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***Social protection in an aspiring 'developmental state':
The political drivers of community-based health
insurance in Ethiopia***

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Abstract

Ethiopia has been piloting and scaling up a community-based health insurance scheme for the informal sector since 2011, alongside preparations for the launch of a social health insurance scheme for the formal sector. This paper examines the political drivers of the adoption and implementation of the scheme, based on key informant interviews with key figures involved in its elaboration. The paper argues that efforts to extend access to healthcare are linked to the ruling coalition's longstanding focus on delivering tangible socioeconomic progress as a means of building its legitimacy and securing political support. Health insurance, meanwhile, has secured elite commitment, primarily due to the 'ideational fit' between this policy idea and core paradigmatic ideas underpinning the ruling coalition.

Keywords: Ethiopia, social protection, health insurance, universal health coverage, political settlements

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Introduction

Ethiopia has taken significant steps towards the introduction and expansion of health insurance since 2010. Community based health insurance (CBHI) was piloted in 13 *wereda* (districts) from 2010-11 and is now being rolled out nationwide, operating in 198 of more than 800 *wereda* at the time of writing. Enrolment in pilot *wereda* reached 41 percent in 2012 and 48 percent in 2013 (Mebratie et al. 2015). This constitutes a more rapid early expansion than that of the *mutuelles de santé* in Rwanda, generally acknowledged as the most successful CBHI scheme in Africa (Chemouni, 2016). At present, Ethiopia's CBHI covers approximately 7 million people, while the government has also been preparing to launch social health insurance (SHI) to cover civil servants and workers in the formal sector.

The 'adapted political settlements' framework guiding the paper is described in Lavers and Hickey (2016). It focuses on the interaction between transnational processes, and the changing balance of interests and ideas within particular political settlements and policy coalitions that provide shifting incentives for the introduction and expansion of social protection. This paper is based on a process tracing methodology (George and Bennett 2004), drawing on 26 key informant interviews with the main figures involved in the policymaking process, including government officials, consultants, donors and representatives of civil society organisations. In many cases, respondents had worked for several of these different organisations – in particular moving from government to development partners or consultancy firms – making it difficult to specify exactly how many respondents were from which type of organisation. A rough classification of the main role that each respondent played with respect to health insurance is: government – eight respondents; consultants – nine respondents; development partners – four respondents; civil society organisations – three respondents; and academics – two respondents. The paper also draws on policy documents and two evaluations of the CBHI pilots.

The analysis that follows shows that elite commitment to adoption and implementation of CBHI is linked to incentives flowing from the dominant coalition political settlement and the 'ideational fit' between the policy idea of health insurance and paradigmatic ideas that underpin the political settlement. The provision of healthcare and improvements in health outcomes have long been among the means by which the Ethiopian People's Democratic Revolutionary Front (EPRDF) has sought to build its legitimacy – both internally and externally. Meanwhile, the dominant party political settlement is influential in terms of the long time horizon of the ruling coalition, leading to a focus on building a sustainable health financing system for the future, rather than reforms that might deliver short-run political benefits. This political settlement has also enabled the development of relatively strong local state capacity, which has proven essential in quickly achieving high enrolment rates through the dissemination of information and pressure on individuals to enrol. The key reason for the appeal of health insurance over other forms of health financing is the strong 'ideational fit' between health insurance and core paradigmatic

ideas within the ruling coalition regarding the need to mobilise all available resources in the pursuit of development, and the imperative that everyone who can contribute, should do so.

Following this introduction, the next section summarises key features of Ethiopia's political settlement and the ideas that underpin it. The following sections trace debates on health financing from the 1990s up to the adoption and roll-out of the health insurance schemes, before analysing this empirical material in light of the theoretical framework. The final section concludes.

An overview of Ethiopia's political settlement

This section summarises key features and dynamics of Ethiopia's political settlement, as they pertain to the health sector. This summary is based on a more detailed discussion in the companion paper on the Productive Safety Net Programme (Lavers forthcoming).

The ruling EPRDF deposed the previous Derg regime in 1991 following an extended civil war. The EPRDF originates in the Tigrayan People's Liberation Front (TPLF), which fought the Derg in Tigray before expanding its ambitions to the whole country and establishing the EPRDF – a coalition of ethnic parties in Amhara, Oromiya, Southern Nations, Nationalities and Peoples Region (SNNPR) and Tigray. Despite Tigray comprising just 6 per cent of the country's population, the TPLF has remained dominant within the EPRDF. The EPRDF government established a system of ethnic federalism, which sought to draw round ethno-linguistic groups, in principle providing for self-determination.

A key rupture within the ruling coalition occurred in 2001, leading to a split in the TPLF and purge of dissidents from EPRDF parties (Milkias 2003, Tadesse and Young 2003). While the flashpoint was the handling of the Eritrean war (1998-2000), the rupture became a more fundamental debate about the future of the party, with dissidents concerned about the move away from the socialist ideology that had guided the liberation struggle. The split forged a more coherent leadership with a highly centralised decision-making structure focused on Prime Minister Meles. Soon after, the government published a coherent set of sectoral strategies that framed rapid socioeconomic progress as essential to the survival of the party and the country (MoI 2002). From 2004, Ethiopia began a period of rapid economic growth that has significantly increased state revenues, increased household incomes and reduced poverty, albeit at the cost of rising inequality.

The 2005 elections were the most competitive in Ethiopian history. The EPRDF, confident of victory until the last moment, was surprised by the coherence of opposition parties and the degree of support that they received, particularly in urban areas. Nonetheless, official results returned the EPRDF with a reduced majority. The state response to opposition protests was heavy-handed, arresting thousands, including the leadership of the main opposition party, and killing some 200 protestors.

Since 2005, political space to oppose the government has closed significantly, with opposition parties systematically undermined and restricted. Subsequent elections have been entirely one-sided affairs, with virtually every seat in local and national elections won by EPRDF parties or affiliates.

As well as restricting political opposition, the EPRDF also reflected on the electoral losses and sought to win back the support of opposition voters. New measures included the mass recruitment of local government officials – *kebele* (sub-district) managers, development agents and health extension workers – in order to improve service delivery (Vaughan 2011), as well as initiatives such as credit for micro and small enterprises to address urban unemployment (Di Nunzio 2014). Reforms from 2001 and, particularly, 2005 strengthened local-level administration and sub-*kebele* structures down to the household level (Vaughan 2011). These top-down control mechanisms enable relatively strong implementation capacity, although this undoubtedly varies across the country.

The highly centralised and cohesive nature of the ruling coalition faced a major challenge in August 2012, when the prime minister passed away. The deputy prime minister, Hailemariam Desalegn, was nominated as prime minister. However, coming from a minority ethnic group – the Wolayita in SNNPR – and a minority Pentecostal religion, he lacks a strong social base of his own. Arguably, Hailemariam reflects a compromise between the TPLF, which though still dominant has declined somewhat in influence, the Amhara National Democratic Movement (ANDM) and Oromiya People's Democratic Organisation (OPDO), which are increasingly assertive. The result has been a move towards a more consensual decision-making process that is, in practice, increasingly fragmented and incoherent. This threatens the ruling coalition's capacity to respond to major new crises, notably the widespread anti-government protests during 2015 and 2016 (Lefort 2014, 2015). At the same time, there is a widespread perception that corruption within the state bureaucracy has grown significantly (Lefort 2015).

