it is challenging to get respondents to talk openly about their experiences and opinions. Moreover, whatever reassurances are provided, the common expectation is that researchers have ties to party-state or donor agencies. There is therefore a tendency for respondents to

[1] Ethiopian administrative structures are organised as follows: federal government; regional states; zones; wereda (districts); kebele (or tabiya in Tigray – sub-districts); zones (or kushet in Tigray).

report what they believe researchers want to hear, rather than what actually happens in practice. This is even more difficult when gender and class relations are overlaid on political sensitivities. Women in conservative rural communities have historically played a limited role in social and political life, and social norms mean that many women find it difficult to speak out. To a limited degree, the research was able to address this by pairing a male and female field researcher, both of whom are fluent in local languages, with the female researchers conducting all interviews and focus group discussions with women. Furthermore, attempts were made to gain respondents' trust, spending an extended period in the community, and to triangulate between the testimony of multiple, independent respondents. However, these strategies are imperfect and, particularly, in a time-bound study such as this, some limitations are inevitable.

Community-based Health Insurance in Ethiopia

In 2008, the Ethiopian government decided to base its UHC strategy on formal and informal sector insurance schemes, which would subsequently merge, leading to compulsory insurance for all. The launch of Social Health Insurance for the formal sector has long been delayed, most recently by civil servant opposition (Lavers 2019). In contrast, CBHI for the informal sector has expanded rapidly since its 2011 launch in 13 wereda. Following the initial 'pilot' phase, CBHI began expansion in 2013 and in 2016 CBHI schemes were standardised, based on lessons from the original pilots (EHIA 2015, 2016). Premiums were set at 240 *birr*[2] a year for a household and 'indigents' constituting 10 percent of the population were to be provided with free coverage. The existing land tax system is to be used to collect CBHI premiumsi,[3] in place of payroll deductions usually used for formal sector schemes. As a result of 1970s land-to-the-tiller reforms, a large proportion of rural households have some landholdings and therefore pay land taxes. With only a small proportion of the population exempt from fees, some 80 per- cent of the population is expected to pay premiums for CBHI membership, with another 10 percent covered by SHI. The CBHI treatment package is, in theory, relatively generous, covering all outpatient treatment, surgery and prescriptions, as long as patients follow the referral system (EHIA 2016). The reality is that many of these services are not available in practice.

The scale-up strategy is enormously ambitious. The 2015 Health Sector Transformation Plan (HSTP), the sectoral component of the national development strategy, set the target of establishing CBHI schemes in 80 percent of wereda and achieving 80 percent coverage by 2020 (MoH 2015). The CBHI rollout strategy rests heavily on the existing health extension system that was established from 2003, and which has attracted considerable attention for its role in recent progress in basic health indicators (Banteyerga 2011, Wang et al. 2016, Rieger et al. 2019). Health extension builds on the gendered division of labour in Ethiopian society, with women seen as the main means of changing health and sanitation behaviour within the

[2] In July 2018, the end of the fieldwork period, 240 birr was the equivalent of GBP 6.50.
[3] Ints. respondents EG12, EG13.

household, while the focus of men's work is on agricultural extension. Key figures in the health extension system are two women health extension workers (HEWs) per kebele, who are responsible for implementation of health extension packages covering basic health and sanitation. Households that complete all 16 packages graduate as 'model households'. Since 2011, model women have been assigned to lead groups of follower households known as 1-to-5 networks (one leader to approximately five followers) and women's development teams (comprising five or six 1-to-5s). Parallel extension structures exist for men – focused on agriculture. The development teams are 'voluntary' (Admasu et al. 2016), in the sense that attendance at meetings and participation in campaigns is unpaid (Maes et al. 2019). However, in many instances, participation is compulsory. Moreover, local political party structures play a vital role in establishing and monitoring the activity of the development teams, and these structures play important roles in the dissemination of party propaganda and political mobilisation, as well as health-related activity and policy implementation across a wide range of sectors.

As the former Minister of Health Kesetebirhan proudly noted, the Health Development Army – another name for the development team structure – is 'instrumental in generating demand for the [CBHI] scheme and providing oversight in its implementation' (Admasu et al. 2016). Moreover, the model household idea has been extended to the kebele level, with kebele in which 80 percent of households are themselves models, proclaimed as model kebele or villages. Vitally, 100 percent CBHI enrolment will be one of the criteria for assessing model kebele, while the aim is to reach 80 percent model kebele by 2020 (Admasu et al. 2016).

In principle, CBHI remains voluntary. However, from the scheme's inception, the government's intention was for CBHI to be compulsory, since, in the words of one of the scheme's main architects, 'we don't have to test something [a voluntary scheme] that had already failed somewhere else'.[4] The Ministry of Health's plan is to make health insurance enrolment compulsory in the period 2020-25.[5] For now, CBHI has an ambiguous status, with a long-term consultant who has been integral to the development of CBHI acknowledging that it has 'an element of compulsory, an element of voluntary'.[6] Indeed, it is necessary to situate the CBHI scheme in the context of the ruling Ethiopian Peoples' Revolutionary Democratic Front's (EPRDF's)[7] approach to governance more broadly. The EPRDF was explicitly a vanguard party, based on the principle of democratic centralism (EPRDF 2010). As such, debate within party structures is encouraged during elaboration of an official position, but once the vanguard decides on a course of action, everyone is expected to comply, with failure to do so taken as an act of resistance (Vaughan and Tronvoll 2003). Where an objective has been made a key national development target and state

[4] Interview. respondent EG15.
[5] Interview. respondentEG13.
[6] Interview respondent ED29.
[7] The EPRDF was disbanded in 2019, with most of its constituent parts forming the Prosperity Party, which remains in power in 2020. Given that these events occurred after fieldwork was completed, they are not a focus of analysis here.

structures have been mobilised in its pursuit, as with CBHI, the notionally 'voluntary' nature of enrolment loses its meaning. CBHI enrolment is far from optional.

The expansion strategy drew on the internal evaluation of the original pilot schemes. Indeed, as one consultant working on the scale-up strategy highlighted,

> 'The whole scale-up strategy revolves around the health development army. It is a political agenda. CBHI will be one of the core performance measures for health extension workers. In the most successful wereda in the pilots it was mandatory for cabinet to go house-to-house demanding enrolment'.[8]

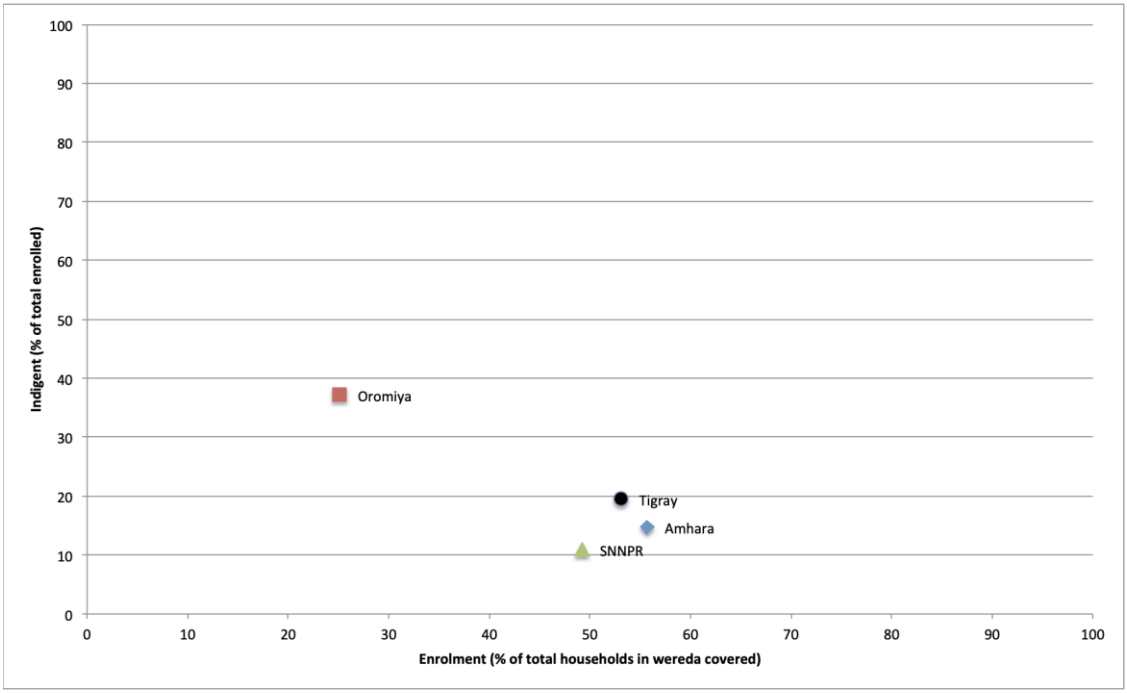
Of vital importance was the decision to set a national target for CBHI enrolment, since this target is then included in the performance evaluation of state officials. As the deputy director of the federal health insurance agency noted, once the target is established, 'the naming and shaming will come'.[9] The result is that the CBHI strategy places a number of demands on state infrastructural power: the state must be able to mobilise people through development teams, to direct this chain of command through performance assessments focused on CBHI enrolment, and the development teams must have sufficient leverage over their members to convince people to enrol.

