

Willingness And Status Of Social Health Insurance Among People Of Pokhara Lekhnath, Nepal

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Research article

Keywords: Awareness, Nepal, Social Health Insurance, Willingness, Knowledge, health insurance

Posted Date: March 18th, 2020

DOI: <https://doi.org/10.21203/rs.3.rs-17840/v1>

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WILLINGNESS AND STATUS OF SOCIAL HEALTH INSURANCE AMONG PEOPLE OF POKHARA LEKHNATH, NEPAL

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ABSTRACT

Background: Social health insurance program was implemented in Nepal with the aim to achieve universal health coverage by removing health and financial barriers to access health care. This study was performed to assess the willingness and status of social health insurance among people of Pokhara Lekhnath, Nepal.

Methods: A cross-sectional study was performed using mixed method. Quantitative study was conducted among 339 participants using interview schedule and qualitative among 27 participants using focus group discussion guidelines. Quantitative data was entered in Epi-data and descriptive analysis done in Statistical Package for Social Sciences. Chi-square tests was used for quantitative data to explore associations. Qualitative data was analyzed thematically keeping verbatim.

Results: Among 339 participants, 51% were willing to pay and 77% were willing to continue, majority were due to the provision of free health services. About quarter enrolled participants were thinking about discontinuation due to lack of quality services. Presence of illness (0.003), age (<0.001), family-type (0.01), family-size (0.002), presence of chronic illness (0.002) and awareness level (<0.001) were significantly associated with enrollment to social health insurance program. Willingness to pay was determined by education (0.002) and awareness level (0.013). Maximum amount willingness to continue with is significantly associated with sex (0.037)

Conclusion and Recommendations: Willingness to continue is higher than willingness to pay. Also, Awareness level is unsatisfactory. This suggests that people who knows about the social health insurance program get enrolled, learn and experience about the program and increase willingness to continue. Awareness was making significant influence over willingness to pay and enrollment. Lack of quality service was affecting willingness. Thus, the program should concerned on raising awareness and quality improvement.

KEYWORDS

Awareness, Nepal, Social Health Insurance, Willingness, Knowledge, health insurance

BACKGROUND

Social health insurance is the health financing mechanism which uses allocated specific conditions to pay for health services. It is a stable source of health care financing system based on health equity in a sense that it doesn't relate risks or doesn't vary with health status or sick individuals paid equally as a healthy individual paid. It has been recommended as the best options to prevent people from falling into poverty due to catastrophic health expenditure especially for developing countries. It enables to mobilize local resources to reduce the health inequalities and prevents financial impoverishment from out of pocket expenditure.⁽¹⁾ Willingness to pay is the state in which people who are not enrolled earlier are prepared to pay and enrolled. Willingness to continue is the stated in which people who are already enrolled are ready to enroll or renew for next year or ready to renew again. Awareness is the level of familiarity or consciousness gained by people related to social health insurance program.

Only 48% of Nepalese have access to essential health services within 30 minutes distance in 2012.⁽²⁾ Nepalese health financing largely resides on revenue collection and almost half to foreign aid.⁽³⁾ Still, 23.8% of Nepalese are living below poverty line.⁽⁴⁾ OOP expenditure that contribute to 48% of THE in 2014.⁽²⁾ Nepal is facing triple burden of diseases: re-emerging, communicable and rapidly rising non-communicable diseases.⁽⁵⁾

The above mentioned data reveals the health care is not accessible and high possibility to push other individuals under the poverty line.⁽⁴⁾ Moreover, increasing CHE in urban areas from 8.5% in 1996 to 18.3% in 2011 makes realized the importance of research to develop sustainable health financing mechanism like SHI in our country.⁽⁶⁾

SHI is initiated as a pilot project to reduce catastrophic health expenditure due to out of pocket expenditure system and to achieve universal health coverage and based on those findings, it has been extended to other districts and aimed to extend throughout the country.⁽⁷⁾

Pokhara Lekhnath is the biggest metropolitan city in areas where people from different districts resides and it is essential to conduct research related to assess about social health insurance program among people to make further improvement in services. Very limited research has been conducted in this area in Nepal. This study also tried to assess awareness level of participants on newly implemented social health insurance program.

