

Barriers and facilitators of community based health insurance membership in rural Amhara region, northwest Ethiopia: A qualitative study

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Abstract

Background: More than 150 million people encounter huge cost of health expenses every year, and most of these treatment seekers face poverty owing to out of pocket payments. Community-based health insurance won popularity as a makeshift health financing mechanism for out of pocket payments in poor communities. The aim of this study was to identify the facilitators and impediments of enrollment to community based health insurance in rural parts of the Amhara region, Ethiopia.

Method: Focus group discussions (FGD) were the main research methodology supplemented by key informant interviews (KII). The FGD participants were selected by purposive sampling techniques based on the membership status of CBHI (members or non-members). Six FGDs and four key informant interviewees were conducted in March 2018 in three districts. Before analyzing the data, all FGDs and KIIs were transcribed and transferred into Atlasti version 7.1 software. Thematic analysis was done according to key themes arising from the data.

Results: Low level of awareness, perception of high amount of premium, poor perception of quality of services and lack of trust in community based health insurance are the barriers to membership in community based health insurance.

Conclusion: There has been a low level of awareness and misconception about community based health insurance. The major reason for not joining CBHI was incapacity to pay the premium.

Background

More than 150 million people encounter huge cost of health expenses every year, and most of these treatment seekers face poverty owing to out of pocket payments. Community-based health insurance(CBHI) won popularity as a makeshift health financing mechanism for out of pocket payments in poor communities (1, 2). CBHI runs by combining resources and risks at the individual and community levels. In similar projects individuals/families willingly cover set amounts for the benefit of packages involving medical services (3).

Studies show that CBHI schemes can reduce catastrophic health expenditure(CHE) by reducing out of pocket payments and increasing resource mobilization (4, 5). Although it has been proved that CBHI schemes can bring financial protection, its effect and coverage is different in certain contexts and conditions (6, 7). This shows that conducting similar interventions in different settings cannot be effective unless a variety of factors are taken in to consideration for its sustainability(8).

In Sub-Saharan Africa CBHI success is seldom over 10% of the goal(9) excluding nations like Rwanda and Ghana (10, 11).Researches investigated and identified barriers that diminished enrolment. Unaffordability of payment, poor and limited referral services and weak management which result lack of client trust have been the major identified constraints to enrolment (5, 9, 12, 13).

A scientific investigation in Burkina Faso pointed out cost of premium, inaccessibility of health facilities, poor quality services, absence of health seeking behavior and local notions were identified as constraints that held down enrolment initiatives (14). A research in Tanzania reported family size, economic status, family members health condition and awareness of CBHI were mentioned to be the major factors connected with membership (15).

In 2011, the Ethiopian Government introduced CBHI as a pilot project in to 13 districts of the four major regional states of the country. This project scored substantial success in the initial stage but dropped in the following years, that is the enrolment decreased by 18%(16). Therefore, the aim of this qualitative study was to explore constraints of CBHI enrolment which have not been addressed by previous quantitative investigations.

Method

Study setting

The study was conducted in the Amhara regional state. The region is divided in to 167 districts in March 2018. Of which, three rural districts; Libo Kemekem, Fogera, and Farta were chosen.

Data collection and sampling

Focus group discussions (FGD) was the main research methods supplemented by key informant interviews (KII). FGD was preferred to In-depth interview to involve group interactions and gain rich information about perceptions and experiences relating to community based health insurance. Six FGDs and four key informants were conducted. There were about 10-12 members in each FGD. Both FGDs and KIIs audio recorded in Amharic, the local language lasted 1-1.5 hours and 40-45 minutes respectively. It was also stratified by CBHI membership status (members and non-members of CBHI).

A pretested interview guide was used to conduct both FGDs and KIIs. All FGDs and KIIs were led by a moderator and notes were written by an independent note- taker. Purposive sampling, specifically mix of criteria based and maximum variation sampling technique, was used based on CBHI membership status. Information was gathered through a semi structured interview which touched the following themes: socio-demographic characteristics, interviewee CBHI enrolment status, CBHI awareness, affordability of the payment, trust in CBHI, and quality of service.