Based on official data, CBHI expansion has been impressive, albeit insufficient to meet the HSTP targets. It should be noted from the outset, though, that many respondents expressed doubt about the accuracy of official data, a concern reinforced by the different enrolment figures reported for the same schemes at different levels of the state during fieldwork. By mid-2017, CBHI was operational in 384 of Ethiopia's 800 or so wereda, with 11 million people enrolled out of a population of more than 100 million[10] and expanding rapidly.

From the perspective of scheme financial viability, a key objective is to get large numbers of people to enrol by paying premiums. Two key measures help to capture this objective: enrolment as percentage of the eligible population; and members who are exempt from premiums (the 'indigent') as a percentage of those enrolled. These measures are plotted for the four regions where CBHI is operational in Figure 1. Good performance – in terms of scheme finances – would require data points in the bottom right corner, with most of the population enrolled and only a small proportion exempt from premiums.[11] Three regions – Amhara, Southern Nations, Nationalities and Peoples' Region (SNNPR) and Tigray – perform similarly in terms of enrolment and fee exemption. Given questions about data accuracy, it would be unwise to draw conclusions about the small variation between the three. However, Oromiya stands

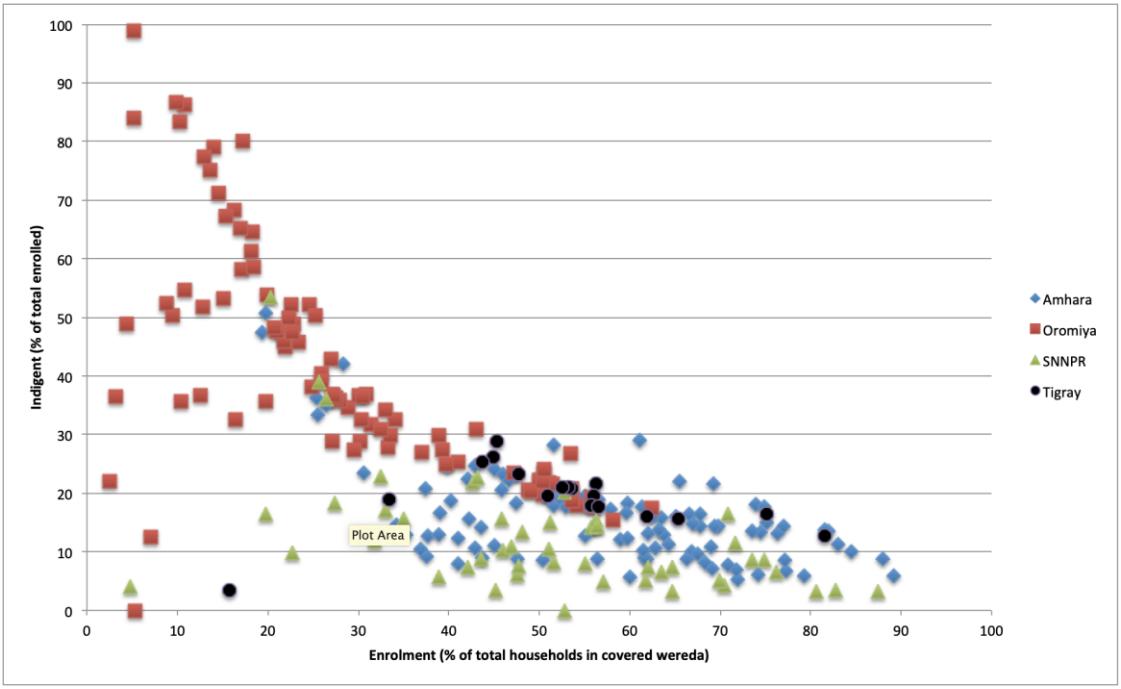
[8] Interview respondent EG14.
[9] Interview respondent EG12.
[10] Interview int. respondent EG13.
[11] UHC's concern with avoiding financial hardship might well lead to a different interpretation, with any data point on the right-hand side considered a positive result.

Figure 1. CBHI enrolment by region



Note: Enrolment figures are the number of people enrolled as a percentage of the population in wereda in which CBHI schemes are operational, not the total population of the region. Figures are for 2017 and exclude wereda added in 2017 due to low initial enrolment.

Figure 2. Wereda CBHI enrolment by region



Note: Figures are for 2017 and exclude wereda added in 2017 due to low initial enrolment. Despite a 2016 rule that all new schemes should have 50 percent enrolment before beginning operation, this is clearly not being applied anywhere.

out for relatively weak performance, with a much lower proportion of the population covered and fewer people actually paying premiums. Figure 2 provides the comparable graph for the wereda level, colour-coded by region. While there is considerable variation within each region, wereda in Amhara, SNNPR and Tigray cluster in the range of 30-90 percent enrolment, with most having no more than 30 percent fee exemptions. Oromiya is again an outlier, with some relatively good performing wereda, but many with very low enrolment and some very heavily reliant on fee exemptions. Comparison of Oromiya and Tigray therefore provides a contrast between the weakest performer and one of the strongest.