OPERATIONAL DEFINATION

Willingness: The state in which people are prepared to buy, join in the social health insurance program. Willingness is assessed as willingness to pay and willingness to continue. Willingness to pay is the state in which people who are not enrolled earlier are prepared to pay and enrolled. Willingness to continue is the stated in which people who are already enrolled are ready to enroll or renew for next year or ready to renew again. Willingness is assessed by using ten questions, five questions each of willingness to pay and continue respectively.

Awareness Level: It is the level of familiarity or consciousness gained by people related to the social health insurance program. Awareness score is assessed using twenty six questions including single and multiple responses, with full mark of seventy one. Awareness score is categorized into good, fair and poor. Participants obtaining less than 33.3% were considered to have poor level of awareness, 33.3% to 66.7% as fair and more than 66.7% as good.

Social Health Insurance: It is a health financing mechanisms that aims to remove health and financial barriers, pools risks among populations and increase access to health services to all.

METHODS

This was a cross-sectional study conducted using mixed method among 339 participants and four FGD group among 27 people of Pokhara Lekhnath, Nepal in between June 25 to December 31, 2017. The study was approved by the Ethical Review Board of the Nepal Health Research Council. Formal permission was taken from the concerned authorities in the research area and social health insurance board Teku and Kaski. The study participants were selected via multistage sampling technique. In first stage, 17 wards were selected among 33 using random number generator. In the second stage, total number of participants for each wards were identified on the basis of population proportion in selected wards and then participants were selected randomly. General interview was conducted using interview schedule to assess quantitative information among the household heads or surrogate. For qualitative information study sample were selected purposive for focus group discussion using focus group discussion guidelines. Tools developed through extensive literature review and supervisors guidance was pretested among 10% of the participants in ward no. 4 of same area which wasn't was not in random sampling, after translation to Nepali language. A day orientation was provided to the data collectors to make familiar with tools before going to field and filled interview schedule were checked for completeness of data.

Data was collected by taking verbal or written consent from participants after describing the objective of the study. Collected data were entered in Epi-Data and imported to SPSS for data cleaning, editing, coding and analysis. Quantitative data were analyzed as per objective and qualitative by thematically keeping verbatim. Descriptive statistical analysis (Frequency, Percentage) and Chi-square test were performed to explore associations.

RESULTS

Table 1: Distribution of participants by socio-demographic characteristics (n=339)

Study Variables	Frequency (n)	Percentage (%)
Age		
Young Adults (18-25 yrs.)	16	4.7
Adulthood (25-40 yrs.)	130	38.3
Middle Age (40-60 yrs.)	145	42.8
Elderly (>60 yrs.)	48	14.2
Mean Age=43.42±13.62, Min.=18 yrs. Max.=83 yrs.		
Sex		
Female	204	60.2
Male	135	39.8
Family Type		
Nuclear	204	60.2
Joint	122	36
Extended	13	3.8
Family Size		
4 members or less	166	49
More than 4 members	173	51
Mean Family size-4.73±1.8, Min.=1, Max.=13		
Education		
Basic or less	162	47.8
Secondary	130	38.3
University Degree	47	13.9

Table 1 shows that majority 52% of participants were aged of years and between 42-52 years and more than or equal to 52 years. Mean age of participants was 43.42±13.62 years, minimum 18 years and Maximum 83 years. More than half (60.2%) of participants were from nuclear family and 51% of the family composed of less than 4 members with mean family size 4.73±1.8. 47.8% of participants had Basic education or less.

Table 2: Distribution of participants by awareness level

Awareness Level	Frequency (n)	Percentage (%)
Fair	54	15.9
Poor	285	84.1

Table 2 shows that, 84.1% participants had poor knowledge about social health insurance program. None of them had good knowledge regarding social health insurance program. Participants obtaining less than 33.3% were categorized as poor, 33.33% to 66.67% as fair and more than 66.67 as good level of awareness related to social health insurance program,.

