

**Willingness to join and Pay for Newly Proposed
Social Health Insurance Among Teachers in Wolaita
Sodo Town Government Educational Institutions,
South Ethiopia**



By: Tesfamichael Alaro (BSc. PH)

A Research Thesis Submitted to Jimma University, College of Public Health and Medical Sciences, Department of Health Services Management, in Partial Fulfillment of the Requirements for the Degree of Masters of Public Health in Health Services Management

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Jimma University**

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Abstract

Back-ground: Cost sharing between beneficiaries and government in the health sector is critical to achieve universal health care coverage, yet only 1.1% of Ethiopians had any kind of insurance and the government spends 1% of its health expenditure on insurance activities.

Objective: To assess willingness to join and pay for newly proposed social health insurance scheme among teachers in Wolaita Sodo town government educational institutions, South Ethiopia, 2012.

Methods: A cross-sectional Study was conducted during February 5 to March 10, 2012 among 335 teachers in Sodo town government educational institutions. A stratified simple random sampling technique was used. Data analyzed using SPSS version 16.0 statistical software. Binary and multiple logistic regressions were used to estimate the crude and adjusted odds ratios for the willingness to join and pay for social health insurance.

Results: A total of 328 teachers in government educational institution were included in the study. One hundred eighty one (55.2 %) of the teachers were never heard of health insurance scheme. However, 234(71.3 %) of the teachers were willing to join the suggested insurance scheme; and 174(74.4 %) of these were willing to pay. Eighty two (47.1 %) of those willing to pay, agreed to contribute greater than or equal to 4 % of their monthly salary. Moreover, the median willingness to pay was 81.66 (\pm 59.653) Ethiopian birr (4.66 United Sate dollars) per person per month. Willingness to join and pay for the scheme was more likely among those who have heard about health insurance, problem of paying medical bills and higher educational status as compared to those who did not have these characteristics.

Conclusion and recommendation: More than half of teachers in this study have never heard about health insurance scheme though, about three fourth were willing to pay. Policy maker should market the scheme so that every employee will be conversant with it for successful implementation and introduce strategies to win the trust of government employee in relation to a health insurance system, particularly among those with relatively lower educational status and greater service year.

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Acronyms

BBP: Basic Benefit Package

CV: Contingent Valuation

CVM: Contingent Valuation method

HIV/AIDS: Human immune virus/ Acquired immune deficiency syndrome

HSDP: Health sector development program

IMCI: Integrated management of childhood illness

MoH: Ministry of health

NHIS: National Health insurance scheme

OOPs: Out of Pocket payments

SHI: Social Health Insurance

SI: Social insurance

SSA: Sub-Saharan Africa

WHO: World Health Organization

WSU: Wolaita Sodo University

WTJ: Willingness to join

WTP: Willingness to pay

Chapter One: Introduction

1.1. Back-ground

Affordability of health care is a key issue in most countries. In middle- and low-income countries, ensuring affordable health care is high on the development agenda given the large numbers of people lacking sufficient financial means to access health services. Worldwide, more than 100 million people are pushed into poverty every year by the need to pay for health care (1).

In many countries, contributions for health care insurances are in some way wage related in the formal sector. The advantage of wage-related or income-related contributions is that they take into account the ability to pay of each individual, so that everybody can afford SHI. This is particularly important in countries with very unequal distribution of income (2). SHI does not merely generate additional revenues, but it also increases access and equity, and provides financial protection (3). This is a very important factor since policy objectives on improving health and reaching universal access require equitable and effective health financing arrangements affordable by all population segments.

Even if the potential benefit of health insurance is seen, there is no utility in insurance if formal sector workers have no geographical access to health facilities that are accredited by a health insurance. Similarly, the non-availability of quality health care services (including lack of drugs and other quality deficits) negatively affects demand for health insurance (3).

There are some challenges those countries face in the process of developing and delivering effective SHI mechanisms such as, lack of political will and commitment due to low awareness about SHI, poor regulatory and coordinating mechanisms, limited knowledge, skills, information and experience sharing are common issues that need to be addressed effectively (4).

SHI has more become mandatory for all people working in the formal sector in Ethiopia. Expansion of the scheme will be through a step-by-step process. It will start with the civil servants, government officials, police, public servants, politicians and pensioners; and then will expand to private enterprise employees and people working in private organizations (5).

Social health protection systems are mechanisms that countries use to address the challenges related to providing access to health care services to their citizens, especially to those poor segments of the population. The benefits of extending social protection in health include reducing financial barriers associated with access to health care services and protection from financial catastrophe and impoverishment related to health care expenditures (6). One of the categories of social health protection systems is the social health insurance (SHI), which is a financing scheme where monies are pooled into a common fund and used for paying for healthcare costs of members (6). SHI pools low- and high-risk people, avoids adverse selection and people's failure to address risks, and allows enrollees to contribute based on their ability to pay (7).

SHI establishment has been advocated by the World Health Organization as a key to achieving universal coverage of health care and to protect access to health services, particularly for the disadvantaged in less developed countries (8).

In developing countries, protection under classical social security schemes is limited. In Africa, for example, estimates indicate that only 4.8 % of the population is protected by classical social security schemes (9). Those covered consist mainly of people with stable employment in the urban sector and an insignificant minority of rural wage earners (9). However, social protection which includes insurance against the risks of ill health is an important element of poverty prevention and reduction. SHI for all is thus a step towards achieving the first of the Millennium Development Goal (10).

In Ethiopia SHI will be financed through payroll/pension contributions made by employers and employees; where contribution will be based on members' level of income and will be a fixed rate of their salary (11).

In the absence of real world experience, economists gauge the willingness to pay (WTP) for health insurance in low income countries by means of contingent valuation (CV) methods which elicit directly what individuals would be willing to pay for a hypothetical health insurance package (12).

Willingness to pay (WTP) is used to estimate utility in monetary terms. Economic theory tends to indicate that the maximum amount of money an individual is willing to pay for a commodity or service is an indicator of the utility or satisfaction by a consumer to that

particular commodity or service (12). Recently WTP studies have been carried out in the various fields of health. However, there have been relatively few WTP studies in developing countries, especially in the area of health insurance (13).

Contingent valuation (CV) is a survey method to elicit the maximum WTP for a good. First, the good and a hypothetical market in which the good can be bought are described to the respondent (the contingency). The respondent is then asked to state the maximum amount s/he would be willing to pay for the good (the valuation) (14).

A range of technique have been developed to ensure that this process is more accurate, that the respondents answer is rational and realistic and more likely to reflect what they would pay if given real chance to contribute towards a particular service. There are essentially five elicitation methods including the direct open ended question method, the iterative bidding game, payment cards, take it or leave it (referendum voting) technique and the contingent ranking technique (12). From all WTP elicitation technique, it has been suggested to use binary choice questions in a bidding game, as this format, out of all existing contingent techniques, simulates the normal price taking behavior of the local markets in many low-income countries (15).

In Ethiopia, teachers form amongst the largest category of formal employees. They form a key and wide social network in the country that easily influences people's opinions about government policy. Through their students, teachers have access to the community. They have access to current and future generations through their teaching. And it is important that the government gains their support for the policy through educating them on the content of the policy, its operations and implications, because it has significant effect not only on their access to health care but also on their take-home salary.