Another important aspect of the political settlement is the relationship between the ruling coalition and the private sector. Observers have frequently noted the dominant economic role played by party conglomerates– notably the TPLF-owned Endowment Fund for the Rehabilitation of Tigray (EFFORT) (Vaughan and Gebremichael 2011), state-owned enterprises and the business empire of Sheik Mohammed Al-Amoudi, who has close ties to the ruling party (Vaughan and Tronvoll 2003). While the government took steps to liberalise the economy after 1991 and frequently emphasises the importance of the 'free market' in policy documents, there remains considerable scepticism regarding the private sector within government and, indeed, differences of opinion regarding the appropriate role for private companies in Ethiopian development. Notably, the state is seen as having a vital role to play in directing the private sector to 'productive' activities, and thereby preventing private companies from following their natural inclination for 'rent seeking' (EPRDF 2006, Vaughan and Gebremichael 2011).

The relative cohesion of the political settlement during the period 2001-12 and the lack of strong elite opponents provided the space for a strong developmental vision to emerge. Following the 2001 split, Meles highlighted the importance of rapid socioeconomic progress as the solution to a series of existential crises facing the EPRDF (Mol 2002). Ever since the liberation struggle, the TPLF had based its political struggle on securing support and building legitimacy through the delivery of tangible socioeconomic progress. Since 1991, this challenge has been amplified for a ruling coalition that remains associated with the Tigrayan ethnic minority. The construction of a 'developmental state' was proposed as a means of delivering rapid growth by mobilising all available resources, public and private, to be directed by the state in line with the national development strategy (EPRDF 2006, Zenawi 2006). This developmental state model has clear implications for social policy, as is evident in the 2014 National Social Protection Policy (NSPP), and even the 1996 Developmental Social Welfare Policy. First, social protection policies must not only protect the poorest and most vulnerable, but also make a productive contribution to the economy – a balance of priorities that has not always proven easy to achieve in practice. Second, no one who is able to contribute – whether with their labour or financial resources – should receive support without doing so.

Background to health insurance initiatives

The recent introduction of health insurance can be traced to longstanding policy debates regarding health service provision and health financing. This section analyses these debates from the TPLF struggle up to 2005.

Health provisioning under the TPLF and early EPRDF (1975-98)

The TPLF's fight against the Derg was guided by a Maoist strategy of securing the support of the peasantry through an ethno-nationalist message and the delivery of tangible socioeconomic progress (Young 1997, Vaughan 2003, Berhe 2008), including the delivery of health services (Vaughan 2011: 625). The TPLF adopted the slogan of 'health for the struggle' (Barnabas and Zwi 1997: 44, Kloos 1998: 518) with health provision expected to contribute to a more effective army and raise political morale. Healthcare was managed as part of the TPLF's local social services committees (Young 1997, Berhe 2008).

The TPLF provided 3,000 community health workers (CHWs) and traditional birth attendants with basic training and set up 88 health clinics (Adhanom Ghebreyesus et al. 1996, Barnabas and Zwi 1997). Health provision was based on the fundamental principles of self-reliance and community participation, with CHWs selected based on their desire to join the TPLF and serve the community for free, and treatment subject to user fees for those able to pay and fee exemptions for those that could not (Adhanom Ghebreyesus et al. 1996, Barnabas and Zwi 1997). The TPLF also set up revolving funds to mobilise community resources to purchase drugs and equipment (Barnabas and Zwi 1997, Kloos 1998: 518). These early ideas about the instrumental role of healthcare and the importance of community resource mobilisation remained a consistent feature of government policy.

The health system inherited by the EPRDF in 1991 was extremely limited and biased towards costly curative services in urban areas (Kloos 1998, Bilal et al. 2011). The Transitional Government of Ethiopia's 1993 health policy led to an increase in health spending and an attempt to rehabilitate health facilities and train extra health workers. However, by the end of the 1990s, severe shortages in provision and drug availability continued. User fees introduced under Haile Selassie had remained ever since. However, these fees were not adjusted for changing prices and, in practice, were frequently not collected (Zezelew 2012). Under a fee waiver system – supposed to exempt only the poorest – up to half of patients were eligible for free treatment (HCF Secretariat 2002), while user fees provided just 7.9 percent of recurrent health expenditure in 1994 (HCF Secretariat 2000: iv). While some state enterprises reimbursed 50 percent of medical fees for their staff, by the early 2000s the only health insurance provider was the state-owned Ethiopian Insurance Corporation (EIC). The EIC only provided health insurance as a loss leader for life insurance (int. respondent EC10) and in 1998 covered just 0.02 percent of the population (Haile Mariam 2001: 158).

Health financing reform and expansion of provision (1998-2005)

The government noted insurance as a possible source of health finance as far back as the 1993 health policy and the 1994 economic strategy. It was not until 1998, however, that the healthcare financing strategy (HCFS) aimed to put the health system on a stable financial footing (int. respondent EG15), highlighting the need to increase revenues as a first step towards improving healthcare provision. The strategy proposed multiple financing mechanisms: increased user fees; the ability of health facilities to retain a portion of the fees to provide greater incentives for collection; increased donor funding; and health insurance. Specifically, the HCFS proposed two separate schemes: SHI for the formal sector and CBHI for the informal sector. From this point on, respondents report that there was no consideration of alternative health insurance models, such as an integrated national health insurance (NHI) scheme. Nonetheless, health insurance remained part of a list of future policy options, without a clear strategy for implementation (int. respondent EC6). Ever since the HCFS, USAID has been the main donor supporting health financing through a contract with Abt Associates.¹ Indeed, the involvement of Abt in the HCFS may well be one reason for the proposal of separate SHI and CBHI schemes; Abt had long-term experience of working with mutual health organisations in West Africa and their advice probably foreclosed other policy options (int. respondent EC6).

Little was done to implement HCFS until 2000, when Abt was asked to set up and run a health financing secretariat in the Ministry of Health (MoH) (ints. respondents EC6, EC7; HCF Secretariat 2000). At this stage the idea of introducing health insurance was being taken seriously within the MoH and was expected to be relatively straightforward. The new secretariat commissioned a series of studies on

¹ Abt Associates is a global research organisation and consultancy operating in a variety of fields, including healthcare.

health financing, including a pre-feasibility study on CBHI in cash crop areas and a study examining Ethiopians' willingness to pay for health (int. respondent EC7). A team from the MoH also undertook a study tour to Senegal to view what was then considered the leading example of CBHI in Africa. The study tour and pre-feasibility study, however, concluded that Ethiopia was not ready for CBHI, both due to the lack of understanding of insurance among the population and to the inaccessibility of healthcare (int. respondent EC6, HCF Secretariat 2002). According to the head of the secretariat at the time, part of the rationale for commissioning these studies was to dampen expectations in the MoH: 'It was to put some sanity or realism into the process' (int. respondent EC6).

The main focus areas of the 2002 Health Sector Development Plan (HSDP II) were a new health extension programme (HEP) and the implementation of retention reforms. Reference was made to the 2001 pre-feasibility study on CBHI and the need to conduct further feasibility studies, but health insurance was clearly not a priority. HEP aimed to train two health extension workers (HEWs) – young women² with 12 months' basic training – and to build one health post per *kebele*. The programme focused on preventive healthcare as the most cost-effective means of improving health outcomes, and a diffusion model that assumed behaviour can be changed by first training early adopters who are made 'model' families and who subsequently change the perceptions of those who are initially more resistant (Banteyerga 2011). HEP also had a strong emphasis on extending basic curative services through construction of 2,500 new health centres staffed by 5,000 new health officers with three years' university training and two years in hospitals (Bilal et al. 2011). The HEP design process in 2002-03 was chaired by Prime Minister Meles (int. respondent EC6), and began operation from 2004-05 with the graduation of the first HEWs. The government proceeded with the initiative, despite initial opposition from health sector donors who thought that it was unfeasible (Banteyerga 2011).