Data analysis

Before analyzing the data, all FGDs and KIIs were transcribed the local language Amharic, and translated to English. Atlasti version 7.1 software package was used to aid analysis of the data. The transcribed FGD and KII texts were read several times to familiarize the material. Transcripts were analyzed line by line, several codes were developed and clustered into categories and subcategories. The categories and subcategories were modified on the basis of themes which emerged as the analysis proceeded. Thematic

analysis was done according to key themes arising from the data. Initial coding was done by the lead author and commented on by the co-author.

Trustworthiness of the study

Credibility, dependability, transferability, and conformability were considered. Member check was done to ensure the credibility and conformability of findings. The participants shared their opinions about whether the findings were in line with their experiences. The researchers also had prolonged and deep engagement with qualitative data. A peer check was done on the second review of the transcripts, codes, concepts and designed relationships on which several colleagues took part. Documentation was done throughout the study to ensure the conformability of the findings. Purposive sampling (maximal variation in participant's selection) and the guidance of experts experienced in qualitative inquiry to ensure dependability and transferability of the finding.

Result

A total of six FGDs (3 CBHI members and 3 non-members) and 4 key informant interviews were conducted. All of the participants were farmers and almost 50% of whom were female participants. (Table 1).

In this qualitative study 6 themes were identified: (I) awareness of households about CBHI, (II) reasons not joining CBHI, (III) readiness for CBHI membership renewal, (IV) perception of premium amount of CBHI, (V) trust in CBHI, and (VI) qualities of services provided by the schemes. Varying opinions were often expressed in the key informant interviews and focus group discussions by both members and non-members of the community-based health insurance.

Awareness on CBHI

Though the majority of the members and non-members of CBHI were aware of the scheme, a good number of community members were still not very clear.

"CBHI focal persons simply informed us to be members, but they did not tell us about the benefits and the principles of governing its implementation in detail." (P₂, FGD₁, CBHI non-member)

This idea is was confirmed by community health extension workers who explained that there were no sufficient awareness creation session.

"No specific meetings were called for CBHI, so we tried to use other opportunity meetings to create awareness about the scheme. We believe that if some information is given to the community, could develop their awareness about CBHI through discussion that include questions and answers. Similar chances did not exist in relation to CBHI. So, awareness sessions on the issue were not given." (KII₁, Farta district)

Reasons for not becoming CBHI member

The reasons for the majority of non-members of FGD participants for not joining CBHI were financial constraints, that is, inability to cover CBHI premiums.

“Currently we have different payment responsibilities, like taxes, student educational fees which makes this insurance payment difficult.” (P₃, FGD₃, CBHI non-member)

Another FGD participant point out *“As the previous speaker mentioned, economic problem is the main reason for the majority for not joining.. In addition, CBHI premium is increasing every year, so it makes difficult to join.”(P₅, FGD₄, CBHI non-member)*

Readiness for renewalship

A large number of CBHI members are not ready to renew their membership.

“We have been discussing the issue during our coffee and local beer ceremonies. May be, persons with chronic sicknesses are ready to renew their membership, but members who have not been sick for more than a year are not ready because they did not use their previous payments. They said we will be treated by selling our goats when we do not have money.”(P₁₀, FGD₅, CBHI member)

A key informant district CBHI focal person confirmed, *“At the beginning 33 % of our target population joined CBHI. But these days, we have faced challenges to get new members and membership renewals. At present membership renewal rate is less than 10 %.”(KII₄, Addiszemen)*

A key informant, another CBHI manager from one district said:

“Due to lack of integration between local community leaders, CBHI coordinators, and community health workers. The community has faced challenges. Therefore the problem of poor membership renewal is not due to members, rather it is a problem of the CBHI scheme and stakeholders. Moreover, CBHI has a structural problem, we are not clear which minister we have to report to, and the office has a scarcity of both human and financial resources. So we are still begging the zonal and regional offices to settle this issue.”(KII₂, Fogera district)

Perception about CBHI premium

The majority of both members and non-members of CBHI complained that the premium of CBHI was increasing yearly was not fair, but there were also some participants who thought that the payment was fair.