1.2. Statement of the problem

In many developing countries lack of adequate health care budgets is a severe problem. Innovative ways to raise funds for the provision of health services are often sought. However, raising health care tariffs is not an adequate response to the increasing costs of health care (16). Lower in-come groups unlike medium and higher income groups, lack

the ability to pay and are more sensitive to price changes in health care services. Developing risk sharing mechanisms, such as the provision of health care insurance can shield individuals from some of the cost of health care (16).

The important feature of health insurance is that it does not put the whole financing burden on government, but instead spread the total cost of insured health care among various partners (17). This may partly explain why government policymakers nowadays seem to have a greater interest in health insurance (17). Indeed Cost sharing between beneficiaries and government in the health sector is critical to achieve universal health care coverage and social health insurance is one of the sustainable health care financing mechanisms which enhance equitable access to improved health services by principle of cost sharing.

Major policy issue in developing countries is lack of formal health insurance markets. Popular approach to this problem is a form of mandated social insurance (SI) that finances medical care through compulsory payroll taxes and allows beneficiaries to purchase medical care from both private and public providers. However, the movement towards this form of SI has been motivated not only out of the desire to expand insurance coverage, but also to reduce financial pressure on public budgets (18).

Good health status is imperative for the good life, wellbeing and development of nations. If workers are not healthier, cannot do their jobs properly and in fact, this situation will affect the whole family even more if no social insurance is in place (19). A possible solution for many developing countries and countries in transition is to set up a health insurance scheme financed on the principle of solidarity (20). Looking for ways of properly and effectively financing health care is one of the most important preoccupations of governments everywhere. Even-though this problem affects both developed and poor countries and it is more acute in developing countries since they cannot collect as high a proportion of their gross domestic product in taxes (21).

Developed countries often use SHI to mobilize funds and pool risks. However, low and middle-income countries rarely use this approach and rely mostly on general revenues and direct out-of-pocket payments as sources of health care financing (7). But the escalating health care costs, inadequate tax revenues and the unsustainable donor funding have alerted governments of developing countries to the fact that their health sectors need

money from sources other than conventional financing sources. Moreover, the single largest source of financing for health services is out-of-pocket payments, which exceed 25 % of total health care expenditure in more than 75 % of sub-Saharan countries (22).

Similarly health financing has been a major challenge for Ethiopia. In Ethiopia, the coverage with formal health insurance is very minimal, representing only 0.02 % to 0.03 % of the total population between 1997 and 1998 (23), similarly as of 2008, only 1.1 % of Ethiopians had any kind of insurance and the government spends 1 % of its health expenditure on insurance activities (24).

It is currently estimated that the overall expenditure for health in Ethiopia is about US\$ 5 to 7.5 per person per year and is much less compared to the \$34 per capita recommended by the Commission for Macro Economics and Health (22, 25). This includes government, donors, employers and out of- pocket expenditure. The Ministry of Health estimates that the total government public health expenditure, in 2004, was 910,588,000 ETB, which makes about 12.8 ETB (about US \$ 1) per person per year (25). Correspondingly, the average Ethiopian household spent only 0.9 % of the total household expenditure on medical and health care (26).

In order to address this problem & create equitable financing mechanism, the government of Ethiopia is currently undertaking a number of activities to introduce social health insurance with the overall objective of achieving universal access. During the initial three years starting from 2011/12, the SHI scheme is expected to cover about 7.77 % of the population (6.36 million), and with the inclusion of the private sector, at the end of HSDP IV, it will cover 10.46 % (9.24 million) of the population and the resources to be generated will reach USD of 77.058 million per annum (5).

However, this poses a number of questions: are individuals willing to join and pay for health insurance and if so, how much? What factors determine their willingness to pay? Does the average individuals willingness to pay match or exceed the cost of their health care? To answer these questions it is important to understand the demand for health care services and health insurance (16). So, WTP studies for SHI assist policy makers to determine premiums in a more accurate way and empirically evidence the determinants for WTJ and WTP for SHI. Therefore, this study is to assess the willingness to join and

pay for SHI among teachers in government educational institutions in Sodo town, Wolaita Zone, South Ethiopia.

Chapter Two: Literature Review

In a recent study of quality of life in developing countries, income and social security have been treated as one of the major indicators of quality of life (27). This standpoint stresses the significance of insurance to human life. SHI was found to be a promising new tool for health system improvement among populations in low-income countries, particularly Sub-Saharan Africa (28). Ironically, however, insurance services seem not to have been so accepted enthusiastically in developing countries in general and SSA region in particular (27).

Most formal social security schemes are usually tied to formal employment, with contributions shared between employer and employee and the benefits are accessible to the employee and his/her immediate family. However, in Africa the number of people in formal employment being very small, this has limited the use of social health insurance as a significant financing mechanism. Instead, community health insurance schemes have thrived better (27). Social health insurance is undoubtedly a viable financing option as it serves not only to ensure equity and quality, but also increases economic accessibility to health care services by the population (29).

2.1. Socio demographic determinants

A Contingent valuation studies conducted in different parts of India and China in 2006 and 2007 respectively reported that age, sex and education significantly influenced willingness to pay for SHI. Where, individuals with junior high education are 1.37–1.45 times more likely to join the SHI than with illiteracy education status (14, 30).

In Africa studies conducted in Burkinafaso and Ghana during 2009 and 2002 respectively reported a number of reasons and factors which were responsible for low level of willingness to participate in social health insurance and pay premium which include factors such as being a female, older age and low level of education (31, 32). A similar study in Tanzania and Ecuador in 2003 and 2011 respectively also reported that willingness to pay for health insurance were lower among females and the elderly than males and young persons and less formal education was significantly associated with a higher willingness to join (33, 34).

A study on determinants of health insurance ownership among South African women in 2005 reported that household size variable had a statistically significant negative effect on

the willingness to join for SHI and as age increases the willingness to pay for health insurance increase significantly (35).

Furthermore the study on economic value of willingness to join and pay for community based prepayment scheme in rural Cameron in 2011 reported that age, religion and sex as key determinants of willingness to pay (36). Another cross sectional evidence on demand for health insurance among women in Ghana during 2009 reported that marital status, age and religion were the most significant determinants for willingness to pay for health insurance (37). The effects of demographic and economic factors such as age, marital status, employment and gender on health insurance have been variously studied. Married respondents are more likely to take insurance coverage (38, 39). And those employed are also more likely to undertake coverage (40, 41).

In Ethiopia a community based cross-sectional study conducted in Jimma city, southwest Ethiopia on indigenous community insurance (Iddirs) as an alternative health care financing in 2009 reported that the WTJ the scheme showed progressive increment with educational status, where individuals in tertiary educational level were 4.5 times more likely WTJ as compared to illiterates (OR= 4.565, 95% CI: 1.808, 11.524) (42).

2.2. Socioeconomic Determinants

A study conducted on willingness to pay for SHI in Wuhan China in 2007 reported that income and employment status significantly influenced the willingness to pay (14). A similar study in China during 2006 reported that 50 % of rural dwellers were willing to participate in SHI and among these less people were willing to pay a premium and higher willingness to pay value were associated with higher income level that is individual who own luxury asset are 1.37–1.66 times more likely to join the SHI than those who do not own luxury asset (30). A study asked the heads of 1000 households in a rural area of India in 1998 reported that compared to the low-income group the middle and high-income groups had a significantly higher rate of willingness to enroll and higher WTP for health insurance (43). Similar studies conducted in different parts of African countries at different time reported income level, access to TV and news paper and social capital as key determinants of willingness to pay for SHI (31, 32, 44, and 45).