Meanwhile, from 2001-02, a team comprising MoH and Abt Associates began implementing HCFS, with reform of the user fee system, the implementation of retention reforms and the introduction of private wings in public hospitals to improve retention of health professionals (Zeleelew 2012). The team of MoH and Abt also drafted a federal proclamation to enable user fee retention in 2004 (int. respondent EC7). This proclamation contradicted the federal finance proclamation that provided for a consolidated fund and was blocked by the Ministry of Finance and Economic Development (MoFED) (HCF Secretariat 2000). Ultimately, the support of the prime minister was instrumental to passing the reform. The team in the MoH,

'managed to develop the strategy and shared it with Meles through informal channels. You know when I was at MoFED we would prepare a three to four page document that went to Meles and he really read it. He would highlight parts of it. He was a technical person, rather than a politician. So he read this

² The model was explicitly gendered, with a focus on female HEWs and women as the main conduit of behavioural change within households.

document and he said to MoFED, "why are you stopping this reform?" (int. respondent EG15).

Securing support for health insurance (2005-10)

In 2005 there were changes in the leadership of the MoH, with Dr Tedros Adhanom appointed minister, and the launch of the HSDP III. Several donors held negative views of the previous minister, including the head of one major donor agency, who felt compelled to tell Meles that he had the 'worst minister of health in Africa, he is incompetent' (int. respondent ED9). In contrast, Dr Tedros is widely credited with transforming the MoH, building a health system in contrast to the donor-driven vertical, disease-focused approach that had previously held sway (Bradley et al. 2011). This assessment was widely shared among my respondents, also,

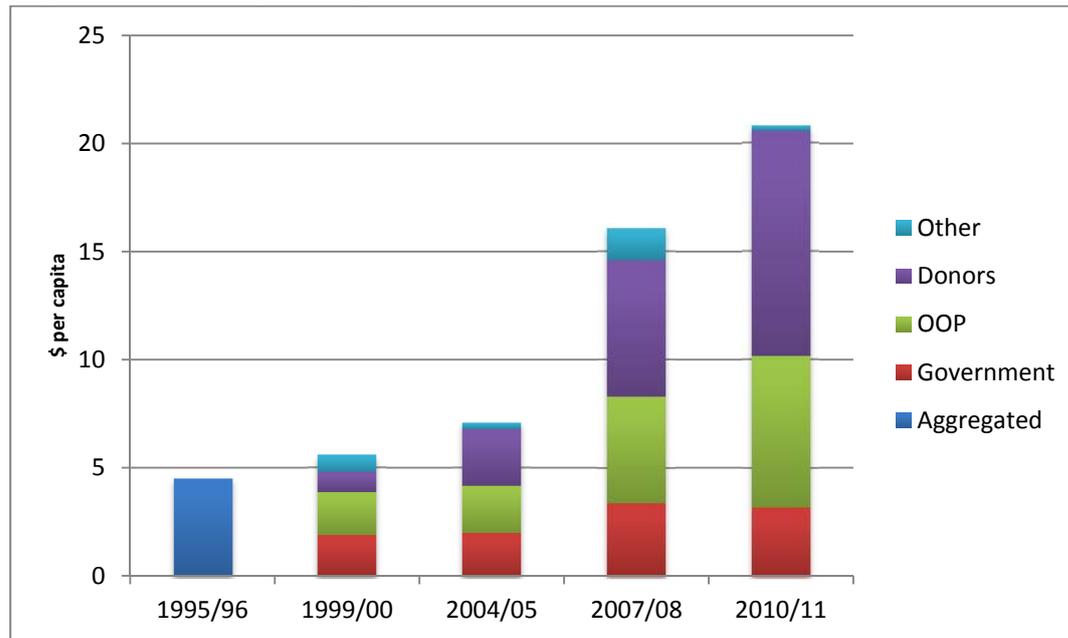
'He was really transformational. He picked a number of agendas to push ... He galvanized support. He was always there. We would meet him for half a day at a time. He was very involved in the detail' (int. respondent EC7).

At the same time, a new director of planning was appointed in the MoH, having recently completed an MSc in Health Policy and Planning. In his view, Dr Tedros was aiming for 'a paradigm shift' and both HEP, just beginning at that time, and proposals for health insurance 'fit that bill'.

The result was a massive scale-up of HEP to cover every *kebele* in the country by 2008. This expansion fitted well with the government's decentralisation and strengthening of local government following the 2001 split and the 2005 elections. By 2009, the government had indeed trained more than 30,000 HEWs (Koblinsky et al. 2010: 106) and constructed 14,000 health posts by 2010 (Bilal et al. 2011: 11). Per capita spending also more than doubled by 2007-08 as a result of an increase in government spending, increased user fees and out of pocket (OOP) spending, but also an increase in donor funding linked to the multi-donor Protection of Basic Services (PBS) project that channelled health and education funding to *wereda* (see Figure 1).³

³ Donors introduced PBS in 2006 to ringfence funding for key services following the withdrawal of general budget support in protest at the 2005 elections.

Figure 1: Health spending and sources of revenue



Source: Wang and Ramana (2014).

The first serious discussions on health insurance took place in 2006, as part of a broader debate within the MoH regarding health financing and access. Analysis of the national health accounts showed a significant increase in OOP spending (int. respondent EG13), leading to concerns that rising user fees threatened financial access (int. respondent EC12, Abay Asfaw et al. 2004). Among the options considered was the removal of user fees and provision of free-to-access care (ints. respondents EG13, ED27). Despite the health sector receiving large amounts of aid at that time, making such a policy plausible, the idea was rejected (int. respondent EG13). This was because of doubts regarding the sustainability of a health system reliant on aid flows (int. respondent EG13),⁴ but also the impacts of free-to-access care on health users,

‘There is no such thing as free healthcare, someone always has to pay for it. So we wanted to avoid introducing free at the point of service as it misleads people’ (int. respondent EG13).

Ultimately, the removal of user fees was incompatible with paradigmatic ideas – going back to the TPLF struggle – regarding the need for social spending to be productive and for anyone that can to contribute to the national development agenda. The reliance on aid to finance user fee removal also clashed with a strong emphasis within government on maintaining fiscal independence as a means to protecting

⁴ This was evident in later statements by the minister of health: ‘That [aid cuts] is something that we have really worried about. The past 10 years have been exceptional in global solidarity, and the financing for global health was really unprecedented. But now we’re seeing some decline, and I think it’s really important that we try to cope with the possible international budget cuts ... Now we’re starting health insurance, which will help raise domestic resources as well’ (Dr Tedros, cited in USAID 2012).

policy autonomy and limiting the impact of unreliable aid (Mascagni 2016). In contrast, health insurance clearly resonated with these broader concerns, and was also thought likely to lead to greater healthcare utilisation,

'For some communities, contributing all of the costs would be difficult but a nominal contribution would be possible. We were looking at various mechanisms for developing health-seeking behaviour. We thought that asking people to make contributions to health insurance would help this, it would give them a sense of ownership' (int. respondent EG13).