“The premium for a family member of five was around ETB 202, which was affordable to the community. However, this premium increased by ETB 38 in this year. So the community is worried about the increment which is beyond their capacity to pay.”(P₄, FGD₁,CBHI member)

This was confirmed by a community health extension worker who said,

“There are issues drop-outs; if someone was a member last year and failed to renew membership, and if he wants to continue after dropping-out for a year, they are supposed to pay that missed year and the current year which adds to the burden. The other reason for not joining CBHI is extra or additional payment for family members aged above 18 years. Moreover, membership renewal premium has increased and this makes joining difficult.” (KII₂, Fogera district).

On the other hand some members and non-members of CBHI explained that the premium was fair.

“I have known a non-member lady whose child got sick, and she went to Bahirdar and spent more than ETB 300. Another CBHI member paid only transport costs for a similar case. So the premium is much lower than the health care expenses.”(P₄, FGD6, CBHI member)

Another FGD participant also said, “For me, totally, I am not a member, but as a community member I do not think that this amount of money is high because if we get sick suddenly, we might pay ETB 4000 or more at one time.”(P₇, FGD5, CBHI non-member)

Trust on CBHI

The majority of FGD participants have trust in CBHI.

“I and other persons believe that this health insurance payment is only for our health, and I know one woman who was seriously sick and got treatment at Bahirdar hospital. The treatment costs more than ETB 9,000 but she paid only five hundred for the card. The insurance covered the cost. She asked what would happen if she was not a member? When we look at this it has high benefits. So we all believe the payment is used for our health, not for other purposes.”(P₈, FGD2, CBHI non-member)

On the other hand one FGD participant said, *“I think the community used to have trust in the CBHI scheme. But this year (2009) the community started to question if they should trust CBHI due to the misbehavior of some health professionals.”(P₉, FGD3, CBHI member)*

Another FGD participant said,

“Although I am poor, the payment is fair. I joined the scheme when the payment was ETB 85 but next year the payment rose to ETB 144, without any services due to delays in the issuance of identification cards. In the meantime I and my child got sick and went to the health center, but they told us we needed to renew our membership which disappointed us very much. Then, we started to think about the importance of insurance, if we pay but cannot get the service which is not fair. Therefore, we decided to leave the scheme”. (P₁₀, FGD₄, CBHI member).

A key informant head of one health center explained,

"We had an agreement with the insurance company, but they did not transfer the payment of the last six months our health center. Government offices are not responding according to agreement. Members who get treatments at referral centers and private institutions do not get their money back early enough. That is, health institutions are not working according to the schedule."(KII₁,Farta district)

Perception on quality of care

The majority of both members and non-members criticized the quality of services from different perspectives. Criticisms focused on three aspects: long waiting times, excessive prescribing, and differential treatment depending on patient membership status.

"The quality of health service provided by health facilities is not satisfactory. Most of the professionals discourage and mistreat CBHI members when they visit health facilities. During our monthly meeting, most CBHI members are complaining about the problems relating to health professionals." (P₁, FGD₄, CBHI member)

"The government has provided this great opportunity, but the professionals serving at health centers are disappointing. There are no enough drugs, no good services; they have only empty offices. We get better services when we are referred to higher health service institutions, like hospitals. For example, I had a neighbor who had breast cancer; she went to Bahirdar hospital and got very good service without payment. So I can say the insurance is a very good mechanism for good health services; the problem is with the health providers."(P₈, FGD₃, CBHI member)

"I am not happy about the health professionals. They always seek their own advantages and benefits. They do not even want to give attention to critical patients. When we are sick, we are not able to talk with them. They say they are tired and tell patients to come again. This is my real experience. If they say to me, what will do to rural people?. They discriminate patients. There is a gap among health professionals on how to treat patients."(P₉, FGD₂, CBHI member)