Ethiopian state building and the legacy of state infrastructural power

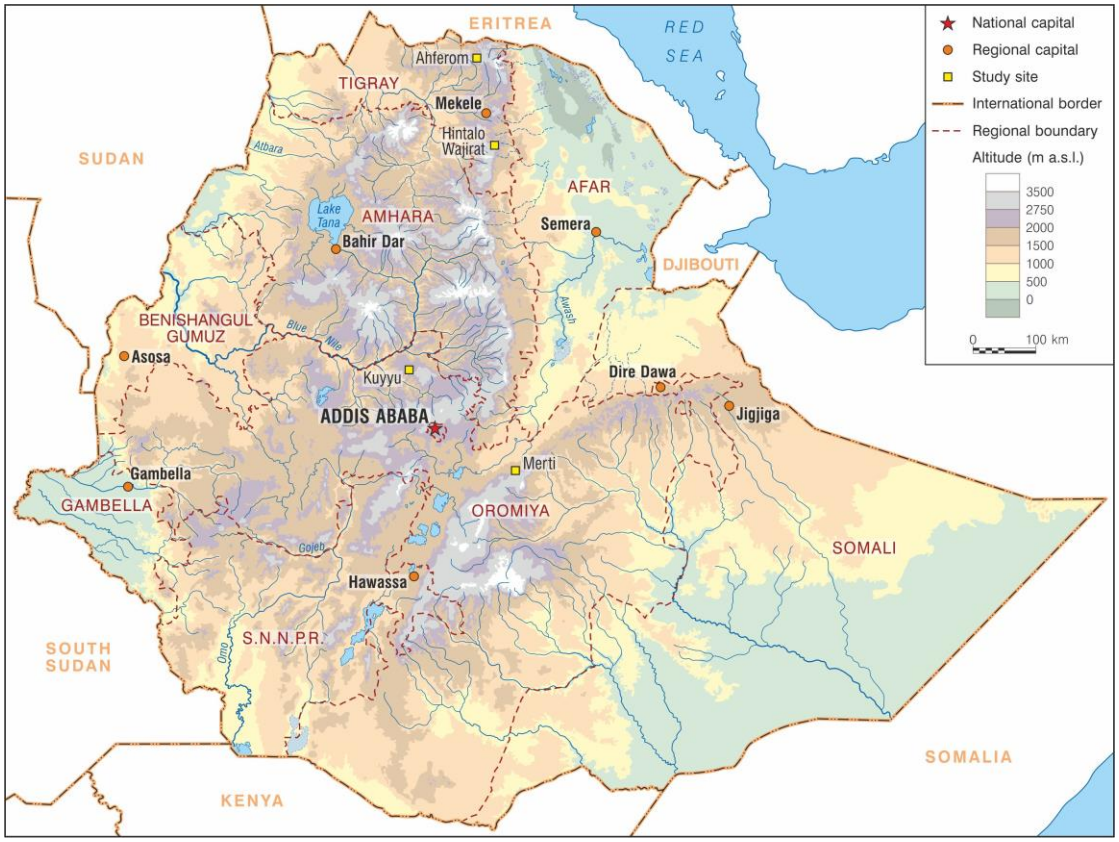
The CBHI expansion strategy places demands on the state's decentralised administrative structures. This section sets out the long-run historical processes and more recent political events that have shaped state infrastructural power across the country, with important implications for the state's ability to implement the CBHI scale-up strategy.

The Ethiopian polity has a history of several thousand years, originating in contemporary Tigray and Amhara regions and neighbouring Eritrea (see Figure 3). In contrast, much of Oromiya and other parts of the west, south and east of the country were only incorporated into Ethiopia at the end of the 19th century, through conquest under Emperor Menelik II (Zewde 1991). Within the central highlands, comprising much of Tigray, Amhara, Oromiya and SNNPR, initial variations in state structures gradually gave way to relative uniformity during the reign of Haile Selassie (1930-74) and, particularly, under the military-Marxist *Derg* regime (1974-91).

The Derg initiated a 'project of *encadrement*, or incorporation into structures of control, which was pursued with remarkable speed and ruthlessness' (Clapham 2002: 14) across highland areas. The Derg conducted land reform, villagisation and collectivisation of agriculture as means to '"capture" … the peasantry in a way that subjected them increasingly to state control' (Clapham 200: 15). In Tigray, the Derg's reforms were contested from the mid-1970s by the rival Tigrayan People's Liberation Front (TPLF). In certain respects, TPLF mirrored the Derg's encadrement project, creating administrative structures in liberated areas, as well as carrying out land reform. However, while the Derg alienated the peasantry through villagisation and surplus extraction, the TPLF's Maoist strategy was built on winning and securing the support of the peasantry (Young 1997). Though tested at times, this close relationship between the TPLF and the rural population of Tigray has remained to the present.

Having liberated Tigray by the late 1980s, the TPLF formed the Ethiopian Peoples' Revolutionary Democratic Front (EPRDF) coalition to represent Ethiopia's ethnic groups. The EPRDF defeated the Derg and since taking power in 1991 reconfigured

Figure 3: Ethiopia's regions under the EPRDF



the Ethiopian state in important ways, with great relevance for the subsequent analysis. First, the 1995 constitution created a federal system, which sought to provide self-administration for the main ethnic groups in the country. Second, the EPRDF launched a massive state-building project that has taken the encadrement of the Derg to another level. This state-building project has entailed fusing party and state structures, and expanding the reach of the state beyond the Derg's peasant associations, now known as kebele, right down to the household level through development teams and 1-to-5s (Emmenegger et al. 2011, Vaughan 2011).

The Oromo People's Development Organisation (OPDO) was created as the Oromo branch of the EPRDF in the late 1980s. While the OPDO had controlled Oromiya since 1991, it was long regarded as a creation of, and accountable, to the TPLF rather than the Oromo people (Clapham 2009). It is only very recently that this dynamic has started to change. Anti-government protests swept Oromiya from late 2015, sparked by expansion plans for Addis Ababa, but driven by a range of issues, including unemployment and landlessness, ethno-nationalism and the heavy-handed military response to initially peaceful protests (Davison 2016). The protests led to the replacement of the OPDO leadership with Lemma Megersa as regional president and Abiy Ahmed as his deputy in 2016. This new leadership aligned themselves with the protestors, achieving a remarkable turnaround in perceptions of the OPDO. When the protests ultimately forced the resignation of Prime Minister Hailemariam

Desalegn in early 2018, Abiy Ahmed of the OPDO was selected as party chairman and prime minister, despite opposition from the once dominant TPLF.[12]

Markakis (2011) usefully divided Ethiopia into three main areas: the highland core, comprising Tigray and Amhara; the highland periphery, including much of Oromiya and SNNPR, which was incorporated more recently but where state presence is well established; and the lowland periphery, where state-building efforts over the past century have made much less progress. While Oromiya's peripheral status is open to question now that Oromo comprise many of the most influential figures in the federal government, this distinction remains useful in terms of the party-state's infrastructural power. The case selection therefore also represents two regions with very different histories and present relationships with federal and region states. Tigray was relatively untouched by recent protests, with the alliance between the TPLF and the Tigrayan population perhaps even strengthened in the face of anti-Tigrayan sentiment elsewhere in Ethiopia. In contrast, significant hopes were vested in Abiy Ahmed as a representative of the Oromo people, yet this boost in legitimacy, however tentative, has come at the expense of fragmentation of the control structures used to sustain past OPDO dominance.

Party-state infrastructural power and CBHI enrolment in Tigray

This section applies the concept of infrastructural power to examine efforts to promote CBHI enrolment in the two Tigrayan cases. In line with the framework outlined above, the focus is on three components of infrastructural power: competence and resources; state–society relations and intra-state relations.

The first site is Ahferom wereda, one of three CBHI pilots in Tigray. According to national data, the wereda had 45 percent enrolment, of whom 29 percent were indigent in 2017. Within Ahferom, fieldwork focused on Ende Mariam tabiya, where the administration claimed 96 percent enrolment, with 17 percent indigent. The second site is Hintalo Wajirat wereda, where CBHI was in its second year of operation. In its first year, enrolment reached 53 pe cent, with 21 percent indigent. However, officials reported that enrolment had dropped the following year to 19 per-cent.[13] Within Hintalo Wajirat, fieldwork focused on Tsehafti tabiya, which exhibited a similar pattern, achieving 60 percent the first year before declining to 48 percent, with 23 percent exemptions.[14]

Both sites had established Health Insurance Initiative Steering Committees, responsible for overseeing CBHI, at wereda and tabiya levels. However, a common complaint among respondents was that CBHI had been added to existing responsibilities of wereda and tabiya staff, further stretching officials' ability to cope

[12] In 2019-20, Abiy merged the EPRDF into the integrated Prosperity Party, with the TPLF leaving the coalition it founded. As these events occurred some time after fieldwork was concluded, they are not covered here.
[13] Interview respondents THW1, THW3.
[14] Interview respondents THK1, THK4.