Dr Tedros requested the director of planning and Abt Associates to produce a one-page proposal on the potential of health insurance. This note was inconclusive, but argued that in order to come to a firm decision, it would be necessary to look at the experiences of other countries and to build the technical expertise of the MoH and Abt team (int. respondent EC7). A request was made to USAID for financial support, and health insurance was added to Abt's financing project (ints. respondents EG13, EC7, EC12).

Between 2007 and 2009, a team comprising staff from the MoH, Abt, regional health bureaux and the Public Sector Social Security Agency (PSSSA) conducted study tours to Ghana, Rwanda, Senegal, China, Korea, Mexico, Thailand and Vietnam, based on suggestions from USAID, Abt and other donors (ints. respondents EG13, EC7, EC9, EC12). After each tour, the team presented their findings and the lessons learned to the minister of health (ints. respondents EC7, EC12). While the team drew insights from several countries, Ethiopia's CBHI was strongly influenced by Rwanda's *Mutuelles de Santé* (ints. respondents EG11, EG12, EG13, EG15, EC9, EC11, EC12). During a two-week study tour in 2007, the Ethiopian team visited the Rwandan Ministry of Health and several districts to observe the scheme in operation (ints. respondents EG13, EC13). One MoH official was so impressed that he exclaimed that the success of the *Mutuelles* in Rwanda – a much smaller country than Ethiopia – essentially meant that 'Rwanda has already done the pilot for us! We can scale it up straight away in Ethiopia' (ints. respondents EC7, EC12). Following the study tour, the Ethiopian government requested technical assistance and a Rwandan official involved in the *Mutuelles* from their inception was brought to Ethiopia for three months with World Bank support (ints. respondents EG13, EC13). Furthermore, when it came to producing the Ethiopian Health Insurance Strategy in 2008, an international consultant working for Abt, who had been involved in the initial *Mutuelles* pilots, was brought in to draft the text (ints. respondents EC7, EC12).

The *Mutuelles de Santé* are very different from other, frequently criticised (Acharya *et al.* 2012), CBHI schemes in Africa. *Mutuelles* in several West African countries are voluntary, small-scale, lacking in government support and, with no specific provisions for the poor, tend to favour relatively wealthy groups. In contrast, Rwanda's scheme is a nationwide initiative with strong government support that has achieved unprecedented enrolment rates of 76 percent (Chemouni 2016). The high enrolment and inclusive nature of the *Mutuelles* were attractive to the Ethiopian officials, as was

Rwanda's decentralised governance, which was deemed a better fit for Ethiopia's decentralised system than Ghana's more centralised NHIS (ints. respondents EG11, EC9, EC12). Furthermore, influential ideas in Rwanda regarding the importance of self-reliance and working towards independence from foreign aid (Chemouni 2016), are likely to have resonated with paradigmatic ideas underpinning the Ethiopian political settlement.⁵ Unlike CBHI, designs for SHI drew on a range of experiences from these study tours, with no single policy model. Various observers noted that Rwanda's *Rwandaise d'Assurance Maladie* (RAMA), Ghana's National Health Insurance (NHI) (int. respondent EG12) and Korean health insurance (int. respondent EC5) had all been influential to some degree.

In 2008, the Council of Ministers approved the health insurance strategy that presented an enormously ambitious timetable to make both schemes operational within the year, reflecting a high degree of political support and pressure for quick implementation (int. respondent EG13).

Piloting and scaling up health insurance (2010 to the present)

The ambitious timetable in the 2008 health insurance strategy was not met. However, preparations were made to launch the two schemes. The 2010 HSDP IV set a target of 50 percent coverage by 2015, with SHI expected to reach all 10 percent working in the formal sector and CBHI accounting for the remaining 40 percent. With that target in mind, an SHI proclamation was approved in 2010, followed by a regulation to establish the Ethiopian Health Insurance Agency (EHIA) to administer both schemes. The proclamation made enrolment in SHI mandatory for civil servants, pensioners and formal sector workers.

The MoH launched 13 CBHI pilots in 2010-11 across Ethiopia's four main regions: Amhara, Oromiya, SNNPR and Tigray. While the *Mutuelles* model was hugely influential, it is also clear that the Ethiopian team did not blindly copy the *Mutuelles*, but adapted the policy model to the local context. For example, while Rwanda subsidised premiums for the poorest households, Ethiopia introduced two subsidies; a targeted subsidy for the so-called 'indigent', funded by the regional and *wereda* governments, and a general subsidy of 25 percent of premiums financed by the federal government. Furthermore, Ethiopia, unlike Rwanda, did not require co-payments for treatment, with a view to improving utilisation (int. respondent EG15). The CBHI is therefore an example of policy translation – adapting lessons from the *Mutuelles* to the local context – rather than diffusion – in which policies are copied with few changes (Lendvai and Stubbs 2007, Vaughan and Rafanell 2012).

The MoH's original intention was to establish mandatory CBHI. The Rwandan secondee to Ethiopia in 2007 specifically advised the MoH that it had to be mandatory to work (int. respondent EC13). Dr Tedros and the director of planning

⁵ While there are strong links between the EPRDF and the Rwandan Patriotic Front at very high levels, with Meles and Paul Kagame thought to have been particularly close, interviews did not provide evidence that these were directly influential in the policy transfer.

were both in favour of compulsory insurance and this was reportedly included in an early draft of the 2008 health insurance strategy (int. respondent EC12). The director of planning was clear, 'we don't have to test something [voluntary schemes] that has already failed somewhere else' (int. respondent EG13). After the departure of the director of planning in 2010, however, resistance from regional health bureaux and local governments led to reconsideration, and the schemes were made voluntary at the household level (int. respondent EG15). Nevertheless, the long-term plan all along was to move towards a law on CBHI with mandatory enrolment (ints. respondents EG11, EG12, EC9, EC11).

CBHI began scaling up in 2013, expanding from 13 pilots to 161 additional *wereda* in July 2013. This decision was, at best, based on a rather selective reading of available evidence. The EHIA-commissioned evaluation of the CBHI pilots was only published in 2015. An independent academic evaluation (Derseh et al. 2013) did share results with Abt in late 2012.⁶ However, any impact this independent study may have had on government decision-making is purely coincidental; the MoH was initially resistant to the proposal to conduct the research and only latterly became interested in the findings (int. respondent EA2). While administrative data showed some positive results, such as high enrolment and an increase in utilisation, more concerning results regarding the availability and quality of health provision were ignored.

Nonetheless, the scale-up is proceeding apace. In 2015, the MoH launched the five-year Health Sector Transformation Plan (HSTP), which targets CBHI coverage of 80 percent of the population and 80 percent of *wereda* by 2020 (MoH 2015). By late 2015, CBHI schemes were established in every *kebele* in 198 *wereda*, and the EHIA planned to reach 322 *wereda* in 2015-16, expanding beyond the four main regions to Addis Ababa, Harari and Benishangul-Gumuz (int. respondent EG12). The Rwandan *Mutuelles* have once again influenced the scale-up, since they were able to achieve something like the rapid expansion envisaged in Ethiopia, albeit in a much smaller country. In late 2014, a Rwandan consultant for Abt, who worked on the scale-up strategy there, was brought to Ethiopia specifically to provide technical expertise (int. respondent EC11).