Table 3: Distributions of participants by family enrollment related factors

Study variables	Frequency (n)	Percentage (%)
Family enrollment to SHI		
Yes	52	23.3
No	171	76.7
*Factors motivating to enrolled in SHI		
Encouraged by enrollment assistant	33	63.5
Provide free health service to us	17	32.7
My family members are always sick and don't have money to treat	15	28.8
My relatives and neighbors encourage	12	23.1
Encouraged by media	6	11.5
As most people have and I buy	2	3.8
Encouraged by FCHV, compulsory to FCHV	2	3.8
Reason for not enrolling to SHI		
Not much aware about program	59	34.5
Low quality of services	39	22.8
Lack of money	29	17
Low health expenditure	20	11.7
Negligence	19	11.1
Crowd in service delivery site, long waiting time	19	11.1
Lack trust towards service and service providers	18	10.5
Think of no need	17	9.9
No access to enrollment assistant	9	5.3
Don't know where to be enrolled	9	5.3
Chance of migration	5	2.9
Profit oriented as like other private	5	2.9
Government responsibility to pay for health of citizen	3	1.8
Less benefit	3	1.8
OOP is better	3	1.8
Complex process	2	1.2
Lack of time	2	1.2
Lack of family support	1	0.6

*Multiple response

Table 3 shows that, 23.3% (52) of the participant's family were enrolled to social health insurance whereas majority 76.7% (172) weren't. Majority 34.5% (59) of the participants were not enrolled till now because they were not much aware about the program. 17% and 11.7% were not enrolled due to lack of money and negligence. Participants were not enrolled due to lack of trust towards services features such as service and service providers, service delivery site, complex process, etc.

In the FGD, participants expressed that they weren't enrolled in the program till now due to lack of trust, fear of poor implementation, the absence of chronic illness or frequent ill members at home, low health expenses, not access to enrollment assistant, not much aware about the program features, negligence, thinking of government responsibility to pay for health services, , husbands disagreement, heard about the queue, complex procedure, untimely services, discrimination between insured and uninsured clients in the health institutions.

"I am very much interested to be enrolled in social health insurance program but I cannot trust in the scheme. So, I am not enrolled till date..... I am neglecting this program." **P6, L64 FGD1, Uninsured male**

"I will be interested to be enrolled if there might be frequent and chronic ill member at home. It has been about one year, I have heard about the program but I neglect. There may not be money to enroll all the time. I might be enrolled if anybody comes to my home and encouraged to be enrolled when I had money."..... **P4, L111, FGD-3, Uninsured female**

Table 4: Distribution of participants by willingness to pay (WTP) related factors (n=171)

Study Variables	Frequency (n)	Percentage (%)
Willingness to Pay (WTP)		
Yes	87	50.9
No	84	49.1
*Reason for WTP		
Free health services	49	56.3
Health care access to poor	19	21.8
Prevent premature death due to lack of treatment	15	17.2
Family members become ill frequently	16	18.4
Can get health services	15	17.2
Motivated by media	13	14.9
Maximum services with minimum costs	11	12.6
Government Policy	5	5.7
Others (Encouraged by enrollment assistant, as all are enrolling, etc.)	4	4.6
*If no, Reason for no WTP		
Lack of money	22	26.2
Nearby health institution doesn't provide services	22	26.2
Found not much useful	16	19
Lack of quality services	14	16.7
Low health expenditure	10	11.9
Need family decision	8	9.5
Fear of poor implementation	6	7.1
Queue and lack timely services	4	4.8
Chance of migration	4	4.8
Difficult to renew, can't get used medicines	2	2.4

*Multiple Response

Table 4 shows that, half of the participants were willing to pay for social health insurance and 56.3% were willing to pay due to provision of free health service. 26.2% of the participants said lack of money and 26.2% said nearby health institution doesn't provide services were main reason of no willingness to pay. This data shows that, mobility is one of the reason of no willingness to pay.

In the FGD, there is mixed pattern of response regarding willingness to pay among uninsured participants. Some were willing to pay where as some weren't. Whoever willing to pay were also confused. However, participants were encouraged for willing to pay when they saw their neighbors and relatives receiving more services by less investment, to test whether the service will be better or not. The factors that discourage willingness to pay were lack of trust, lack of money while enrollment assistant comes to home, lack of awareness regarding the program.