with the already heavy workload.[15] With the tabiya, CBHI enrolment is a joint responsibility of the tabiya leadership, though given their focus on health activities, HEWs are considered to have primary responsibility. HEWs work with sub-tabiya structures to promote CBHI and the health extension packages. Both Tigray sites are sub-divided into four *kushet* (hamlets) originally introduced in liberated areas during the TPLF armed struggle, which have effectively become an additional unofficial tier of state administration. The population of each kushet is, in turn, divided into male, female and youth development teams and 1-to-5 networks, to which every community household is assigned.[16] The development teams have become the central mechanism for implementation across virtually every aspect of the tabiya's work, with the result that the development teams effectively control access to key livelihood supports, for example, through access to PSNP transfers, emergency food aid, agricultural inputs, microcredit and vocational training (Focus Group Discussions (FGDs) TAF1, TAF2, THF9, THF10). Alongside these 'developmental' roles, development teams and 1-to-5s are also effectively party structures, with development teams used to mobilise people for party political activities and evaluated by the party-affiliated women's and youth leagues.[17]

Development teams are supposed to meet every two weeks, and 1-to-5 networks every week, to discuss their progress and plan future activities, with attendance monitored and compulsory. While this almost certainly exaggerates their activity, respondents unanimously reported that meetings take place regularly and it was straightforward for researchers to observe development team and 1-to-5 network meetings, suggesting that they are regular occurrences. That said, the performance of the women's development teams is widely considered inferior to that of the men's.[18] Respondents highlighted women's multiple other responsibilities in both social reproduction and economic activities, which limits their attendance of meetings, with married women particularly affected.[19] However, many women blamed the Health Extension Programme, which has comprised the same 16 packages since 2003 and has become repetitive.[20,21]Several respondents also noted that development teams were less effective in remote areas, where tabiya officials visit less frequently. Development team performance has also ebbed and flowed over time. When the structures were initially established, attendance was strictly enforced. However, subsequently people began to lose interest and participation declined. The 'Deep Renewal' initiative, launched in 2016 to re-invigorate party structures, is considered to have increased performance again.[22]

[15] Interview respondents THW3, THK1, THK4.
[16] Interview respondents THK1, THK4, THZ5, TAK5.
[17] Interview respondents TAK5, TAK7, TAZ2, THF6).
[18] Interview respondents TAK5, TAK7.
[19] Interview respondent THZ5.
[20] Interview respondents THF8, THF7, THK4.
[21] In 2018 the Ministry of Health was in the process of revising the health extension packages for the first time since their introduction in 2003.
[22] Interview respondents TAK2, THF5.

Importantly, the 1-to-5s – like the EPRDF – operate on the principle of democratic centralism, according to which debate within the party is encouraged, but once the party has come to a decision, that decision is binding on all. Accordingly, once the network decides on a course of action, compliance is mandatory:[23]

> 'Anyone can raise his concern and even oppose what is being discussed or decided. But what governs is the interest of the majority. So you should accept what the majority decided. There is no formal punishment but you will be outcast and criticised for not accepting the majority's decision'.[24]

The development teams and 1-to-5s provide a means of penetrating society, underpinning the infrastructural power of a fused party-state. However, another key requirement is that policymakers can direct these structures to pursue desired policy objectives. The EPRDF party-state has a well-established system of performance assessment, known as *gim gema*. Used by the TPLF in the 1970s and 1980s to promote discipline and accountability, this system has spread throughout the party-state since 1991. Gim gema requires that officials, including tabiya administrators and HEWs, regularly self-critique their performance in front of their superiors and those they represent, and they are subsequently critiqued by others. Good performance in gim gema should affect future career opportunities, with promotion and access to training reserved for the best performers.[25] In contrast, criticism for poor performance can be severe, potentially leading to dismissal.[26] As one kushet leader noted,

> 'Being severely criticised in gim gema is considered as disgrace or disrespecting the community who elects you. Leaders who are severely criticised must either resign or the community will dismiss them'.[27]

Meanwhile, targets taken from national development plans are cascaded down through tiers of state administration to the lowest levels. Each wereda, tabiya and kushet is required to prepare performance plans based on these targets, and administrations are ranked against one another, based on the results.[28] In both study wereda the CBHI enrolment target was 80 percent, in line with the national target for 2020, while the tabiya had 100 percent targets, also one of the criteria required for a tabiya to be identified as a 'model'. The systems for performance assessment do not stop, however, with state officials. Development teams are also regularly assessed and ranked against each other, by both the tabiya administration and the party-affiliated women's league.[29] There are no material rewards for development teams;

[23] Interview respondent TAI3.
[24] Interview respondent TAI1.
[25] Interview respondents THW1, THK4.
[26] Interview respondent THK1.
[27] Interview respondent THZ1.
[28] Interview respondents TAW1, TAK2, THK1.
[29] Interview respondents THK1, THZ5.

however, team leaders are subject to gim gema and good performers are rewarded with esteem, while, in the case of poor performance, the leadership is severely criticised and given feedback.[30]Individual community residents and households are also annually assessed by the party-state according to their adherence to government policies and initiatives. Households who adopt all 16 of the health extension packages and enrol in CBHI are classified as *model households*; *half models* are those that meet at least some of the model criteria; and *non-models* are those that have not met any of the criteria. Respondents report that the pressure from higher levels of the party-state to meet performance targets has changed over time. Pressure was particularly high at the end of the first Growth and Transformation Plan (2010-15).[31] After a relative lull, more recently pressure from above has increased with 'Deep Renewal'.[32]

CBHI targets, such as enrolment, premium collection and re-certification, are included in performance evaluations for wereda administrators,[33] wereda health offices, [34] tabiya administrations, [35] HEWs, [36] kushet administrations [37] and development teams. Furthermore, CBHI enrolment is now among the criteria for assessing and identifying 'model tabiya' and 'model farmers'.[38] Indeed, in Ende Mariam tabiya, the achievement of 96 percent CBHI enrolment, along with success with the other health extension packages, resulted in the award of 'model kebele' status. Overall, while there are many limitations to gim gema and the top-down system of performance evaluation, in terms of its focus on quantitative, easily measurable targets, this system does provide an effective means of focusing the attention of party-state officials on the challenge of raising CBHI enrolment. The result has been, according to one tabiya official, that 'massive public mobilisation and awareness creation activities are in place' to enrol people in the programme.[39]

It is hardly surprising, therefore, that the health extension system, comprising the HEWs, development teams and 1-to-5 networks, was widely considered 'instrumental' to CBHI promotion and formed the central focus of efforts to expand enrolment.[40] CBHI promotion has particularly focused on women's development teams, in line with the health extension programme. However, the HEWs in both sites have also worked with their male counterparts – the agriculture-focused Development Agents – and the male development teams to convince them to enrol. While women may have the main responsibility for health within the household, engaging with men is likely to be particularly important, given that male household

[30] Interview respondent TAZ2.
[31] Interview respondent THK1.
[32] Interview respondent TAK2.
[33] Interview respondent TAW1.
[34] Interview respondents TAW2, THW1, THW3.
[35] Interview respondents TAK2, THK1.
[36] Interview respondentsTAK5, THW3.
[37] Interview respondent THZ1.
[38] Interview respondent TAW2.
[39] Interview respondent TAK4.
[40] Interview respondents TAK5, TAZ2, TAF7.

heads generally control the household budget in rural Ethiopia. Respondents report that CBHI promotion for male and female teams takes place at every one of the development team and 1-to-5 network meetings.[41] In the words of one development team member,

> 'We always discuss health issues and the need to be member of health insurance … Development team leaders teach members about the benefits of CBHI and encourage us to enrol in the programme'.[42]

While development teams and 1-to-5s are the most important single mechanism of promoting CBHI, the scheme has been a prominent focus of all other tabiya and kushet meetings also, with all members of the KHIISC expected to promote enrolment,[43]

> 'There is always discussion on the merits of CBHI and the need for membership. The tabiya administration makes it part of its agenda in any meeting'.[44]

In line with regional government instructions, the party-state has also used its influence to engage other non-state actors, including the Church, revolving credit associations (*equb*) and burial associations (*iddir*).[45] Every community resident is a member of at least one iddir, which collect regular contributions and cover funeral expenses. According to one iddir leader, 'we get a direction from tabiya administrators to promote CBHI to our members, so anyone in the leadership position begin to promote it'.[46]