Compared to CBHI, progress with SHI has been slow. The scheme was intended to start in July 2012, but the launch has been repeatedly delayed. Nevertheless, the launch did finally appear to be imminent in early 2016. Premiums were deducted from pensioners in the public sector pension scheme in January 2016 and there were plans to deduct civil servants' premiums in February 2016 and those of private sector workers later in the year. The EHIA estimates that enrolment will reach 2 million workers, and therefore cover approximately 10 million people, including family members (Atakiltili Abreha, EHIA director cited in Ashenafi 2015).

⁶ Personal communication from one of the authors.

The current rollout is part of a longer-term strategy to strengthen health insurance and health financing. Ever since the initial design discussions, there has been an acknowledgement within government and Abt that ultimately the CBHI and SHI will need to be merged, both administratively and financially (ints. respondents EG11, EG12, EG14, EG15, EG17, EC7, EC9, ED27). The MoH decided that the initial fortunes of the two schemes should not depend on one another and that rural and urban areas are, at the moment, just too different to be integrated into one single scheme. Nonetheless, the government acknowledges that allowing separate schemes to develop will ultimately institutionalise a two-tier healthcare system and that CBHI, on its own, is unlikely to be financially sustainable. Integration of the schemes with the same benefit package and level of provision would necessarily involve cross-subsidisation, with the SHI – covering the wealthier formal sector – supporting the finances of the CBHI. As part of this integration – planned for as early as 2020-25, when the next development strategy is in operation – the EHIA will also revise the SHI proclamation to make health insurance mandatory for all,

'in GTPIII [2020-25] we are going to merge the CBHI and SHI like in Ghana. When that happens, the CBHI will also be compulsory. By that time, when it has been running for a while, they [the general population] will understand it and the benefits of health insurance. Through the new proclamation we will make it mandatory, just like the SHI' (int. respondent EG12).

In the view of the then minister of health, Dr Kesetebirhan⁷, at that time 'health insurance contributions will become an earmarked tax ... like a payroll tax' (int. respondent EG17).

State capacity and implementation

Coverage in the pilot schemes averaged 48 percent by 2013. However, this masks considerable variation between a low of 25 percent and a reported high of 100 percent in one scheme. Regional averages varied between 36.1 percent in Oromiya and 61.2 percent in SNNPR (EHIA 2015). By late 2015, CBHI consultants estimated that 6.5 to 7 million people were enrolled (ints. respondents EC7, EC11), while evaluations suggest that CBHI resulted in an increase in healthcare utilisation and a reduction in OOP expenditure (Mebratie et al. 2013, EHIA 2015).

In principle, CBHI enrolment at both *kebele* and household levels is voluntary. However, the reality is not so simple. Despite expanding to 198 *wereda*, no *kebele* has ever rejected the establishment of CBHI (int. respondent EC8, Derseh *et al.* 2013). The pressure for *wereda* and *kebele* officials to establish CBHI schemes will only increase following the inclusion of CBHI enrolment in the *wereda* transformation agenda (WTA), an implementing strategy of the HSTP. The WTA extends the 'model farmer' principle, creating model *wereda* and *kebele* – where all households in the community are themselves 'models', requiring adoption of all health extension packages and universal CBHI enrolment (int. respondent EG12, MoH 2015, Admasu

⁷ Dr Kesetebirhan was replaced as minister of health in late 2016.

et al. 2016). Once *wereda* and *kebele* have been rated, 'then the naming and shaming will come' as a means of motivating better local government performance (int. respondent EG12). The HSTP target is to graduate 80 percent of *kebele* as models by 2020.

At household level also, there is considerable ambiguity in terms of what instructions *wereda* are being given and how these instructions are interpreted in implementation. Senior officials in the EHIA reported that the advice from the EHIA was that once a *kebele* opted to establish a CBHI scheme, enrolment should be compulsory (int. respondent EG11, EG16), as was the original intention during the design phase. Moreover, several respondents closely involved in the operation of the schemes acknowledged that enrolment was not purely voluntary,

'Right now we are somewhere in between. The *wereda* are strong in pushing to join, but ultimately the household has to decide ... there is an element of compulsory, an element of voluntary at the household level' (int. respondent EC7).

'CBHI is not mandatory. You could call it voluntary, but you shouldn't really call it that either. It is somewhere in between' (int. respondent EG15)

Whether or not CBHI enrolment is formally voluntary, the mechanisms for implementing the scheme and the structure of incentives for local government officials lead to considerable pressure, even compulsion, on households to enrol. Ethiopian government officials are assessed based on their success in meeting targets set in their annual performance scorecards, with important implications for promotion prospects. These targets are set so as to contribute to national development and sectoral objectives, but with some space, in principle, for the officials themselves to suggest possible targets. In one of the most successful pilot *wereda*, 13 percent of the *kebele* manager's performance scorecard was based on CBHI enrolment (int. respondent EG11), while each member of the *wereda* cabinet was tasked with following up on CBHI performance in a set of *kebele* (EHIA 2015),

'In the most successful *wereda* in the pilots, it was mandatory for cabinet to go house-to-house demanding enrolment. In this *wereda*, re-enrolment was even higher than the initial. It all depends, where there is less political commitment in some *wereda*, enrolment is not so much' (int. respondent EG15)

CBHI enrolment is now identified as an important target in the HSTP and WTA, and, drawing on this experience from the pilots, enrolment targets will be systematically included in the performance scorecards for *wereda* and *kebele* administrations, the *kebele* manager, HEWs and even agricultural development agents (ints. respondents EG14, EG15, EC8). While the scorecard system can be an effective means of achieving policy objectives, existing research shows how they can become top-down enforcement mechanisms, with targets interpreted at local levels as quotas to be

enforced, even if the targets set are unreasonably ambitious (Lavers forthcoming, 2013, Segers et al. 2009).

With CBHI enrolment identified as a key objective for HEWs, their scale-up efforts will be based on the mobilisation of the full array of sub-*kebele* structures (EHIA 2015). Since 2011, the HEWs have been working to forge a health development army (HDA), a network of female community volunteers who help spread government messages on health (with equivalent male teams focusing on agriculture) through regular meetings, and mobilise the community for campaigns. This HDA comprises in the region of 3 million women from model households who are assigned to lead 'development teams' of 30 households and 'one-to-five' groups used to mobilise five households (MoH 2015, Admasu et al. 2016). Though the effectiveness of this initiative clearly varies by region and locality, the HDA nonetheless constitutes a formidable means of encouraging, even coercing, individuals into following policy priorities, as well as an important mechanism for collecting information about non-compliant households (Bevan et al. 2014). This HDA also parallels as the local EPRDF party structure, with models generally enrolled as party members.

Some local government officials have also been successful in enrolling households in the CBHI by linking enrolment to other activities and services. For example, PSNP participation increased the probability of CBHI enrolment by 24 percentage points and reduced the probability of dropping out by 10 percentage points (Shigute et al. 2016). Some *kebele* took the opportunity presented by distributing PSNP payments to provide information about CBHI and collect premiums, involuntarily in some cases (Shigute et al. 2016). The EHIA evaluation notes that 14 percent of CBHI members in SNNPR and 4 percent across all the pilots were enrolled based on a deduction from their PSNP payments (EHIA 2015: 57). While deeply problematic from the perspective of food security, this may be one reason why the poor were well represented in the CBHI (Derseh et al. 2013). Another *wereda*, meanwhile, decided 'to collect health insurance contributions at the same time as the agriculture tax, because they go door to door for both at the same time' (int. respondent EG11). While this may be an efficient use of administrators' time, there is obviously considerable potential for the supposedly voluntary nature of the insurance premiums to be confused with the compulsory payment of land taxes.