Another WTP study conducted in Sengerema district in northwestern Tanzania in 2005 reported that factors such as level of salary, business income and other monetary sources of

income such as sales of crops, animals or any commodity influence community's willingness to pay (46). Indeed low-income households may therefore initially be reluctant to join insurance schemes because they do not readily like the idea of 'paying' for services they might not use (47).

Furthermore demands for health insurance were also determined by the ability to pay membership contributions. Lack of money was indeed a major reason why many do not join (48). And as expenditure studies show, higher-income quintiles are more likely to be covered by insurance (49).

2.3. Health status and health care utilization

A recent study from Mexico analyzed the relationship between health insurance coverage and use of preventive health care services, which the result showed that the detection of disease and the treatment in relatively early stage is more likely among the insured than among the non insured (50).

Study conducted in rural area of India reported that variables such as health condition, number of hospital episodes and number of working days lost due to ill health as significant determinants of willingness to join and pay for proposed SHI scheme. People who were sick have 296 % higher chance of willingness to join but only 172 % higher willingness to pay for proposed scheme compared to people registering no illness at that time (43). Thus the probability of willingness to pay for rural SHI scheme were found to be less than the probability of willingness to join, which means there is significance difference between willingness to join and willingness to pay for the same scheme (43).

A study on social health protection in Vietnam in 2005 found that a reduction of out-of-pocket payments leads to a higher than average increase in consumption, indicating with the hypothesis that households tend to considerably hold back consumption when faced with the risk of high out of pocket expenditures (51). Furthermore a study conducted in rural Cameron in 2011 showed that the usual means of seeking treatment when the rural population gate sick as key determinants of willingness to pay for social health insurance (36). A study on teachers' expectations from the SHI scheme in Ghana during 2009 revealed that 70.5 % expect the scheme to cover both in-patient and out-patient services while 8.5 % expect in-patient services only, 5.6 % expect out-patient services only and 2.1

% expect other services like costs of transport, costs of the coffin and burial expenses to be covered (52).

And moreover Availability of quality health care significantly influenced the willingness to pay for health insurance (53).

2.4. Exposure and perception regarding Insurance

A Study done on the assessment of health insurance needs and awareness in Bahraich district, Uttar Pradesh in 2008 reported that 20.2 % of the respondents did not believe that insurance is similar to monthly thrift/savings, 31.9 % think insurance is an amount you pay to get some compensation if something bad happens and 38 % of the respondents reported that they have ever heard of health insurance and have seen someone buying or taking some kind of insurance instrument, highlighting the first level of awareness about the health insurance (54).

Study on SHI in Nigeria during 2005 reported that high level of awareness and willingness to participate and pay a premium are undoubtedly some of the prerequisite factor, which could contribute to a successful social insurance scheme (51).

A similar study conducted in Kenya in 2008 reported that absence of risk management alternatives, understanding and perception of insurance rationale, credibility and trust in fund management, knowledge and awareness of health insurance were significantly influenced the willingness to pay (53).

A study conducted in Taiwan in 2002 reported that education and knowledge about the advantage of making regular small insurance payments to avoid the risk of catastrophic medical expenditures were significantly influenced willingness to join (39).

2.5. Past health expenditure

The effect of past health expenditure on health insurance have been studied and higher willingness to join and pay for health insurance were associated with higher previous medical expenditure and knowledge of true hospital costs (14, 53, 27)

A demand study conducted in Ghana in 2007 reported that the value attached to and demand for health insurance is influenced by knowledge of the full costs of health care and experience or knowledge of how and when health care costs become 'catastrophic'. That is health insurance would have diminishing marginal utility for someone who underestimates

the high costs of inpatient care and also the likelihood of high-risk events by comparison with someone who is fully aware of the high cost of inpatient care and whose demand would therefore be higher (55).

Moreover the concern to the medical expense is also positively associated with the WTJ the SHI. Individuals who were in the very worry bracket are 1.60–2.51 times more likely to join the SHI than those who are not worried about medical expenditure (32).

2.6. Willingness to Join and pay for Social health insurance

A willingness to pay study in Kampala district, Uganda in 2009 reported that 41.2 % of the respondents were willing to contribute for the proposed Social Health Insurance scheme and 36.6 % preferred to contribute through payroll deductions off them, thirty eight percent were willing to contribute less than 4 % of their salary and 16.3 % were willing to contribute 4 % of their salary as has been proposed by the government (52).

A valuation method study to assess willingness of individuals from the working sector in Accra, Ghana, to join and pay for proposed SHI, showed that over 97% of the respondent agreed to join the scheme and 62.8% were willing to contribute 2% of their income as premium (32).

A cross-sectional study conducted in Nigeria in 2010 reported that 83.9 % of the respondents expressed their willingness to participate in a SHI scheme; whereas 76.6% were willing to pay a premium (56).

Another study in India reported that 50% of rural dwellers were willing to participate in SHI, and among these, less people were willing to pay a premium (43).

Moreover feasibility assessment and financial projection results for a SHI Scheme in Lesotho and Swaziland reported that formal sector employees make monthly contribution payments (payroll deductions) of 5% and 7 % respectively that are shared between employees and employers (57-59).

However, the extent to which the objectives of social health insurance are achieved is dependent on a number of factors, including willingness to participate and pay a premium. For example, low level of participation was reported as a major constraint to successful implementation of social health insurance (56).