"I am fully trusting on the social health insurance program nowadays. I have seen that a sister nearby my house who was enrolled to the program had leg fracture and admitted in Manipal Teaching Hospital for about 1 months. She was scared whether she had to pay about one lakh rupees but had to pay RS100 only during discharge. After listening to this, I and my neighbors were very much willing to pay." **P7, L137 FGD3, Uninsured female**

"In my view, insured clients might be treated differently than that of uninsured because of taking services by investing less amount" **P4, L115 FGD3, Uninsured female**

Table 5: Distribution of participants by willingness to Continue (WTC) related factors (n=52)

Study Variables	Frequency (n)	Percentage (%)
Willingness to continue		
Yes	40	76.9
No	12	23.1
*Factors motivating WTC		
Free health services	33	82.5
Illness are diagnosed and treated on time	17	42.5
Quality health services	2	5
Others (government policy, compulsory to FCHV,)	2	5
Don't know	7	17.5
*Reason for no WTC		
Long waiting time and complex process	6	50
Will be decided after receiving services	6	50
Lack of positive attitude among service providers	5	41.7
Include very less services	4	33.3
No consultation by specialist	3	25
OOP is better	1	8.3

*Multiple Responses

Table 5 shows that, more than three fourth of the participants were willing to continue. Majority 82.5% of the participants were willing to continue with social health insurance due to provision of free health services. Half, 50% (6) of the participants weren't willing to continue because of long waiting time & complex process and same proportion of participants will decide after receiving services.

In the FGD, insured participants not utilizing services are willing to continue till now but it will be decided after receiving services throughout the year but those who utilized services were not willing to continue if the system of service providing won't change. Factors which discourage them to continue are the unsystematic queue, lack of consideration of the severity of illness in the queue, untimely services, complex process, wastage of time, lack of positive attitude of health and non-health providers, frequent server problem and availability of low-cost medicines but not medicines used for chronic illness. They will be willing to continue if queue system will be managed if insured clients were treated equally as uninsured, the attitude of health and non-health providers changed, server problem was managed, services provided in time and making more medicines available.

"I think I will continue the enrollment in future. I haven't utilized any services. It will be decide after utilizing program services" **P1, L107 FGD3, Insured female**

"I can't get enough services at first visit. If systems will be easier in second or third visits, if we can get required medicines, I will continue again. But if discrimination existed between insured and uninsured clients in hospital, Renewing and enrolling again will be useless.....Let see....It might be easier when everybody enrolled..... Let's see." **P6, L109 FGD4, Insured male**

"Who are elderly? Who are young adults? Who are the women suffering from labor pain? There is no consideration in queue system..... Initially, there were fewer clients receiving insurance services but is crowd since service begins from Mangsir 2074 B.S." **P4, L6 FGD4, Insured male**

".....Whatever health institution existed and operated in Pokhara Lekhnath, by taking permission from Nepal Government, If were compelled to provide insurance services, clients load in the Manipal and Western Regional Hospital decreased. We used to expect services but we had to pay for the medicines prescribed by doctors. In such situation, we feel "It has been useless of being enrolled in the program."..... Thus, the system should provide services at free of cost up to RS 50000 whatever the service might be....." **P4, L10 FGD4, Insured male**

Table 6: Association between enrollment to Social Health Insurance and socio-demographic factors (n=223)

Socio-demographic factors	Enrollment to SHI						Test of significance	p-value
	Yes		No		Total			
	N	%	N	%	n	%		
Age								
<32 yrs.	5	9.1	50	91.9	55	100	$\chi^2_3 = 15.67$	<0.001**
32-42 yrs.	13	20.3	51	79.7	64	100		
42-52 yrs.	14	25	42	75	56	100		
>52 yrs.	20	41.7	28	58.3	48	100		
Family Type								
Nuclear	25	17.7	116	82.3	141	100	$\chi^2_1 = 6.69$	0.01**
Joint	27	32.9	55	67.1	82	100		
Family Size								
≤ 4 members	18	15.1	101	84.9	119	100	$\chi^2_1 = 9.57$	<0.002**
>4 members	34	32.7	70	67.3	104	100		

** Highly significant * Significant

Table 6 shows that awareness level increases with increase in age, family type and family size. There is high statistical significant association between age, family type, family size and enrollment ($p < 0.05$).