Explaining the adoption and evolution of the CBHI

This section analyses the previous empirical material in light of the theoretical framework guiding the research, considering: first, the relative importance of technocratic choices, political interests and ideas; second, the importance of the policy coalition and its links to the ruling coalition; and third, the importance of state implementation capacity.

Technocratic choices, political interests or ideational fit?

From the present, it may appear as though the 1998 HCFS laid out a clear set of objectives that the government has diligently been working towards over the subsequent 18 years, through revision of user fees and fee retention, to the implementation of health insurance. Indeed, some respondents took this view, regarding the entire process as a technocratic exercise. Those involved in earlier phases were clear, however, that this was not the case. As late as 2004-05 the sole focus was on the retention reforms and there was no certainty whatsoever that health insurance would follow (ints. respondents EC7, EC10). While the HCFS did mention health insurance, the intention of the strategy was to open up the possibility of different financing options and, in fact, was very vague about whether health insurance was a priority or what form it would take.

The decision to pursue health insurance dates to 2005-06. This coincides with a number of important events. The first of these is the 2005 elections. Alongside the widely publicised crackdown on the opposition and the closing of political space at this time, the elections also prompted a period of reflection in the EPRDF, which subsequently held a series of consultations that sought “to ask forgiveness” for its mistakes and win back the population’ (Vaughan 2011: 632). For some within the ruling coalition, this constituted a ‘learning opportunity’ to study why people had voted against them and to launch initiatives to address the problems revealed (Simon 2011).

Since the liberation struggle, health provision had been seen within the TPLF/EPRDF as a means of building political legitimacy. One possibility, therefore, is that health insurance was part of the broader government response to the elections and the desire to re-gain political support. Technical staff involved in this part of the decision-making process explicitly denied this, however. One respondent, for example, argued that CBHI would have been an illogical response to the elections, since the EPRDF’s main electoral losses were in urban areas, especially Addis Ababa (int. respondent EG13). While there is an element of truth in this, EPRDF losses were not restricted to urban areas (Arriola 2008). Furthermore, the government’s response to the elections did include attempts to improve local government effectiveness in rural areas, recruiting a new position of *kebele* manager with responsibility for service delivery, as well as additional HEWs and agricultural extension agents (Vaughan 2011). It is, therefore, at least plausible that the expansion of health provision was partly spurred by the elections, while the appeal of health insurance, in turn, lay in the potential to address the growing costs of health provisioning. Indeed, the expansion of local government capacity that was launched following the 2001 TPLF split and continued following 2005 may well provide a partial explanation for the timing of CBHI. Before these decentralisation efforts, state capacity to implement health insurance was lacking, and it was only in the period around 2005-06 that this process had reached a point at which health insurance became a viable option.

The second major change – within the health sector – at that time was the appointment of a new minister and a new director of planning. Here there is evidence of a direct impact of these actors and the ideas that they brought to the policy coalition. Notably, the problem frames and policy ideas that were proposed under their leadership clearly resonated with core paradigmatic ideas underpinning the political settlement and, indeed, longstanding ideological commitments within the party going back to the TPLF liberation struggle. The minister, Dr Tedros, was not a TPLF fighter himself, but joined the new government after 1991, initially in the Tigray Health Bureau. At that time he wrote about how he had consciously built on the TPLF legacy of community mobilisation, employing CHWs trained under the TPLF as a key part of the anti-malaria strategy in Tigray in the 1990s (Adhanom Ghebreyesus *et al.* 1996). Furthermore, Dr Tedros was seen as a reformer, and ideologically close to Meles in the 2000s, as he was articulating the 'developmental state' model.

A key factor generating elite commitment to health insurance was therefore what might be described as the 'ideational fit' across different levels of ideas (see Table 1). As noted by Minister of Health, Dr Kesetebirhan, (int. respondent EG17), the policy idea of health insurance fits with paradigmatic ideas central to the political settlement, namely that no one should receive support without contributing and that all available resources should be mobilised in the pursuit of rapid development. In this respect, there is a clear precedent in the liberation era TPLF approach to health provisioning, with the focus on self-reliance and the mobilisation of community resources through revolving funds. Furthermore, the cognitive problem framing within the health sector had started to shift by 2005-06 compared to the 2000-02 period, when health insurance was previously considered. At that time, the most pressing concerns were identified as the shortage of revenues and the poor coverage of health services. As a result, health insurance was put on ice, while the HEP and retention reforms were prioritised. By 2006, these programmes were making progress and the affordability of healthcare and low rates of utilisation were instead identified as the most pressing problems. This shift in problem framing led to serious consideration of different models of health financing.

Table 1: Community-based health insurance and ideational fit

Level of idea	Type of idea	Ideas relevant to CBHI
Paradigmatic ideas	<i>Normative</i>	Rapid socioeconomic development and structural transformation are essential to overcome existential crises, securing legitimacy through inclusive development that eradicates poverty. No one should receive support without contributing in return.
	<i>Cognitive</i>	The state mobilises all available resources in the pursuit of national development, directing private investment to priority areas and filling gaps through public investment, as necessary.
Problem definition	<i>Normative</i>	Healthcare is a means of securing legitimacy and a productive economic investment that contributes to development.
	<i>Cognitive</i>	Shifting from the shortage of financial resources and lack of provision (1990s and early 2000s) to a problem of access and low utilisation (mid-2000s).
Policy ideas	<i>Normative</i>	Healthcare should be accessible for all, but anyone who is able should contribute with money and labour.
	<i>Cognitive</i>	CBHI / SHI share costs between state and users, while pooling risks and limiting financial exposure. Offers the (long-term) potential of financial sustainability.

Source: Based on the typology in Lavers and Hickey (2016), drawing on Schmidt (2008).

Another important point about the decision-making process is that normative ideational fit consistently appears to trump evidence. First, despite being adopted as part of a health-financing strategy, there are major doubts about when, if at all, health insurance will become a significant means of mobilising resources. From the initial pre-feasibility assessments onwards, external experts have cautioned that health insurance involves significant operational costs and may not offer a panacea to the shortage of health finance (Fairbank 2001, HCF Secretariat 2002). The relevance of these warnings is clear with respect to the financial projections in the HSTP (MoH 2015: 134-38). These figures show that over the next five years –when coverage is expected to expand to 80 per cent of the population – SHI will require state subsidies of \$92m, while CBHI will generate a surplus of approximately \$110m. The net contributions from both schemes combined represent just 0.1 percent of the \$15bn baseline costs of HSTP. As a mechanism for resource mobilisation, the adoption and implementation of these schemes appears to be based on a leap of faith – rather than strong evidence – that they will be able to cover a significant proportion of health spending in the future. Instead, health insurance appears to be a triumph for normative ideological fit; the policy idea resonates with core paradigmatic ideas regarding the need to mobilise all available resources in the pursuit of development, the importance of everyone contributing what they can and the resistance to anyone receiving support without contributing something in return. The result is a very selective use of evidence in decision making.