The sub-kebele structure is also playing an important role in collecting CBHI premiums. Initially CBHI members had to come to the tabiya administration to pay their premium. In an effort to boost enrolment, this responsibility is now decentralised, with the kushet leaders and HEWs tasked with going from door to door across the tabiya to collect premiums.[47]). CBHI premiums are usually collected along with other mandatory contributions, such as land taxes and party membership.[48] Land tax is particularly important, as the land tax receipt is widely used in Ethiopia to provide proof of holding rights. Land in Ethiopia is state-owned, with landholders granted use rights by the state. Though land is in short supply, 80 percent of households in Ende Mariam[49] and 88 percent of households in Tsehafti[50] have some landholdings, requiring them to pay taxes. In Ende Mariam, 18 percent of the total

[41] FGD respondents THF5, THF6, THF7, THF8.
[42] FGD respondent THF5.
[43] Interview respondent TAZ2, THK4.
[44] Interview respondent TAF8.
[45] Interview respondents TAK2, TAZ2, TAF7, THK4, THF5, THF6, THF8.
[46] Interview respondent TAN1.
[47] Interview respondents TAK2, TAK5, THK4, THK1.
[48] Interview respondents THF6, THF7, THK4.
[49] Interview respondent TAK2.
[50] Interview respondent THK1.

population (including children) are members of the TPLF, [51] roughly equivalent to one for each household. In Tsehafti, 9 percent of the population are members of the party,[52] roughly equivalent to one member for every two households. Collecting CBHI contributions alongside other mandatory and vitally important payments clearly has the potential to further blur the voluntary nature of the CBHI.

Despite this array of promotional activities, several tabiya officials and development team leaders reported that it was initially difficult to convince people to enrol. One strategy that they pursued was to ask those who had received treatment to share their experiences.[53] Indeed, once people started to hear stories of others getting expensive treatment having paid no more than the 240 birr premium, officials reported that people became more willing to enrol.[54] Notable among these was one case of a woman whose treatment at the top regional hospital – Aydar Referral Hospital in Mekele – was covered by CBHI[55]

While the selection of success stories may have helped enrolment in certain instances, it is also clear that the poor quality and availability of health services has also been a major deterrent. Healthcare access is particularly challenging in Tsehafti. As a result of drug shortages, the health post staffed by the HEWs in the tabiya was limited to providing contraceptives and malaria treatment. [56] For any other healthcare, patients were required to travel to a health centre in a neighbouring tabiya or town. The result is that those requiring treatment in Tsehafti must pay for public transport from the main road running through the tabiya, while even reaching this road may take several hours walking. Officials and community residents highlighted poor health services as a major barrier to enrolment.[57] Health services are less of a problem in Ende Mariam tabiya, where there is a health post in the tabiya and the tabiya is a few kilometres from Enticho town, which has a primary hospital. Yet even here, the HEW readily admitted that 'the existing quality of health services has affected the attitude of some people towards CBHI membership'[58] and leaders of women's development teams believed that the poor health services had reduced their team members' desire to re-enrol.[59]

Several respondents noted that the increase in premiums following the 2016 standardisation of CBHI schemes resulted in a near doubling of premiums to 240 birr and had affected people's willingness to enrol.[60] Moreover, the minimal quota for premium exemptions for 'indigent' households is widely considered inadequate, given levels of poverty and food insecurity in the area, with the result that many people

[51] Interview respondent TAK1.
[52] Interview respondent THK2.
[53] Interview respondent THK4.
[54] Interview respondents TAK5.
[55] Interview respondent TAI3.
[56] Interview respondent THK4.
[57] Intervew respondents THW3, THK1, THZ5, THF8, THF5.
[58] Interview respondent TAK5.
[59] Interview respondent TAZ2.
[60] Interview respondents THK1, THF6, THF7, THF8.

struggle to pay the premiums.[61] Each tabiya is allocated a quota for fee exemptions. This is, in turn, allocated to each kushet, based on population, and development teams and 1-to-5s identify the poorest of their members for support.[62]

In both sites, the full weight of the party-state was mobilised to promote CBHI and encourage the local population to enrol in spite of the cost and quality of health services. Having achieved high enrolment rates, however, the pressure to maintain this level of activity appears to have declined in Hintalo Wajirat, leading to the reduction in enrolment rates. The implication is that annual campaigns to promote enrolment and re-enrolment are required to sustain high rates. As the Tsehafti HEW noted, 'In the second round of renewal, mobilisation and promotion was not as such effective like the first round'.[63]

For the most part, CBHI promotional efforts have rested on promotion rather than explicit compulsion, albeit in a context in which residents are dependent on party-state structures and are well aware that failure to adhere to state initiatives is likely to be taken as a sign of resistance. However, fieldwork highlighted a few instances of local government officials forcing individuals to enrol. In the early phases of implementation in Ende Mariam tabiya and across Ahferom wereda, the tabiya administration announced that priority for participation in the Productive Safety Net Programme (PSNP) would be given to CBHI members.[64] (mirroring findings from a past study by Shigute et al*.* 2017). The PSNP is a social transfer programme that provides food and cash support to the most chronically food insecure people in the country, contingent on participation on participation in public works. The threat of losing PSNP support would therefore provide a major incentive to enrol. Officials were clear that while PSNP participants were required to enrol in the past, this is no longer the case. However, one focus group participant was explicit that this was the reason that she enrolled in the first place:

> 'I decided to enrol at CBHI not to be excluded from PSNP. I was pressured by the public work coordinator, he gave me a warning twice if I didn't enrol in CBHI, not to comeback to public works again'.[65]

The Tigray case studies therefore suggest that extremely high levels of the infrastructural power of the fused party-state underpin the relative success of the CBHI. This power depends on the decentralised structures of party-state administration and the performance evaluations used to direct these, but also, to a degree, the ability of the party-state to mobilise non-state actors, such as churches and burial associations, to promote the scheme. Based on Mann's definition of infrastructural power, the party-state in Tigray has certainly 'penetrated' society (Mann 1984); arguably, it has subsumed it. In this context of overwhelming party-

[61] Interview respondents TAK5, THK1, THK4.
[62] Interview respondents TAK5, TAZ2, THK4, THZ5.
[63] Interview respondent THK4.
[64] Interview respondents TAW2, TAK4, TAK5.
[65] Interview respondent TAF9.

state dominance, the dependence of the local population on the party-state for nearly every aspect of their livelihoods – from land to agricultural inputs and credit to social transfers and food aid – and the clear communication from the party-state of what constitutes 'good' behaviour by adhering to government initiatives, the voluntary status of the CBHI scheme is blurred, to say the least.

Erosion of the party-state and limits to mobilisation in Oromiya

The Oromiya case studies present a stark contrast. As with Tigray, the Oromiya cases comprise one wereda, Kuyyu, from the original 13 pilots and one, Merti, which is part of the scale-up phase. In Kuyyu CBHI enrolment was 27 percent with 37 percent indigents. Within Kuyyu, fieldwork focused on Halelo Cerri kebele, where the enrolment rate was 45 percent, of whom 21 percent were indigent. During fieldwork, Merti wereda was in the second year of operation. Having achieved 51 percent enrolment in the first year, with 24 percent of these exempt from fees, wereda officials were concerned at extremely low re-enrolment. Fieldwork focused on Shamo Gado kebele, where 256 households were paying members the previous year, giving a total enrolment rate of 52 percent. At the end of the enrolment period, just seven people had renewed their membership.[66]

Kebele administrations in the two sites used existing health committees to oversee CBHI rather than a dedicated Health Insurance Initiative Steering Committee. [67] .Respondents at the wereda and kebele – like their Tigrayan counterparts – voiced concerns that a major new initiative like CBHI had been launched without additional staffing. [68] Each kebele had two HEWs with similar qualifications to those in Tigray, albeit that in Shamo Gado kebele, one HEW was away for training at the time of fieldwork.