Table 7: Association between family enrollment to social health insurance and health related factors

health related factors	Enrollment to social health insurance						Test of significance	p-value
	Yes		No		Total			
	N	%	N	%	n	%		
Presence of chronic illness (OR=2.745)								
Yes	28	35.4	51	64.5	79	100	$\chi^2_1 = 10.058$	0.002**
No	24	16.7	120	83.3	144	100		
No. of members with chronic illness								
none (0)	24	16.7	120	83.3	144	100	$\chi^2_2 = 13.005$	0.001**
1	21	31.8	45	68.2	66	100		

2	7	53.8	6	46.2	13	100
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** Highly significant * Significant

Table 7 shows that enrollment increases with the presence of chronic illness and increase in members with chronic illness. This research found that these above-mentioned factors rise family health expenditure and social health insurance provide maximum service by minimum investments. Illness frequency, chronic illness and no. of members with chronic illness shows significant association with enrollment to SHI. ($p < 0.05$)

Table 8: Association between Willingness to Pay with education and awareness level

Education	Willingness to Pay						Test of significance	p-value
	Yes		No		Total			
	N	%	n	%	n	%		
Education								
Basic or less	24	37.5	40	62.5	64	100	$\chi^2 = 12.601$	0.002**
Secondary	40	51.9	37	48.1	77	100		
University degree	23	76.7	7	23.3	30	100		
Awareness Level								
Fair	16	76.2	5	23.8	21	100	$\chi^2 = 6.138$	0.013**
Poor	71	47.3	79	52.7	150	100		

Table 8 shows that increase in education level and awareness level makes increases in willingness to pay. There is high statistical significant association between education and awareness level with willingness to pay. ($p < 0.05$)

Table 9: Association between Max. Amount WTC with sex

Sex	Max. amount WTC						Test of significance	p-value
	\leq RS 2500		$>$ RS 2500		Total			
	N	%	n	%	n	%		
Female	17	73.9	6	26.1	23	100	$\chi^2 = 4.365$	0.037**
Male	7	41.2	10	58.8	17	100		

** Highly significant * Significant

Table 9 shows that, male are willing to continue with maximum amount than female for social health insurance. It shows statistical significant association between maximum amount willing to continue and sex. ($p < 0.05$)

DISCUSSION

Study shows that none of them had good level of awareness which disagree with the study conducted in Olowora, Lagos, shows better results, 49.5% had good knowledge on CBHI. Most (84%) of participants had poor level of awareness in this study but 25.5% had poor knowledge in the aforementioned study. ⁽⁸⁾ Significant association between level of education ($p=0.003$) and awareness level was found in Osun States South-western Nigeria and Southern Nigeria as like in this study ($p=0.003$)^(9,10). Presence of illness during last 6 months ($p=0.032$) and illness frequency were found to be significantly associated with awareness level since peoples mind can be triggered after knowing about scheme.

Half of the participants (50.9%) were willing to pay which is in line with the results reported in urban area study conducted in Osun State, Nigeria that is 50.6%⁽¹¹⁾ but better than the findings of WTP study for CBHI in Nigeria⁽¹²⁾

Willingness to pay in our study is less than that of WTP study in Mangalbare VDC of Ilam district. It is because people have heard and become the witness of the complexity of service utilization process, untimely services, different attitude of service providers among insured clients and lack trust. Hereby, this study agree more with the findings that level of education ($p=0.002$) as important factors affecting willingness to pay ($p=0.002$) from WTP study in Illam, Iran, Punjab.⁽¹³⁻¹⁵⁾ The study result lack of money (26.2%) and nearby health institution doesn't provide services (26.2%) were the main factors affecting WTP is similar to the WTP study of Mangalbare VDC of Illam where 64% participants responded lack of money is reason.⁽¹²⁾ WTP significantly associated with awareness level. It is because those who were familiar with the scheme features were willing to check whether the scheme works as stated theoretically or not. Family size influence WTP significantly in the study of Iran⁽¹³⁾ but not in this study.

We tried to find the association of enrollment to SHI with socio-demographic, health-related factors and awareness level. We have found highly significant associations of age ($p=0.001$), family type ($p=0.01$), and family size ($p=0.002$) with enrollment. It is because increasing age increases the risk of illness and degrading health, the number of people generally will be more in the joint family and health expenditure increases by the increase in family size. Also, this study findings demonstrates the risks of adverse selection in the scheme because the presence of chronic illness in the family shows highly significant association (0.002) with enrollment, which is opposite to the findings from the study conducted in Iran which demonstrate no association between health status and enrollment. We found that awareness level was highly significantly associated with enrollment to social health insurance ($p\text{-value}<0.001$) which agrees with the findings of above mentioned study.⁽⁸⁾

Even though significant association wasn't determined between illness frequencies occurred in during last six months and enrollment, increasing illness frequency experienced by participants families were less likely to be enrolled. It is because those participants were frequently visiting health institution providing SHI services and become witness of the different challenge that the insured clients had faced.