Second, the triumph of ideational fit is also evident in the decision to scale up CBHI. The 'pilots' seem to have been used primarily to fine-tune scheme design, rather than a real test of whether or not CBHI was suitable. The 2010 HSDP IV had already outlined clear plans to scale up the pilots from 2013-14 and while the evaluations have latterly informed the design of the scale-up, results from the official evaluation were only published in 2015 – well after the scale-up began. More ad hoc assessments, field visits and feedback provided input into decision making earlier on, but the decision to proceed seems to have been based on normative ideological concerns, rather than a balanced assessment of the pilots' success.

The policy coalition and links to the ruling coalition

From early discussions on health insurance in 2006, and even back to the 1998 HCFS, there has been a relatively stable policy coalition, consisting of key figures in the MoH, long-term consultants in Abt Associates, and USAID representatives. In many cases, key individuals have been involved in the sector for periods of a decade or more. This stability has been enabled by the rather unusual situation in which the majority of staff working on health insurance in all of these agencies are Ethiopian, with foreign experts only brought in on rare occasions. Abt, in particular, was vital to the process, given the lack of technical expertise within government early on. For the director of planning in the MoH,

'they were my right hand ... We had interest but we didn't have the expertise ... I took Abt all over the world with me on the study tours. The chief at Abt was my right hand. He even represented the government in national meetings' (int. respondent EG13).

Also important is the fact that key donor officials and consultants all previously worked in either the MoH or MoFED, with the result that they understand the objectives and constraints that government is facing and know which proposals will be acceptable and which not (int. respondent EG15).

The extent of involvement of donors and consultants throughout the decision-making process does raise questions about national ownership. Indeed, there are suggestions that donor influence in the health sector is a source of some concern, even within the EPRDF leadership. However, those involved in the sector are in no doubt that, 'in Ethiopia the government is in charge ... Nothing happens unless the government decides ... We brought in experience but if the government doesn't agree, then Abt does nothing' (int. respondent EG15). This even meant that, early on, the Abt country team had problems with their headquarters, which thought that Abt should have a greater say in the process (int. respondent EG15). The extensive use of Abt Associates, financed by USAID, does though present a challenge to the development of state capacity and technical expertise in the long term. The positive aspect of this relationship is that Abt has likely enabled the retention of staff working on health financing and the development of expertise over a long period, compensating for low public sector salaries. Inevitably, however, the result has been

that many top civil servants have left government and now work as consultants earning salaries that could not be supported through domestic financing alone.

The appointment of a new minister of health and director of planning in 2005 was a key step that mobilised this policy coalition and secured close links with, and strong support from, key figures in the ruling coalition. The minister of health until 2012 was an increasingly important figure in the ruling coalition, joining the TPLF executive committee as a by-product of the 2001 split, and was known to be close to Meles. As minister, he was closely involved in detailed policy discussions and proposals on health insurance (ints. respondents EG11, EC6, EC9), as well as playing an important political role in securing broader support for reforms,

'Tedros is a very good leader ... He pushed SHI and CBHI through cabinet. We cannot fully attribute it to him, but it probably wouldn't have happened without him. He was the prime mover' (int. respondent EG15).

At the same time, several respondents noted that Meles himself was a strong supporter of health insurance. In general, Meles is well known to have taken a close interest in detailed policy discussions, rather than delegating to colleagues. Likewise with health insurance, 'he was on it, he was very conversant in the issues' (int. respondent EC7). Meles also played an instrumental role securing support in the Council of Ministers for the health insurance proclamation, gaining the support of the regional health bureaux and deflecting opposition within government (ints. respondents EG15, EC7),

'the former Prime Minister Meles definitely wanted this project to be implemented. I clearly remember one debate in which MoFED was very defensive. Meles intervened and said "this is essential. It is not a luxury, we have to do this. No one else is going to help"' (int. respondent EG11).

The alignment between the policy coalition and key political figures was therefore vital to moving the debate on and securing support. In the words of the director of planning at the time,

'At that time [2008] there was strong momentum, the minister was on board, the prime minister was absolutely supportive. The alignment at all levels was something that you can only dream of' (int. respondent EG13).

The importance of this alignment between the policy coalition and the political settlement was evident when it disintegrated following the health insurance proclamation in 2010. First, the highly regarded director of planning in the MoH left government in 2010, then Meles Zenawi passed away in August 2012 and, finally, Dr Tedros was made minister of foreign affairs in the re-shuffle following Meles' death. For several observers, the disruption resulting from these changes was the main

cause of the delay in the SHI scheme⁸ (ints. respondents EG11, EG13, EG16). Health insurance may well have fallen down the pecking order, given the higher political priority of securing stability within the ruling coalition following Meles' death, the fragmentation within the ruling elite and the scattered priorities within government since then.

What is evident from the analysis is that there are no strong opponents to health insurance from outside the ruling coalition. The Ethiopian Employers' Association (EEF) was reportedly very resistant to SHI initially (int. respondent EG13), complaining that the proposal to deduct contributions from employers came on the back of the introduction of VAT and contributions for the private sector pension scheme (int. respondent EN2). While the EEF claim that they had contributed to earlier delays in the SHI, they admitted that 'this time [in 2016] there is no way' they can do so in the face of strong government commitment to push ahead (int. respondent EN2). There was also some resistance from the Confederation of Ethiopian Trade Unions (CETU), which, though broadly supportive of the idea, was concerned about the deductions from workers' salaries, the exclusion of private healthcare from the benefit package and the poor quality of existing public healthcare (ints. respondents EN1, EN2). Ultimately, though, both CETU and EEF gave their support to SHI and have been given seats on the EHIA board. The Ethiopian Medical Association – the main organisation of health professionals – was consulted in discussions, but is regarded within government as being weak and 'not influential' (int. respondent EG16).

Strong elite commitment in the context of the centralised dominant coalition also offers an explanation for the repeated examples of policies and strategies setting enormously ambitious – and frequently unattainable – targets. As the director of planning noted of the period 2005-10: 'with that kind of commitment [from the minister and PM] you cannot talk about a timescale of 15-20 years' (int. respondent EG13). The result was, first, the plan to make CBHI and SHI operational within a year of the 2008 Health Insurance Strategy and, second, the HSDP IV target of reaching 50 percent enrolment of the population by 2015. Most recently, HSTP has set targets for 80 percent coverage by 2020, and in this respect the failure to meet previous targets serves as a cautionary tale.

State capacity and implementation

Overall performance of the CBHI to date has been relatively successful, though significant challenges remain, especially given the massive planned expansion. Several important aspects of this implementation can be directly linked to Ethiopia's dominant coalition political settlement. Notably, a key dimension of the CBHI success

⁸ Several contending explanations were raised by other respondents. The Ethiopian Employers' Federation (EEF) claim that their resistance to SHI delayed implementation, while the delay of the proposed SHI launch in early 2015 was rumoured to be due to the proximity of the May 2015 national elections (ints. respondents EC5, EN3). How much credence either theory should be given, in light of the one-sided nature of the elections and weakness of the EEF, is questionable.

to date – high enrolment rates – is directly related to the relatively strong state capacity and top-down control mechanisms that verge on an attempt by the state to dominate society and which have proven to be key means of disseminating knowledge and mobilising people. The state capacity to implement the decisions of political elites – what Mann (1984) calls the 'infrastructural power' of the state – flows directly from the centralisation of power and control of elites over lower-level factions that is characteristic of such a dominant coalition.