> In Oromiya, as in Tigray, each kebele (equivalent to the tabiya in Tigray) is divided into several zones (equivalent to the kushet in Tigray), which should be administered by a committee. However, the zone administrative structure only exists in Merti, not Kuyyu.[69] All residents of these zones are assigned to male and female development teams and 1-to-5 networks. Moreover, state officials in both sites acknowledge the importance of the structures for communicating with the local population and delivering services.[70] However, in both sites, the effectiveness of the development teams is limited. The assessment of the Merti wereda health extension coordinator was particularly frank: 'it cannot be said that it is active and is doing well, it is more theoretical'.[71] Similarly, one leader

[66] Interview respondent OMK4.
[67] Interview respondent OMK3.
[68] Interview respondents OMW2, OKW2.
[69] Interview respondent OKK6.
[70] Intervew respondents OMZ3, OMW5, OMK1.
[71] Interview respondent OMW5.

> of a development team readily admitted that, 'the development teams are not functional at all, the organisation is just on paper'.[72]

While most respondents stated that the development teams had declined over time,[73] some stated that they had never been very effective.[74] Indeed, earlier research found that it has long been a challenge for the OPDO to get development teams to work effectively (Emmenegger et al. 2011). A challenge to the promotion of health insurance is that the women's development teams have been particularly dysfunctional[75] and there was no evidence of any women's meetings being held during the fieldwork period. Several respondents highlighted the 2015 national elections as the last time that the structures were active, with development teams used for campaigning and voter registration.[76] Indeed, the political nature of the development teams is one reason why they have fallen out of use. The Oromo Protests effectively became an anti-OPDO/EPRDF protest. While the study sites were not severely affected by the protests, the crisis within the party and increased unwillingness of the local population to acquiesce to its demands contributed to the decline of the development teams.[77] The change in the population's willingness to adhere to party demands was starkly noted in one focus group,

> 'we do not fear to express our views and dissents anymore. Previously if you speak against the kebele cabinet they label you as OLF,[78] they say you have "anti-government view". The kebele militia, including this guy [pointing to another FGD participant], used to harass you. Now that has decreased'. [79]

Unsurprisingly, given development teams' state of dysfunction, the democratic centralism that requires strict discipline and adherence to party-state initiatives, as evident in Tigray, has fallen away in Oromiya. In the words of one respondent, 'Nothing happens to anyone who does not follow the messages that come from 1-to-5 groups. If you like you apply it, if you don't like, you can leave it. It is voluntary'. [80]

During fieldwork, regional party officials were attempting to revive the development teams, based on the essential role that they previously played in service delivery. [81]However, it is highly doubtful that the party-state retains either the legitimacy or coercive power to succeed. For the time being, at least, party-state infrastructural power in Oromiya is limited by the absence of these structures. Nonetheless, the

[72] Interview respondent OMZ4.
[73] FGD respondents OMF1, OMF3.
[74] FGD respondents OMF2.
[75] Interview respondent OKK6.
[76] Interview respondent OMK1.
[77] Interview respondents OMK3, OKK4.
[78] The Oromo Liberation Front (OLF) is an opposition group that was banned as a terrorist organisation from 1992.
[79] FGD respondent OMF2.
[80] Interview respondent OKI1.
[81] Interview respondent OR2.

kebele administration, health extension workers and remnants of the development team structure can be applied to the task of CBHI promotion. The question remains, therefore, as to the extent to which performance evaluation enables higher-level officials to direct local-level officials to desired objectives. Much like the development team structure, however, the system of performance evaluation depended on the party, with a marked deterioration in recent years.

In principle, the system of setting targets and evaluating performance in Oromiya is very similar to that in Tigray. Wereda administrations develop annual plans based on federal and regional targets, and these are then passed down to the kebele under their jurisdiction.[82] Kuyyu wereda, as one of the original pilots, was given a target of 90 percent CBHI enrolment, but this was reduced to 60 percent, given the failure to get close to this figure.[83] Halelo Cerri kebele still has a target of 100 percent enrolment.[84] Given the more recent establishment of CBHI in Merti wereda, the wereda and Shamo Gado had a lower initial target of 50 percent enrolment. The wereda received a laptop, in recognition of its success in this regard, along with an increased target of 80 percent enrolment, just as enrolment collapsed in the second year of operation.[85]

Performance is assessed through gim gema and the administrations and officials are given a grade A, B or C, and ranked against their peers.[86] CBHI targets are included in the evaluations for wereda health bureau, kebele administrations, HEWs and zone administrations (where they are operational). [87]However, respondents were clear that the regularity of performance evaluations and the pressure on officials to meet their targets has declined sharply in recent years. While performance evaluation was relatively rigorous up to the end of the previous national development plan in 2015, it has fallen away since, with either no or mere token evaluations since.[88] A new regional initiative has been to allow the kebele cabinet, which is responsible for collecting CBHI premiums, to retain 2 percent of the premiums, if they manage to reach 50 percent enrolment. In Shamo Gado kebele, this initiative has backfired, however. Having achieved 50 percent coverage the previous year, the kebele chairman claimed all this reward for himself – contrary to regional guidelines. In response, the kebele manager now refuses to work on CBHI at all, since he does not stand to benefit.[89] Oromiya also differs from Tigray with respect to model households and kebele. Despite the regional government's plan to add CBHI to the model criteria,[90] these had not been updated in either site. Moreover, there has been no attempt to identify model households for several years, a process which should take place annually.

[82] Interview respondents OMK4, OKK5.
[83] Interview respondent OKW2.
[84] Interview respondent OKK5.
[85] Interview respondents OMW2, OMW3, OMK4.
[86] Interview respondents OMW3, OMK1, OMZ3.
[87] Interview respondents OMK1, OKW1, OMW3.
[88] Interview respondents OMW3, OMK4, OKK4, OKK6.
[89] Interview respondent OMK4.
[90] Interview respondent OR2.

In sum, therefore, not only has the ability of the party state to penetrate society and mobilise it for developmental and political ends been severely diminished, but the capacity of higher-level officials to direct the activities of lower levels through performance evaluation has also eroded over time. The result is that party-state infrastructural power is severely undermined and, with it, efforts to promote CBHI enrolment.

Wereda and kebele respondents insisted that CBHI enrolment was being given high priority in line with national plans.[91] However, probably the central challenge facing attempts to promote CBHI enrolment is the state of the development team structure on which the national scale-up strategy is based. HEWs admitted that 'much hasn't been done with health development armies and development teams on raising awareness about CBHI'. [92] Respondents in Kuyyu reported that the male development teams were used to promote CBHI in the past, when these structures were more effective. As one 1-to-5 member noted,

> 'They used to tell us through 1-to-5. They told us it is especially useful for families with children. They told us it is important even to save money from unexpected cost for healthcare'. [93]

Currently, however, the development agents that work with the male development teams have declined to take any responsibility for CBHI, as one noted, 'It does not concern us. It is the responsibility of HEWs'.[94] This again stands in marked contrast to Tigray, where development agents have been active in promoting CBHI to the male development teams, even if HEWs take primary responsibility. Indeed, reaching men is likely to be particularly important, given that in 'the Oromo tradition' it is the male household head who controls the household budget.[95]

In the absence of the development team structure, HEWs and other kebele officials have promoted CBHI at community meetings and social gatherings.[96] Yet the once numerous kebele and zone meetings have been reduced in frequency to two per year, due to low attendance and resistance from the community.[97] As a tool for spreading information and pressurising people to enrol, community meetings do not compare to a functional development team structure.