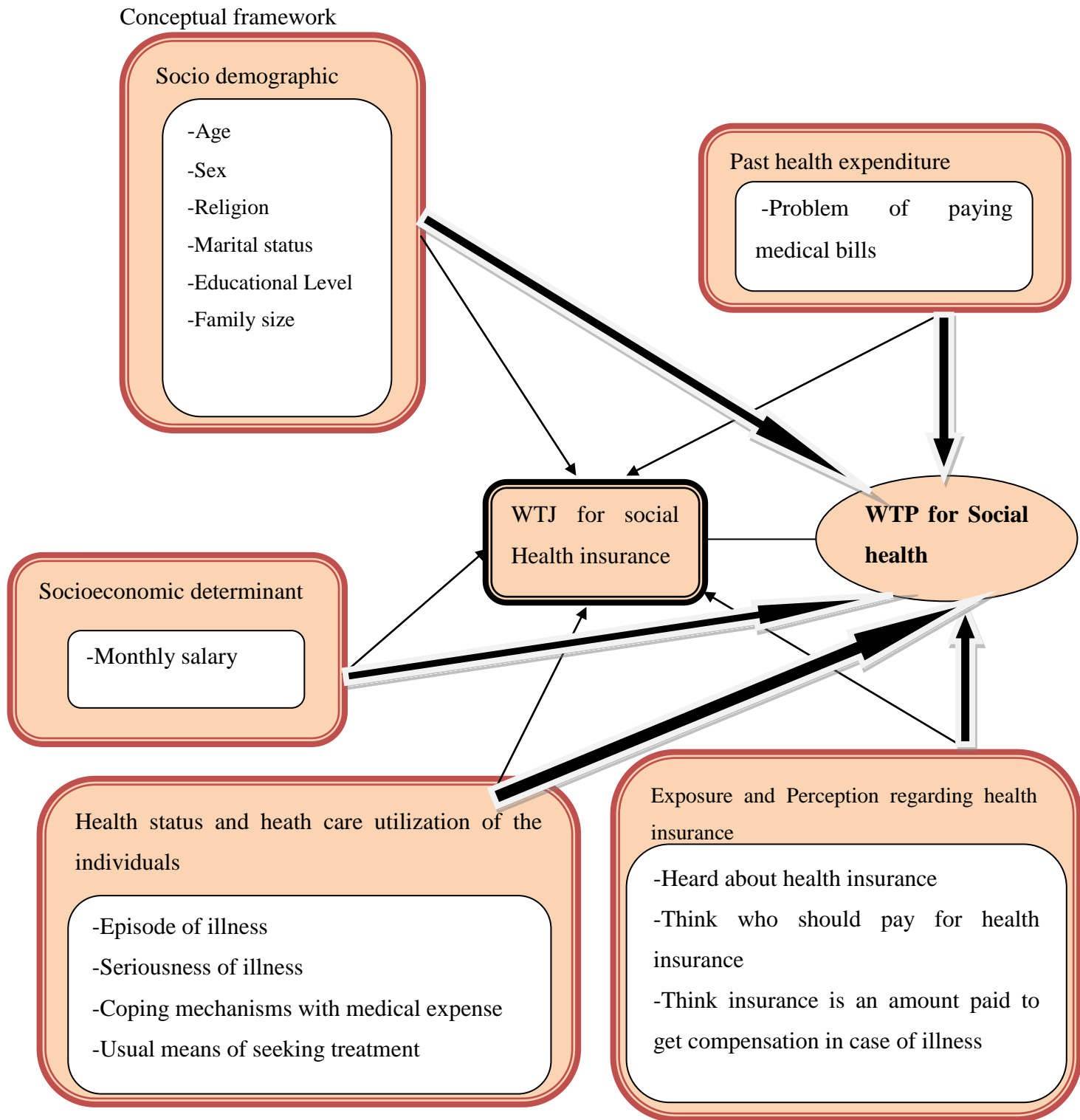


Figure 1: Conceptual framework for the assessment of willingness to join and pay for social health insurance, 2012 G.C

Chapter Three: Significance of the study

Low level of major stakeholder willingness to participate and pay was reported as a major constraint to successful implementation of sustainable social health insurance scheme. However, to the best of the authors' knowledge there was limited availability of empirical evidence on willingness to join and pay for newly proposed social health insurance scheme in Ethiopia.

Assessment of the willingness to join and pay for the scheme was to establish a planning foundation for the implementation of sustainable social health insurance scheme in the future which increase the coverage, effectiveness and efficiency of sustainable and comprehensive health care financing systems in Ethiopia. Before the Social Health Insurance Proclamation No.690 /2010 come in to force and implemented the study would gave insight to the policy maker and implementer how to support stakeholder participation and enable informed choice at the individual level as well as it provides the parameters to underpin financial models needed to evaluate expansion plans and crucial in setting equitable and sustainable tariffs.

Moreover People must be motivated to accept and pay for SHI, even in compulsory systems people have the incentive to prepay if they have the enthusiasm.

The study would also be a base line for other investigators who may interested to make further study in this area.

Chapter Four: Objectives of the study

4.1. General Objective

- To assess individual willingness to join and pay for the newly proposed social health insurance among teachers in Wolaita Sodo town government educational institutions, South Ethiopia, 2012.

4.2. Specific Objectives

1. To determine the level of willingness to join for the social health insurance
2. To measure the level of willingness to pay for social health insurance
3. To identify determinants of willingness to join for social health insurance
4. To identify determinants of willingness to pay for social health insurance

Chapter Five: Methods and Materials

5.1. Study area and period

The study was conducted in Sodo town, Wolaita Zone from February 5 to March 10 / 2012. Sodo is a town in south-central Ethiopia, which is the administrative center of the Wolaita Zone of the Southern Nations, Nationalities, and Peoples Region and it is also the administrative center of Sodo Zuriya Woreda. Sodo has a latitude and longitude of 6°54'N 37°45'E with an elevation between 1600 and 2100 meters above sea level. This town has an estimated total population of 65,737 of whom 34,069 are males and 31,668 are females. Sodo lies approximately 330km south of Addis Ababa, along the main highway that leads to Arbaminch via Hossana and 157 km away from Hawassa town. The town is serving as a junction point of five major roads networking it with different parts of the country thus making it centre of business.

The town has 12 governmental educational institutions employing a total of 1460 teachers and 9 non-governmental educational institutions.

5.2. Study design

A cross sectional study design with quantitative method was used.

5.3. Population

5.3.1. Source population

The source population for this study was all teachers in government educational institutions in Sodo town.

5.3.2. Study population

A sample of teachers in government educational institutions of Sodo town was the study population.

5.3.3. Eligibility Criteria

Inclusion Criteria

- Teachers who were currently working in government educational institution and have served for at least three months.
- Teachers who are Ethiopians by nationality.

Exclusion Criteria

- Part time teachers in government educational institutions.

5.4. Sample size and Sampling Technique

5.4.1. Sample size determination

The sample size was determined by using single population proportion formula with the following assumptions: proportion of teachers willing to pay for SHI was 50 % (p=0.5), 95 % confidence interval (Z= 1.96) and margin of error (d=0.05)

$$n = \frac{Z_{1-\alpha/2}^2}{d^2} p(1-p)$$

The sample size was 384; by using finite population correction formula and adding 10 % for potential non-response, the final sample size was 335.

5.4.2. Sampling technique

A stratified simple random sampling technique was employed to select study subjects. The total 12 government teaching institutions found in the town were stratified based on educational level in to primary level (1-8), secondary level (9-12) and higher educational institution (universities and colleges). The total sample was proportionally allocated to each of the stratum based on the number of teachers in each stratum. The sampling frame for each stratum was made by merging the list of teachers and samples were selected from each stratum using simple random sampling technique.