77% of the people were WTC in our study which is slightly lower than in Abuja Nigeria where 84.3% were willing to renew.⁽¹⁶⁾ Increasing the frequency of illness significantly decreases the willingness to continue or renew. It is because they were tired of staying in queue, managing the process and tolerating the different attitude of service providers.

CONCLUSIONS

From this study it was concluded that maximum participants had poor level of awareness level and coverage of program wasn't adequate. Awareness was lagging behind not enrollment. Willingness to continue was higher than that of willingness to pay.

Education, presence of illness and illness frequency occurred during last six months were significantly associated with awareness level. Age, family type, family size, presence of chronic illness, number of members with chronic illness and awareness level have shown highly significant association and illness frequency during last 6 months shows significant association with enrollment. Education and awareness level were highly significantly associated with willingness to pay. Illness frequency during last 6 months was highly significantly associated with willingness to continue. Sex is associated with maximum amount willing to continue.

Thus, we can focus to massive awareness program to general public regarding the benefits of social health insurance program. We assumed the risks of adverse selection (high illness frequency, chronic illness have high chance of enrollment) and some attempts should be done to manage and sustain the program in future.

LIST OF ABBREVIATIONS

CBHI	Community Based Health Expenditure
CHE	Catastrophic Health Expenditure
FGD1, FGD2.....	Focus Group Discussion 1, 2.....
L33, L109.....	Line 1, 2,109, 110,
OOP	Out of Pocket
P1, P2.....	Participants 1, 2.....
SHI	Social Health Insurance
SPSS	Statistical Package for Social Sciences
THE	Total Health Expenditure
UHC	Universal Health Coverage
WTP	Willingness to Pay
WTC	Willingness to Continue
VDC	Village Development Committee

DECLARATION

1. **Ethics approval and consent to participate:** This research has been conducted after approval by Ethical Review Board of Nepal Health Research Council (approval ref. no.: 948). The research is carried out taking voluntary informed written or verbal consent from participants.
2. **Competing interest:** None
3. **Consent for publication:** Provided
4. **Availability of data and materials:** The datasets analyzed during the current study are available from the corresponding author on reasonable request.
5. **Funding:** 60% of the research budget is funded by Social Health Security Development Committee (SHSDC), Teku, Kathmandu Nepal. SHSDC is the main committee regarding social health insurance program in Nepal.
6. **Authors' contributions**

1st Author did extensive literature review from selection of title selection to report writing, proposal writing, defense, ethical approval, tools development, testing, data collection, analysis, report writing, dissemination of findings. 2nd Author provide extensive guidance from title finalization, tools development, defense, tools development, and orientation to data collector, training on research software's, data analysis, report writing and the literature writing.

7. **Acknowledgements**

It gives me immense pleasure to express my gratitude to my research supervisor Mr. Nand Ram Gahatraj (Assistant Prof., Pokhara University) for his esteemed guidance, continuous encouragement. My sincere gratitude is reserved all the members of Department of Public Health, LA GRANDEE for their constant support

I would like to express my heartfelt thanks to Krishna Prasad Bhattarai (SHSDC, Kaski) and Dr. Gudaraj Lohoni (SHSDC, Teku, Kathmandu) for their continuous cooperation to conduct the research and get financial assistance. I am also grateful for the health workers of PLMC and mothers groups for their valuable input.

Very special gratitude to all the participants who had enthusiastic involvement. I would like to thanks sincerely Mr. Bibash Lamichhane, Ms. Sushila Khatri Ms. Anju Adhikari and Mrs. Anju Sharma for support and their help during data collection.

I wish to thank everybody who directly and indirectly support in completion of this report.

Manju Adhikari

8. Authors' information (optional)

I am undergoing Master of Public Health at Central Queensland University of Melbourne, Victoria, Australia from 2019 and running in third semester..

Prior to this, I worked as Field as Field Researcher in Institute for Social and Environmental Research Center- Nepal, at Pokhara, Nepal in the project entitles “Risk Factors of Uterine Prolapse among Women of Selected Districts of Nepal” for six months in 2018.

I am also a Public Health graduate, completed my Bachelor Degree of Public Health in 2017 from LA GRANDEE International College, Simalchaur-8, Pokhara, Nepal. The college is affiliated by Pokhara University, Nepal.

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