Attempts by the state to mobilise non-state actors to promote CBHI have also been less successful than in Tigray. Several officials attempted to enlist churches, mosques, iddir and clan leaders in the campaign.[98] While the local Muslim leader did

[91] Interview respondents OMW2, OMW3, OKW2.
[92] Interview respondent OKK5.
[93] FGD respondent OKF1.
[94] Interview respondent OKK4.
[95] FGD respondents OMF1, OKF1.
[96] Interview respondents OMK4, OKK5, OKF3, OKF4.
[97] Interview respondents OMK3, OKK2.
[98] Interview respondents OKK6, OMW2.

discuss CBHI during Friday prayers,[99] iddir and equb leaders denied any attempt to promote CBHI amongst their members.[100] Meanwhile a clan leader in Shamo Gado kebele who shared information on CBHI in line with a wereda request, felt he had been misled given the inadequacies of the health service:

> 'When elders and religious fathers engage in such things it really makes a difference because people trust elders and religious leaders ... [however] when the government fails to deliver what it promised it makes us elders liars … This was what happened with the health insurance'.[101]

Indeed, complaints about the lack of availability of medicines in health posts, lack of equipment for testing, long waiting times and poor service were commonly cited as a reason for failure to enrol in CBHI.[102] Yet it is not clear that access to health services is any worse in the Oromiya sites than those in Tigray. In Tigray, Tsehafti tabiya stands out as having particularly limited access to health services compared to Ende Mariam tabiya and the two Oromiya sites, all of which are situated on the outskirts of small towns with health centres and/or primary hospitals. Indeed, in Kuyyu, scheme officials had allowed CBHI members to bypass the referral system by going directly to the primary hospital, rather than going first to the health centre.[103] In Kuyyu, the CBHI scheme had also agreed to reimburse the costs of prescriptions from private pharmacies to compensate for the shortage of medicines in public facilities. [104]

In Oromiya, as in Tigray, another reason for non-enrolment, according to respondents, was the cost of premiums. Since 2016, premiums are the same in both regions and while income and expenditure data are not available, the common perception is that the Tigray sites are poorer than those in Oromiya. As such, while the cost of premiums is no doubt a challenge for many households, it does not provide an obvious explanation as to why enrolment would be lower in Oromiya than Tigray. One of the few tasks male development teams have been used for recently has been to identify 'indigent' households eligible for CBHI premium exemptions. Team leaders identify the households most in need within their teams.[105] However, the quota for fee exemptions is widely considered inadequate.

The attempts of the party-state to raise CBHI enrolment have long gone beyond mere awareness raising in the Oromiya sites. While some CBHI members enrolled because they were convinced of its benefits, many others said that they had been coerced in various ways. While CBHI is, formally, a voluntary scheme, the reality is not so clear. As in Tigray, one way of forcing people to enrol was to threaten PSNP participants with removal from the programme or to simply deduct CBHI premiums

[99] Interview respondent OMC2.
[100] Interview respondent OMN1.
[101] Interview respondent OMC3.
[102] Interview respondents OMW2, OMW3, OMK4, OMF1, OMF2, OMF3, OMF4, OKW2.
[103] Interview respondent OKW2.
[104] Interview respondent OKW2.
[105] Interview respondents OMK4, OMZ3, OKK6.

from the transfer. For example, one CBHI member noted, 'I was in the PSNP and they said it is a must to pay the premium. They told us that it is for our benefit and deducted the money from the payment'.[106]

Most respondents stated that this had happened in the past, but was not the case any longer.[107] More common in both sites is that CBHI premiums were collected by kebele, cabinet members with land taxes and other mandatory payments with landholders often said that they could not pay their land tax until they had paid their CBHI premium. There were no records on landlessness in either site, but in Halelo Cerri kebele there are 1,302 landholders and 1,329 households,[108] (int.), suggesting that, as in Tigray, the majority of households in both sites have access to some land and therefore pay land taxes. Given that land tax receipts are widely seen as a means of demonstrating landholding rights, failure to enrol in CBHI risks the loss of land and livelihood.

Several past and present members of the kebele administration and the health extension workers readily admitted that enrolment was enforced in this way. A former kebele cabinet member noted:

> 'People were still resisting and unwilling and what we did was we told them it is a must to pay with the land tax and we won't take the land tax from them unless they pay for the insurance with it'[109]

The kebele manager in Halelo Cerri stated that this approach was pursued to 'meet the enrolment target'.[110] Numerous participants in the focus group discussions voiced similar experiences,[111] for example,

> 'They said they won't take land tax and other compulsory payments unless I pay for the insurance. So, I was forced to pay for the insurance because I did not want the land tax and other payments to stay with me'.[112]

In addition, there were several – unverified – reports of people being threatened with detention and being detained for failure to enrol. In the period leading up to fieldwork, Oromiya was administered under a military command post, as part of a state of emergency. While the research sites were relatively calm during this period, news of the heavy-handed approach taken by the military elsewhere circulated. As the local party leader in Merti described, these events had an impact,

[106] Interview respondent OKF4.
[107] Interview respondent OKF3.
[108] Interview respondent OKK6.
[109] Interview FGD respondent OKF1.
[110] Interview respondent OKK6.
[111] FGD respondents OMF1, OKF2, OKF3, OKF4.
[112] FGD respondent OMF1.

> 'When the programme was established two years ago, people were paying the money fearing that they will be arrested if they refused ... People were saying that "the command post will arrest us if we refuse to pay". So I cannot say it is voluntary'.[113]

Perhaps most problematic aspect of all is that many people who were forced to pay for health insurance against their will, did not even receive health insurance cards. HEWs and focus group respondents highlighted several instances where premiums were collected but officials did not bother to complete their registration forms.[114] As one man noted,

> 'I also have paid for two consecutive years with the land tax but did not get the card … But when they give you the receipt, they don't tell you when you should come to complete the process and get your card'.[115]

Indeed, in many instances where CBHI premiums are collected with the land tax and other compulsory fees, people are unaware quite what they are paying for, with the result that they do not make any attempt to register for the health insurance they have paid for, as acknowledged by the wereda CBHI coordinator in Kuyyu: 'They just pay with the land tax and they do not have awareness what they are paying for'.[116]

This then is one of the more perverse outcomes of the performance evaluation system, whereby officials make progress towards their targets without any contribution to the real objective of insuring people against health costs.

What is clear from the discussion above is that, compared to Tigray, the party-state in the Oromiya sites has far less infrastructural power and this has constrained its ability to promote CBHI. This is largely attributable to the collapse of the development team structure and the reduction of performance evaluation since 2015, as the Oromo protests have spread across the region. Yet, there are clear indications that party-state infrastructural power has long been lower in Oromiya and Tigray as a result of the limited legitimacy of the OPDO. Indeed, it seems likely that the lack of legitimacy of the ruling party is at least part of the reason for the greater tendency of local officials to resort to outright coercion in their attempts to raise CBHI enrolment compared to Tigray.

Conclusions

This paper underscores the importance of state infrastructural power for any form of compulsory health insurance. Such infrastructural power is important for raising awareness of health insurance and collecting premiums, but also for enforcing legal mandates where required. Where the majority of the population is in formal

[113] Interview respondent OMK2.
[114] Interview respondents OKF1, OKF2, OKF3, OKK5.
[115] Interview respondent OKF2.
[116] Interview respondent OKW2.

employment and health services are relatively good, premiums can be collected relatively straightforwardly through payroll deductions and the problem of enforcement is greatly reduced. The challenge for developing countries seeking to pursue UHC through insurance is that health services are frequently patchy, reducing the incentive for people to enrol, and the majority of the population work in the informal sector, without a clear mechanism for collecting premiums and enforcing enrolment. This heightens the challenge for state infrastructural power. Where it is effective, Ethiopia's CBHI has addressed these challenges in a number of ways. As a result of 1970s land reforms, a large proportion of rural households have some access to land and pay land taxes to establish proof of holdings. Consequently, CBHI has been able to utilise the land tax collection system as a relatively effective means of collecting premiums. Meanwhile, the development team structures extend the territorial reach of the party-state right down to the household level. Given the dependence of most households on the party-state for key livelihood resources – such as land access, agricultural inputs, credit, social transfers and food aid – new initiatives of the development teams are hugely influential on individual behaviour.