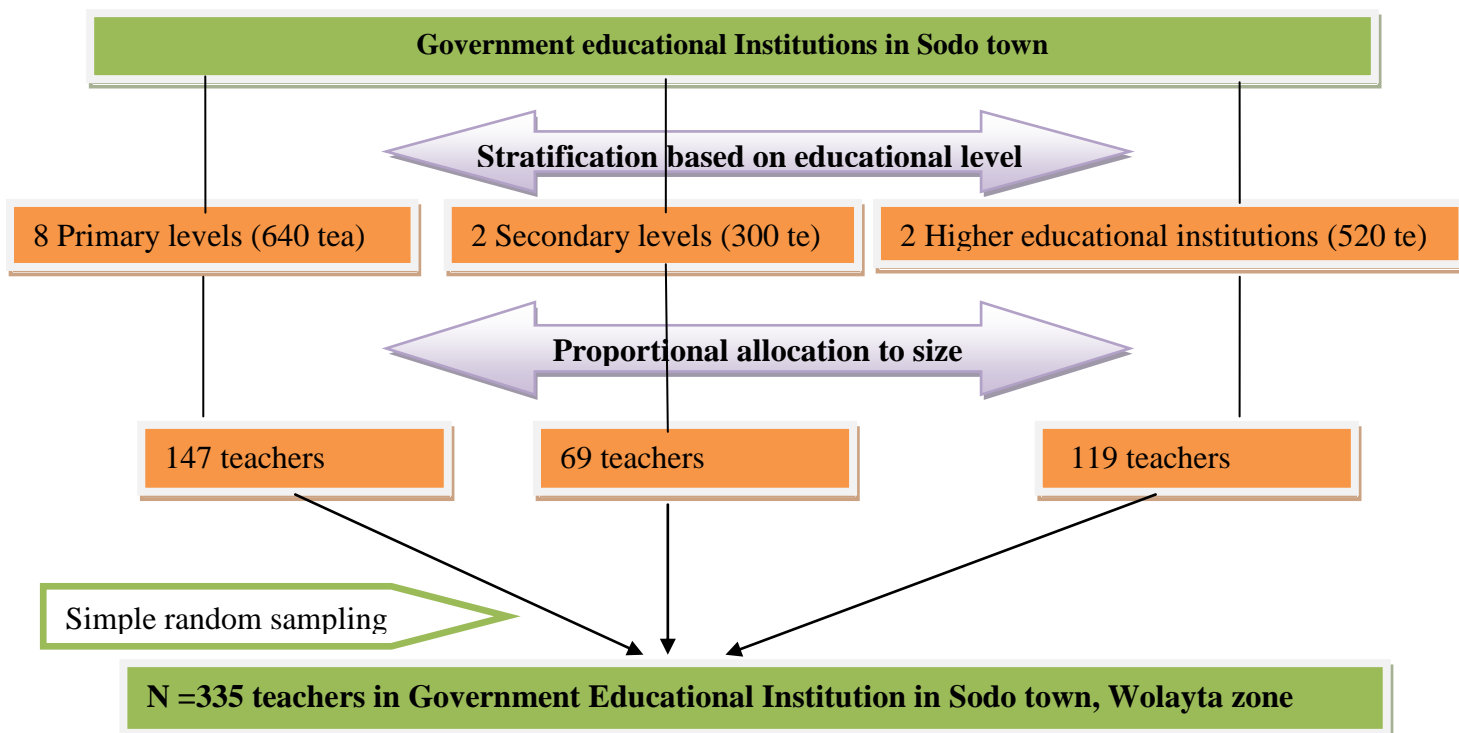


Figure 2: Schematic presentation of the sampling procedure for selecting study subjects from government educational institutions of Wolaita Sodo town, South Ethiopia, February-March 2012 G.C

5.5. Data collection tools and procedures

5.5.1. Data collection instrument

The Data were collected using structured questionnaire adapted from different studies (32, 52, 54, 56 and, 58) and have been modified to fit the local context. The questionnaire sought information on socio demographic, individual characteristics of the respondents and the willingness to pay. The questionnaires were translated into Amharic and back translated into English to check for consistency.

5.5.2. Personnel recruitment and training

Ten data collectors, who were College graduates in health science and two supervisors who were first degree holders in health sciences, were recruited. Training was given once the draft questionnaire was completed through pre-testing. The training included basic objectives of the survey, contingent valuation methodology, background to social health insurance, familiarization of the questionnaire, training in conducting random sampling, emphasizing the importance and method for ensuring that the sample is as random as possible, and role playing on survey technique.

5.5.3. Data collection process

Data were collected through structured interviewer administered questionnaire. First, the interviewers described the purpose of the study and asked respondents whether they were willing to participate in the study. Then the interviewers described the intentions of social health insurance scheme proposed by the government to the study participants. Iddirs' (which are endogenous organizations established by the communities themselves to cover funeral expenses) were selected to be used as a reference point to explain social health insurance and to help respondents to visualize the new scenario (social health insurance) in the context of their personal experience and knowledge. The description included the SHI benefits (inpatient, outpatient and emergency care), as well as the payment vehicle for premium contributions (a monthly premium). The benefits as well as payment vehicle were in line with the 2010 Proclamation No. 690/2010, a proclamation to provide for social health insurance.

Respondents were asked about their maximum WTP for social health insurance when they expressed their willingness to join social health insurance. They were invited to choose a lottery ticket out of a stack of unmarked envelope. Each respondent was randomly assigned to one of two initial values; 4 % of monthly salary and 5 % of monthly salary. A maximum three trials were performed with each respondent if the respondent was not satisfied with the results of the earlier bids. If the answer was 'yes', the interviewer increased the bid by increments of 1 % until the respondent says 'no'. If the initial answer was 'no', the interviewer reduced the amount of money by 1 % and continued doing so until the respondent said yes. Open-ended question was asked if the respondents work their way up to the maximum bid or down to the lowest bid in the bidding process. The last accepted bid was then the maximum willingness to pay (60).

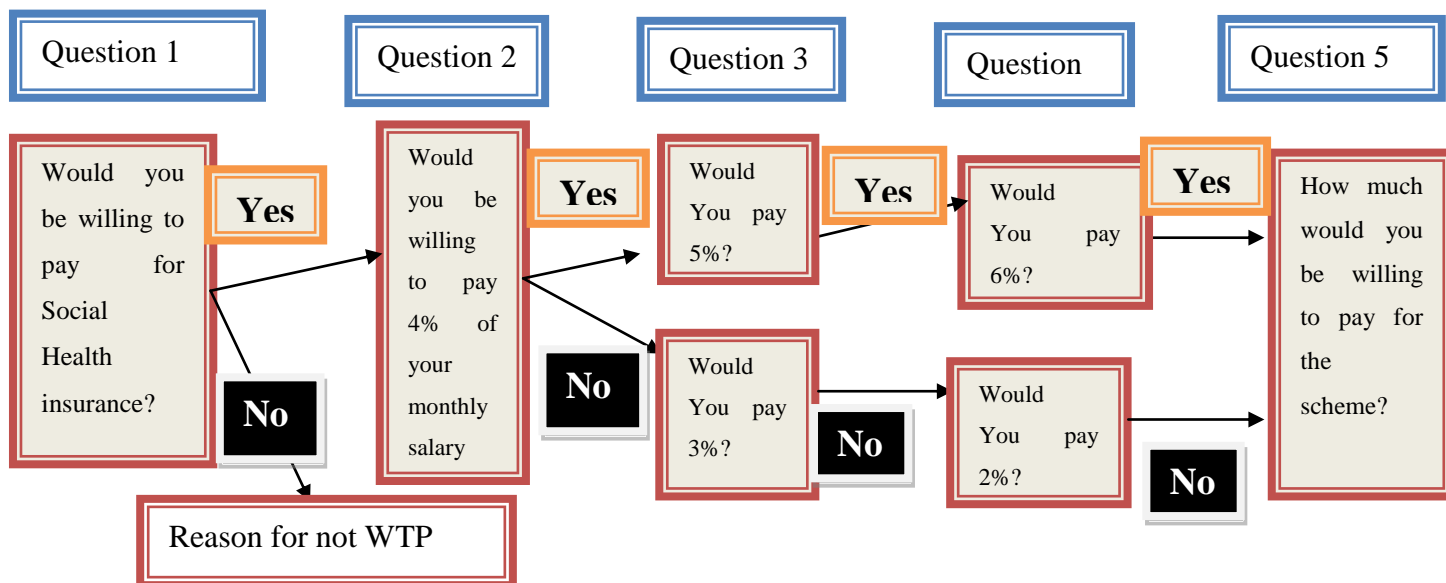


Figure 3: Schematic presentation of sequence of bidding process for willingness to pay with starting point of 4 % of monthly salary, 2012 G.C

5.6. Variables

Dependent Variable

- Willingness to join for social health insurance
- Willingness to pay for social health insurance

Independent variable

- Socio demographic (Age, sex, marital status, education level, religion, family size, service year)
- Socio economic (monthly salary)
- Health status (episode of illness)
- Health care utilization (use health institution)
- Past medical expenditure (difficulty in paying for health care)
- Exposure to health insurance (heard of health insurance)
- Perception regarding health insurance

5.7. Operational Definitions

Bidding game: Is the process whereby the respondent is presented with a price, which is increased each time the respondent accepts the bid or lowered each time the respondent rejects the bid (60).