A Health extension worker key informant said,

"The majority of CBHI members are not satisfied with the services provided by health facilities. People are complaining about service providers. They are considering CBHI member patients healthy and think they come to health facilities because they have free cards. I think there is a problem related to patients who are CBHI members, they make unnecessary visits to health facilities because they can get free services."(KII₃, Farta district)

Discussion

The aim of this study was to explore the determinants of membership in the community based health insurance schemes. Low level of awareness, amount of premium, perception of quality of services, and trust in CBHI were identified as the main barriers to membership in CBHI.

The study revealed that although the majority of members and non-members have awareness there are groups who were not aware enough. This result is similar to other findings which showed that Inadequate knowledge and understanding of insurance and CBHI principles are one of the obstacles to enrolment (17, 18). Poor knowledge of insurance components is likely due to poor communication and sensitization campaigns that do not manage to convey information in an effective manner.

In this study, the main reasons for membership mentioned by the members of CBHI were preventing OOP emergency. On the other hand a significant number of non- members of CBHI raised that a high amount of premium was a barrier to membership. A study conducted in Tanzania reported a similar finding(15). This study also revealed that the majority of both members and non-members of CBHI complained that the premium of CBHI was increasing yearly was not fair. This is supported by other qualitative studies (14, 15).

Different studies showed that premium is one of the main factors associated with CBHI enrolment (19). Rural poor people complain that the linear rate nature of premium prevents them from enrolling. Therefore, strategies which enhance the flexibility of the payment by considering the poorest should be planned(20).

This study revealed that providers do not give similar services to patients who are CBHI members and non-members. Members perceived that CBHI non-members are more respected and treated than members. This is supported by other studies (23, 24). The respect of care providers is one of the main factors for enrolment in CBHI(21).

According to this study, lack of transparency has been one of the constraint for enrolment of CBHI. A similar finding was reported in Uganda(17). Lack of transparency in CBHI administration resulting client distrust and make decrease enrolment in the scheme. (14, 17, 21-23). Premium rates and managing funds set without community participation also affect the sustainability of CBHI(24, 25).

Conclusion

There is a low level of awareness and misconception about CBHI, and the major reason for not joining CBHI is incapacity to pay the premium. So our study suggests that information access about the aim of CBHI, avoiding flat rate payments, ensuring transparency, and monitoring the quality of service are essential empowering tools for increasing enrolment and maintaining sustainability.

Declarations

Ethics approval and consent to participate

Ethical clearance was obtained from the University of Gondar, Institutional Review Board (IRB). Verbal informed consent was obtained from each respondent by explaining the rationale for the study. As the

study is non-clinical and heavily relied on a cross-sectional survey, data were collected after getting verbal consent from each participant. This procedure is approved by the review committee.

Availability of data and materials

The data could be obtained upon reasonable request from the corresponding author.

Consent for publication

Not applicable

Competing interests

The authors declare that they have no competing interests.

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Author's contributions

Both authors participated equally in the conception, design, data collection, analysis and interpretation. The manuscript preparation was done by GD and approved by AA.

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Abbreviations

CBHI-Community based health insurance

OOP-Out of pocket payment

FGD-Focused group discussion

LMICs- low and middle income countries

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Table

Table 1: Socio-demographic characteristics of respondents

Socio-demographic variables	CBHI Members	Non-CBHI Members
sex		
Male	18(51%)	17(48.5%)
Female	17(49%)	18(51.5%)
Age		
20-35	5(45%)	9(25.7%)
36-50	27(77%)	17(49%)
51-65	2(5.6%)	4(11.5%)
>65	1(2.7%)	5(15%)
Educational status		
Illiterate	24(68.6%)	29(82.5%)
Able to read and write	3(8.5%)	3(8.5%)
Primary school	8(22%)	3(8.5%)
Occupation		
Farmer	35(100%)	35(100%)