The health extension system, comprising the HEWs, development teams, 1-to-5s and regular performance evaluation, has proven to be fairly effective in the dissemination of a set of basic health extension packages, the mobilisation of members to enact these and the monitoring of behaviour. There are undoubtedly limitations to this one-size-fits-all approach and it is clear that the infrastructural power of the party-state has not yet adequately met the more complex challenge of providing quality healthcare throughout the country. Nonetheless, the extension system is also well suited to the promotion and monitoring of CBHI enrolment. Yet, this paper shows that the effectiveness of these structures varies significantly within Ethiopia, as a result of the history of state–society and party–society relations across the country. In Tigray, the well-established development team structure has been maintained through the relative continuity of TPLF administration, despite recent political upheaval in the rest of the country. Consequently, the region seems comparatively well placed to confront the challenge of CBHI enrolment. In contrast, the political changes in the country over the past five years have resulted in the collapse of party-state infrastructural power – based to a significant degree on coercion – in Oromiya. The development team structure has in many cases evaporated, while the pressure of performance evaluation has fallen away. Official data up to 2017 suggest that CBHI schemes in Amhara and SNNPR were performing relatively well in terms of enrolment. While these regions were not included in the case studies conducted, recent political upheaval and anecdotal reports suggest that state infrastructural power has also fallen away in these regions in the last two years (Lefort 2018). The experience of Oromiya and concerns about other regions reinforce doubts about the plausibility of Ethiopia's plans for CBHI.

Based on these findings, it is hardly a surprise that Rwanda has emerged as a rare case in Africa where the government has been able to achieve something approaching universal health insurance enrolment. Rwanda is a small and densely populated country with a long history of a centralised state reinforced by the state-

building efforts of the dominant Rwandan Patriotic Front government. As a result, the state has established an extensive network of state officials reaching into communities, which can be mobilised to promote and, where necessary, enforce the legal requirement to enrol in health insurance (Chemouni 2018). While this move to professionally managed and compulsory schemes may be desirable (Ridde et al. 2018), it is highly questionable how viable a strategy this is in other African countries. In recent decades, the Ethiopian state has developed a reputation for its relative effectiveness and ability to implement policies in line with national edicts. Warranted to some degree, this paper nonetheless shows the limits to state infrastructural power in many parts of Ethiopia and consequently the challenges to the pursuit of mass enrolment in health insurance. Rwanda and Ethiopia (particularly Tigray) are exceptional in the degree of infrastructural power possessed by the state. Most African states simply do not have the infrastructural power that would appear so important to the success of Rwanda's Mutuelles.

Finally, the paper reinforces the important links between social protection and state capacity. Researchers have often highlighted the expansion of state capacity – including but not limited to infrastructural power as used here – as a key feature of the development of systems of welfare and social protection (Kuhnle and Sander 2010, Seekings 2017). Different forms of social protection place distinct demands on state capacity and, of course, state capacity can be built over time. As such, the current limits to state infrastructural power should not be seen as an indefinite barrier to the expansion of health insurance. However, the feasibility of achieving universal coverage through insurance in the timeframe envisaged in the SDGs must be called into question.

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Annex: List of respondents

Federal officials

EG12, Deputy director, Ethiopian Health Insurance Agency, Addis Ababa, January 2016.
EG13, Director, Ethiopian Health Insurance Agency, Addis Ababa, June 2017, February 2018.
EG14, former Ministry of Health official and consultant on the CBHI scale-up strategy, Addis Ababa, October 2015.
EG15, former Director of Planning, Ministry of Health, by Skype, November 2015.
ED29, Consultant to the CBHI scheme, Addis Ababa, October 2015.

Tigray case studies

THW1, Bureau officer, Hintalo Wajirat wereda, Hintalo, May 2018.
THW3, Health Bureau expert, Hintalo Wajirat wereda, Hintalo, May 2018.

THK1, Chairman and manager, Tsehafti tabiya, May and June 2018.
THK2, Public and government relations officer, Tsehafti tabiya, April 2018.
THK4, Health extensionw, Tsehafti tabiya, May and June 2018.

THZ1, Kushet leader, Tsehafti tabiya, April 2018.
THZ5, Women's development team leaders, Tsehafti tabiya, April 2018.

THF5, Focus group discussion with men enrolled in CBHI, Tsehafti tabiya, April 2018.
THF6, Focus group discussion with men not enrolled in CBHI, Tsehafti tabiya, April 2018.
THF7, Focus group discussion with women enrolled in CBHI, Tsehafti tabiya, April 2018.
THF8, Focus group discussion with women not enrolled in CBHI, Tsehafti tabiya, April 2018.

TAW1, Administrator, Ahferom wereda, Enticho, March 2018.
TAW2, CBHI coordinator, Ahferom wereda, Enticho, March 2018.

TAK1, Propaganda officer, Ende Mariam tabiya, March 2018.
TAK2, Chair and manager, Ende Mariam tabiya, March and June 2018.
TAK4, Development agents, Ende Mariam tabiya, March and June 2018.
TAK5, Health extension workers, Ende Mariam tabiya, March and June 2018.
TAK7, Women's League leader, Ende Mariam tabiya, June 2018.

TAZ2, Women's development team leaders, Ende Mariam tabiya, March 2018.

TAF7, Focus group discussion with men enrolled in CBHI, Ende Mariam tabiya, March 2018.
TAF8, Focus group discussion with men not enrolled in CBHI, Ende Mariam tabiya, March 2018.
TAF9, Focus group discussion with women enrolled in CBHI, Ende Mariam tabiya, March 2018.

TAI1, Male resident, Ende Mariam tabiya, June 2018.
TAI3, Male resident, Ende Mariam tabiya, June 2018.

TAN1, Iddir leader, Ende Mariam tabiya, March 2018.

Oromiya case studies

OR2, Health extension expert, Bureau of Health, Addis Ababa, July 2018.

OKW2, CBHI coordinator, Kuyyu wereda, Kuyyu, March 2018.

OKK2, Cabinet information officer, Halelo Cerri kebele, July 2018.
OKK4, Development agent, Halelo Cerri kebele, March and July 2018.
OKK5, HEWs, Halelo Cerri kebele, March 2018.
OKK6, Manager, Halelo Cerri kebele, July 2018.
OKF1, Focus group discussion with men enrolled in CBHI, Halelo Cerri kebele, March 2018.
OKF2, Focus group discussion with men not enrolled in CBHI, Halelo Cerri kebele, March 2018.
OKF3, Focus group discussion with women enrolled in CBHI, Halelo Cerri kebele, April 2018.
OKF4, Focus group discussion with women not enrolled in CBHI, Halelo Cerri kebele, March 2018.
OKI1, Male resident, Halelo Cerri kebele, July 2018.

OMW2, CBHI coordinator, Merti wereda, Abomsa, May 2018.
OMW3, Deputy administrator, Merti wereda, Abomsa, May 2018.
OMW5, Health extension coordinator, Merti wereda, Abomsa, May 2018.

OMK1, Development agent, Shamo Gado kebele, May and June 2018.
OMK2, Party leader and militia leader, Shamo Gado kebele, May 2018.
OMK3, Chair and manager, Shamo Gado kebele, May 2018.
OMK4, HEWs, Shamo Gado kebele, May and June 2018.
OMZ3, Zone leader, Shamo Gado kebele, May 2018.
OMZ4, Female development team leader, Shamo Gado kebele, June 2018.
OMF1, Focus group discussion with men enrolled in CBHI, Shamo Gado kebele, May 2018.
OMF2, Focus group discussion with men not enrolled in CBHI, Shamo Gado kebele, May 2018.

OMF3, Focus group discussion with women enrolled in CBHI, Shamo Gado kebele, May 2018.

OMF4, Focus group discussion with men not enrolled in CBHI, Shamo Gado kebele, May 2018.

OMC2, Elder, Shamo Gado kebele, May 2018.

OMC3, Clan leader, Shamo Gado kebele, June 2018.

OMN1, Iddir leader, Shamo Gado kebele, May 2018.

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