Individual WTP: The maximum value that an individual was willing to pay for him/herself for proposed SHI scheme.

Illness or injury: Episode of illness or injury in the last two months

Use of hospital or health institution: Number of Visits to hospital/health institution in the last 2 months.

Exposure to health insurance: The awareness of individuals on the very basic construct of health insurance, heard about any health insurance scheme, whether individual have seen someone buying or selling a type of instrument such as health insurance (54).

Essential Health Services Package:

Family health: ante-natal care; delivery and newborn care; post-natal care; family planning; child health – Integrated Management of Childhood Illness (IMCI); growth monitoring and essential nutrition actions; immunization; adolescent reproductive health,

Communicable diseases: TB and leprosy; HIV/AIDS and sexually transmitted infections; epidemic diseases (including malaria surveillance), basic curative care and treatment of major chronic conditions, hygiene and environmental health (N.B. this excludes the provision of mass sanitation and water supplies, which is the responsibility of a different sector), health education and communication (61).

5.8. Data processing and analysis

The collected data were coded, entered into a database and cleaned for any inconsistencies and missing values using SPSS version 16.0 statistical software. The frequency distribution of dependent and independent variables were worked out. Bivariate analysis was carried out to determine associations of selected variables with dependent variables and p value of less than or equal to 0.25 was taken as cut-off point to candidate variables for the final multiple logistic regression models. Multiple logistic regression was applied to variables which showed significant association in the bivariate analysis to determine independent predictor variables of the outcome variables and p value of less than or equal to 0.05 and or 95 % CI was used to judge statistical significance.

5.9. Data quality control

The questionnaire was translated to Amharic and back translated to English to check for consistency and was pre-tested on 5 % of the total sample size. Opinion discussion with

teachers on government educational institutions in Gesebu town was conducted for settling starting point of the bidding game. Ten data collectors and two supervisors were recruited as well as training was given. At the end of each day, the questionnaire was checked for completeness, and consistency.

5.10. Ethical considerations

Prior to data collection, ethical clearance was obtained from health research and post graduate co-coordinator office of Jimma University. Formal letter of permission was obtained from Sodo Zuriya Woreda education office to the respective teaching institution included in the study. Finally, respondents were requested for their verbal consent to participate in the study after informing their participation was entirely based on their willingness to do so. Thereafter, a detailed explanation was given on the purpose of the study including the benefit of the study. Moreover, confidentiality was assured for the information provided by using coding system rather than stating the name of study participants. Furthermore, one page of informed consent form was attached as a cover page for each questionnaire and after respondents agree, the data collector checked at the bottom of it to show respondents' agreement before administering the questions.

5.11. Dissemination plan

The results will be presented to Jimma University scientific community. After approval by the University, it can also be communicated to health policy makers and Implementers at regional and national level. Publication in peer reviewed, national or international journals will also be considered.

Chapter Six: Results

6.1. Socio-demographic characteristics of respondents

A total of 328 teachers from government educational institutions participated in the study with response rate of 98%. Of them, 147 (44.8%), 69 (21.1%) and 112 (34.1%) were from primary level, secondary level and higher educational institution, respectively. Two hundred thirty four (71.3%) of the teachers in government educational institutions were male. The median age was 33 (SD \pm 10.29) years. Two hundred five (62.5%) were married followed by never married with 118 (36%).

Two hundred fifty three (77.1 %) of the teachers had service year of greater than two years. One hundred forty (42.7%) of the teachers held bachelor degree whereas 128 (39 %) had college diploma. More than half of the respondents were protestant followed by orthodox Christians 110 (33.5 %). The median family size was 4 (SD \pm 2.49)

One hundred thirty six (41.5 %) of the respondents had monthly salary between 1401 and 2350 ETB followed by between 2351 and 3550 ETB with 131 (39.9 %). Moreover, the median monthly salary was 2351 ETB (SD \pm 928.874).

Table 1: Selected socio-demographic characteristics of teachers in government educational institutions of Wolaita Sodo town, South Ethiopia, February-March 2012 (N=328)

Characteristics	Response	Primary level No (%)	Secondary level No (%)	Higher educational institution No (%)	Total No (%)
Sex					
	Male	79 (53.7 %)	52 (75.4 %)	103 (92.0 %)	234 (71.3 %)
	Female	68 (46.3 %)	17 (24.6 %)	9	94 (28.7 %)
Educational status					
	Diploma	119 (81.0 %)	6	3	128 (39.0 %)
	Bachelor degree	19 (12.9 %)	63 (91.3 %)	58 (51.8 %)	140 (42.7 %)
	Masters degree	0	0	50 (44.6 %)	50 (25.2 %)
	PhD	0	0	1	1
	TTI (Certificate)	9	0	0	9
Marital status					
	Never married	13 (8.8 %)	21 (30.4 %)	84 (75.0 %)	118 (36.0 %)
	Currently married	130 (88.4 %)	47 (68.1 %)	28 (25.0 %)	205 (62.5 %)
	Divorced/separated	2	0	0	2
	Widows	2	1	0	3
Ethnicity					
	Wolaita	90 (61.2 %)	54 (78.3 %)	34 (30.4 %)	178 (54.3 %)
	Amhara	42 (28.6 %)	6	34 (30.4 %)	82 (25.0 %)
	Oromo	11 (7.5 %)	2	16 (14.3 %)	29 (8.8 %)
	Tigre	1	1	14 (12.5 %)	16 (4.9 %)
	Gamo	2	1	9 (7.5 %)	12 (3.6 %)
	Others ^a	3	3	5	11(3.4 %)
Age category					
	≤ 25	5	14 (20.3 %)	55 (49.1 %)	74 (22.6 %)
	26 to 35	41 (27.9 %)	24 (34.8 %)	51 (45.5 %)	116 (35.4 %)
	36 to 45	50 (34.0 %)	16 (23.2 %)	5	71 (21.6 %)
	>= 46	51 (34.7 %)	15 (21.7 %)	1	67 (20.4 %)

¹NB: ^a; Gurage, Dawro

6.2. Health status and health care utilization

Out of the total 328 teachers, 129 (39.3 %) had at least one episode of illness over the past two months preceding the survey. Of which, more than three fourth (79.2 %) were with episodes of illness one to two. Furthermore 90 (69.2 %) responded that the illness episodes were not serious, whereas 31 (23.9 %), and 6 responded that their illness were quite serious, and very serious respectively. Meanwhile, half of them visited private health facilities to seek care. Of those who experienced at least one episode of illness, 113 (87.6 %) reported use of out of pocket money to cope with the payment for medical care.