There are indications that this mobilisation of the local state apparatus – the *wereda* and *kebele* administration, HEWs, development teams and one-to-five groups – and the pressure that it is able to bring on individuals and households has, at times, gone beyond the voluntary principles of the scheme's design, using elements of coercion. Nonetheless, this type of state capacity may well be necessary for CBHI to be successful. There are strong similarities between the Ethiopian experience to date and the implementation of the *Mutuelles de Santé* in Rwanda's dominant coalition political settlement, where similar forms of state capacity have proven essential to achieving and maintaining high enrolment rates (Chemouni 2016).

As such, the maintenance of state capacity and coercive power that appears to have been so important in enrolment to date, is likely to constitute a major challenge for the CBHI going forward. Since 2012, a previously cohesive EPRDF elite has fragmented, with repercussions for discipline among lower-level factions within the political settlement. This weakening of the ruling coalition, combined with the escalation of anti-government protests since fieldwork took place in January 2016 and the widespread challenge to state legitimacy that they represent, threatens the key factors driving enrolment, raising questions about the government's ability to expand or perhaps even maintain existing enrolment levels.

Conclusions

Ethiopia's CBHI and SHI schemes are at a relatively early stage of implementation. While there remain significant challenges to the expansion of both, substantial progress on enrolment has been made, making it one of the largest health insurance schemes in Africa. A key factor in the progress made to date and the stalled progress on SHI is the degree of elite commitment to reforms. The adapted political settlements framework used to guide this comparative research project has provided important insights into the origins of this commitment.

Key aspects of the dominant coalition political settlement provide incentives favourable to the adoption of health insurance, rather than other forms of health financing, and shaped the politics of implementation. First, the absence of powerful elite factions outside the ruling coalition has provided the EPRDF with the stability required to adopt a long time horizon and the space for a developmental vision to emerge. This long-term approach favours a focus on health insurance, which requires long-term investments in a health financing system and offers potential benefits in terms of financial sustainability, health outcomes and political favour only

in the medium to long term. In contrast, a short-term focus would likely favour policies with more immediate political returns, such as the exemption of user fees. Furthermore, the absence of powerful external interests within the political settlement also means that common sources of opposition to the expansion of coverage of social insurance programmes in other countries – employers and unions – were unable to exert much influence on health insurance policy, despite their reservations.

Second, the relative strength of elites with respect to non-elite factions within the political settlement, the strengthening of local government capacity since 2001 and the strong top-down control mechanisms over local government officials also shape the implementation of health insurance. Existing evaluations provide no evidence of systematic corruption or patronage. Instead, once elite commitment to CBHI was secured, lower-level officials were subject to strong pressure from above to meet enormously ambitious targets on coverage and expansion of the scheme. As a result, the considerable state capacity in the form of *wereda* and *kebele* administrations, HEWs and the health development army can be mobilised for the purposes of 'sensitisation' and pressurising people to sign up for CBHI. It is the importance of state capacity and state domination of society in the success of the CBHI to date that is particularly threatened by large-scale anti-government protests in 2015-16.

Third, and vitally, these structural conditions were supplemented by the longstanding ideological orientation of the EPRDF ruling coalition, going back to its roots in the TPLF. The EPRDF has long viewed the delivery of tangible socioeconomic progress – including health provision – as a key means of securing political support and building its legitimacy. More specifically, there is a high degree of 'ideational fit' between the policy idea of health insurance and the EPRDF's developmental vision, whereby it is necessary for the state to mobilise all available resources in the pursuit of development, and the imperative, therefore, that everyone should contribute what they can to the developmental effort. While health insurance fits well with this rationale, the idea of tax and aid-financed free-to-access healthcare is incompatible.

While the nature of the political settlement does help to explain elite commitment to CBHI, it does not provide a strong explanation for the timing of policy adoption and implementation. Indeed, many of the causal factors – ideological orientation and the balance of power within the political settlement – had been in place to some degree for 15 years or more prior to serious discussions on health insurance. The 2005 elections may provide a partial explanation, but fieldwork failed to definitively link health insurance to the EPRDF's post-electoral response. Changing dynamics within the policy coalition and its relationship with the ruling elite do provide a stronger explanation for the timing of policy change, with the appointment of key officials in the MoH vital to bring new ideas and political connections. This highlights the importance of agential factors within more structural explanations. Finally, part of the explanation of timing appears to lie in the technical nature of the health sector and the sequencing of reforms. In particular, a series of reforms to service provision, financing systems and strengthening of local government capacity had to be undertaken before health insurance became a feasible option in Ethiopia.

As such, the findings of this CBHI case study largely fit the proposed hypotheses for this type of political settlement (see Lavers and Hickey 2015). These are that a dominant coalition political settlement is likely to adopt a long time horizon in its policymaking, with elite commitment to social protection linked to concerns about political legitimacy, while this type of ruling coalition is likely to have strong ideological commitments that influence the types of policies seen as acceptable. Given the centralised nature of the political settlement, securing elite commitment requires convincing only a relatively small number of key influential figures, while alignment between the ruling and policy coalitions is both key to progress, but also a clear sign of political support. Finally, the case offers partial support for the hypothesis that dominant coalitions are likely to have relatively strong implementation capacities. Certainly, political capture of implementation does not appear to be a systematic problem and the state has proven to be highly effective at securing high enrolment rates. Whether this translates into improved health and other socioeconomic outcomes, however, is an open question. The use of the PSNP as a source of leverage to promote enrolment, for example, could also lead to negative consequences for food security.

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Interviews conducted

Government respondents

EG8, Chair of the Social Protection Platform in MoLSA, Addis Ababa, 9 October 2015

EG11, former Director of the EHIA, Addis Ababa, 8 October 2015

EG12, senior representative of the EHIA, Addis Ababa, 29 January 2016

EG13, former official in the MoH, by Skype, 14 November 2015

EG14, senior official in the MoH, Addis Ababa, 29 January 2016

EG15, former MoFED official and consultant to the health sector, Addis Ababa, 8 October 2015

EG16, former Director of the EHIA, by Skype, 19 February 2016

EG17, Dr Kesetebirhan Admasu, Minister of Health, Geneva, 26 May 2016

Consultants to the health sector

EC5, foreign consultant to the EHIA, by Skype, 13 July 2015

EC6, former consultant to the MoH, by Skype, 4 November 2015

EC7, consultant on health financing, Addis Ababa, 9 October 2015

EC8, consultant on health financing, Addis Ababa, 5 October 2015

EC9, former consultant on health financing, by Skype, 2 November 2015

EC10, foreign consultant on health financing, by Skype, 30 October 2015

EC11, foreign consultant on health financing, Addis Ababa, 27 January 2016

EC12, foreign consultant on health financing, by Skype, 23 November 2015

EC13, foreign consultant on health financing, Geneva, 15 March 2015

Donor representatives

ED9, former head of a donor agency, by phone, 3 November 2015

ED24, representative of a development partner, Addis Ababa, 26 January 2016

ED27, representative of a development partner, Addis Ababa, 27 January 2016

ED30, representative of a development partner, Addis Ababa, 8 October 2015

Civil society representatives

EN1, representative of CETU, Addis Ababa, 29 January 2016

EN2, representative of EEF, Addis Ababa, 29 January 2016

EN3, representative of an NGO, by skype, 18 September 2015

Academics working on health financing

EA2, researcher working on CBHI, by Skype, 14 July 2015

EA4, researcher working on CBHI, Addis Ababa, 6 October 2015

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