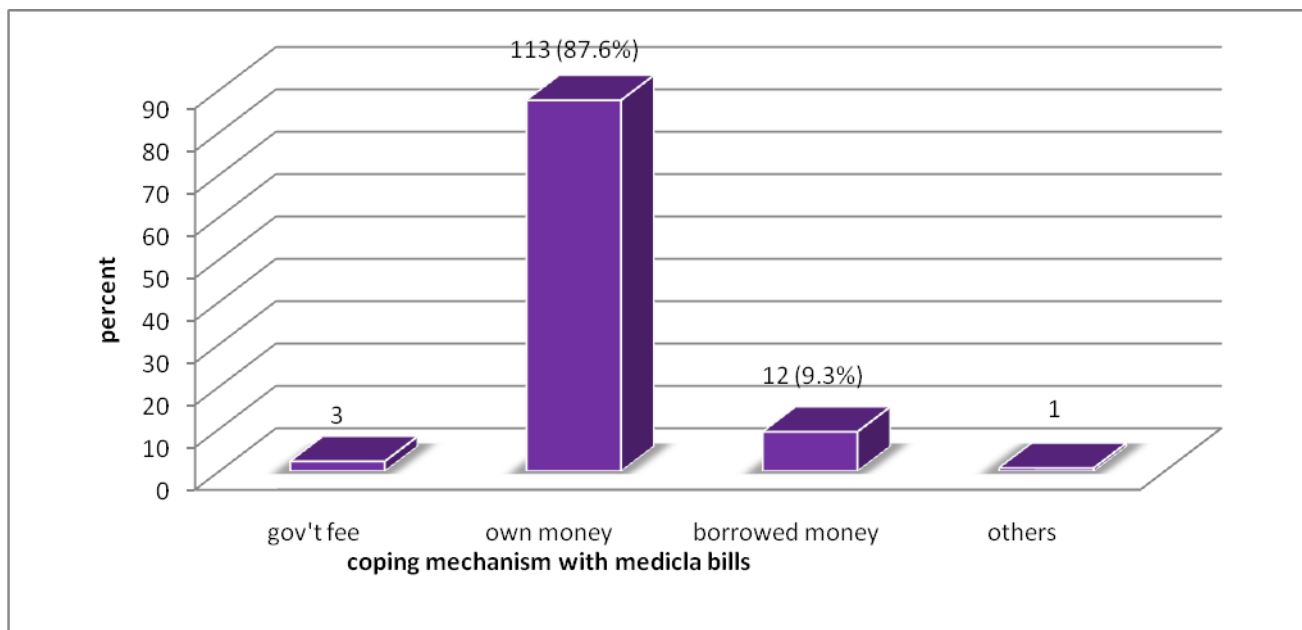


Figure 4: Coping mechanisms with medical expense of the teachers in government educational institutions of Wolaita Sodo town, South Ethiopia, February-March 2012 (N=129)

6.3. Past health expenditure

Out of the total 328 teachers, 86 (26.2 %) faced problem of paying medical bills over the past 12 months. Two hundred thirty three (71.0 %) of the teachers reported that they are not at all confident to afford the health care needs if they would be ill in the future.

Table 2: Problem of paying medical bills and ability to afford the care needed for teachers in government educational institutions of Wolaita Sodo town, South Ethiopia, February-March 2012 (N=328)

Variables	Response	Number	Percent
Problem of paying medical bills			
	yes	86	26.2
	No	232	70.6
	Don't know	10	
Confidence on future ability to pay			
	Very confident	17	5.2
	Confident	44	13.4
	Not at all confident	233	71.0
	Don't know	34	10.4

6.4. Perceptions about health insurance scheme

More than half (55.2 %) of teachers in this study have never heard of health insurance scheme. More specifically, 100 (68.0 %) of primary level, 49 (71.0 %) of secondary level and 32 (28.6 %) of higher educational institution teachers have never heard of health insurance schemes earlier. One hundred thirty three (40.5 %) of the respondents perceived that the payment for insurance is shared between individuals, employers and the government jointly, whereas 83 (25.3 %), 37 (11.3 %) and 33 (10.1 %) perceived that government, employers and individuals alone should pay for insurance, respectively.

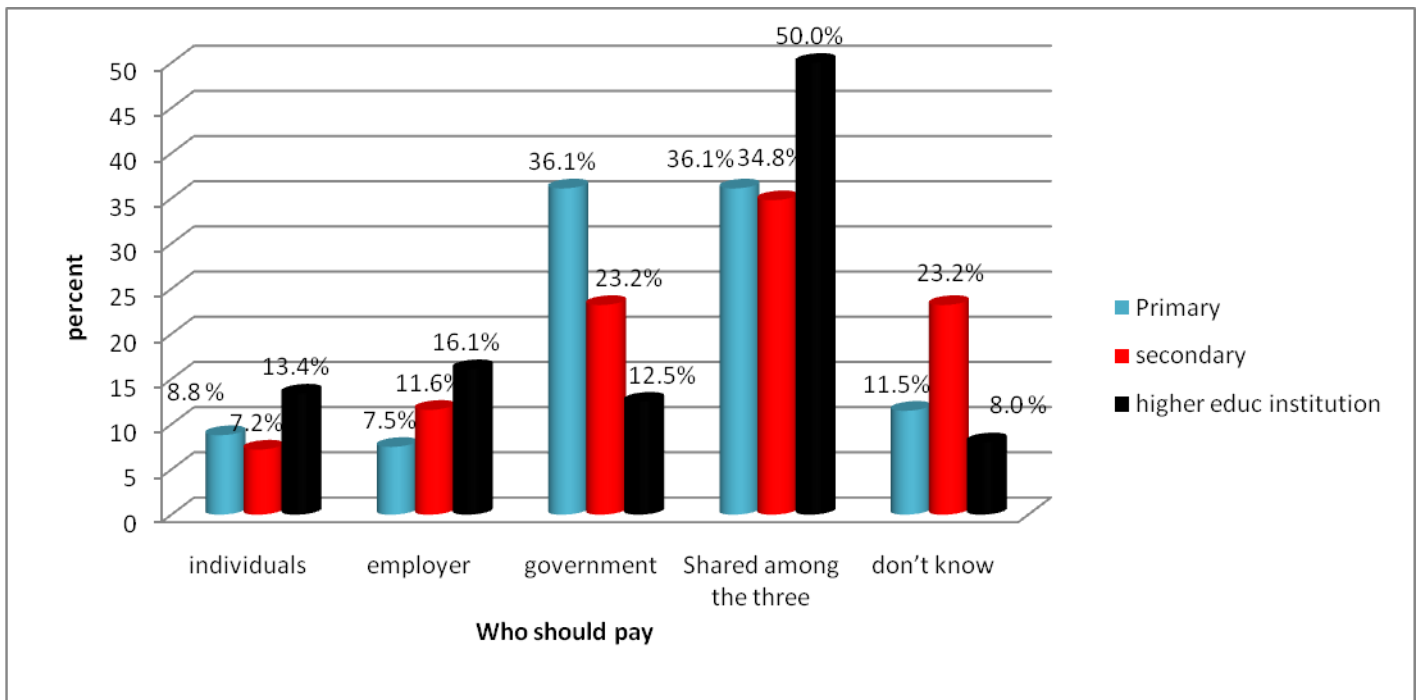


Figure 5: The perception who should pay for insurance within educational level among teachers in government educational institutions at Wolaita Sodo town, South Ethiopia, Februray-March 2012 (N= 328)

One hundred ninety two (58.5%) of the teachers in government educational institutions thought that insurance was an amount paid to get compensation if something bad happens, with 83 (43.2%), 72 (37.5%) and 37 (19.3%) from primary level, higher educational institution and secondary level, respectively.

More than half of the teachers (62.2 %) did not believe that insurance is similar to monthly saving.

6.5 Willingness to join and pay for social health insurance

Two hundred thirty four (71.3 %) of the teachers were willing to join the proposed social health insurance scheme with 41.5 % in higher educational institution, 37.6 % in primary level, and 20.9 % in secondary level.

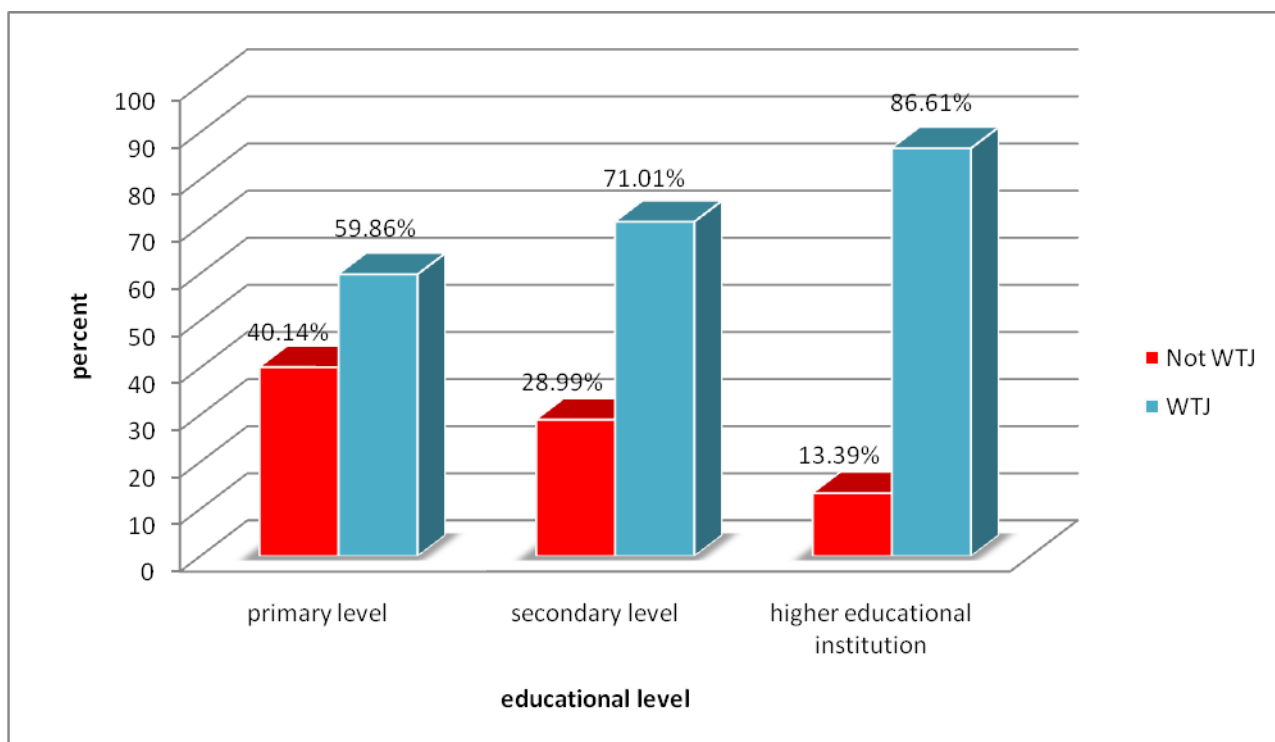


Figure 6: Willingness to join social health insurance among teachers in government educational institution of Wolaita Sodo town, South Ethiopia, February-March 2012 (N=328)

The two most commonly stated reasons for not willing to join the proposed social health insurance scheme were fear of poor implementation and that the scheme might not cover all needed services for 65 (69.1%) and 25 (26.6%) of teachers respectively.

Table 3: The reasons for not willing to join the proposed social health insurance scheme among teachers in government educational institutions of Wolaita Sodo town, South Ethiopia, February- March 2012 (N= 94)

Variable	Response	Number	Percent
Reason for not willing to join			
	Always in good health	3	
	The scheme does not cover needed	25	26.6
	Poor implementation	64	68.1
	Don't know	2	

Out of the 234 teachers who were willing to join the proposed social health insurance scheme, 174 (74.4 %) were willing to pay from their monthly salary for the scheme. This was true for 51.2 % from higher educational institution, 26.4 % from primary level and 22.4 % from secondary level.

Out of 174 teachers who were willing to pay, 47.1 % of them were willing to contribute greater than or equal 4 % of their monthly salary.

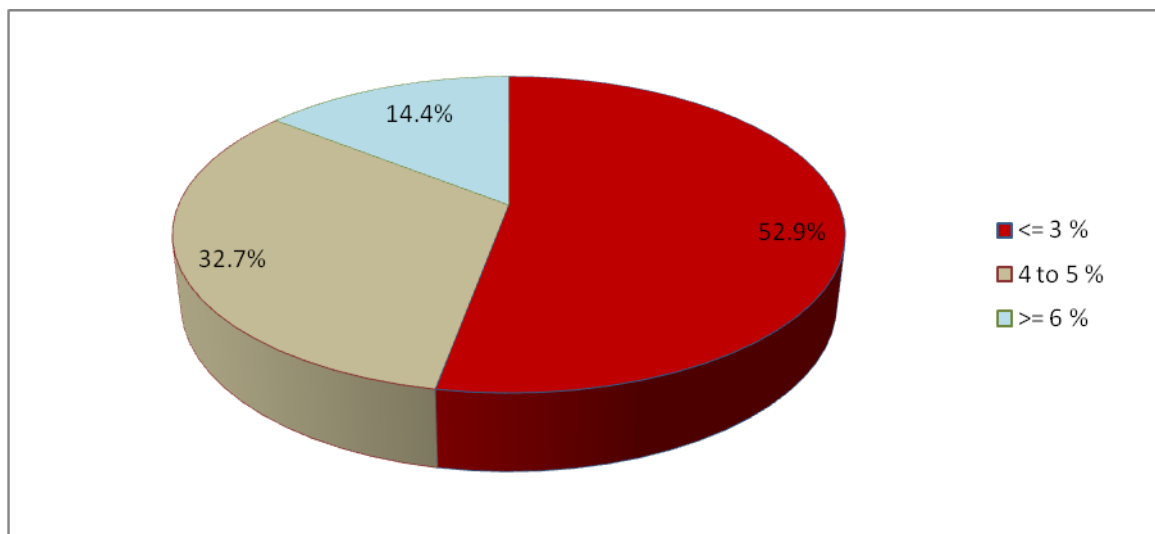


Figure 7: Willingness to pay for social health insurance in percentage of monthly salary of the teachers in government educational institutions of Wolaita Sodo town, South Ethiopia, February-March 2012 (N= 174)

The median WTP was 81.66 (± 59.653) ETB or (4.66 US \$) per person per month and WTP per person per year reached 979.92 ETB or (US\$ 55.99).

Table 4: Descriptive statistics of willingness to pay per person per month for social health insurance among teachers in government educational institutions of Wolaita Sodo town, South Ethiopia, February-March 2012 (N = 174)

statistics	ETB	US\$
Minimum	12	0.69
Mean	98.36	5.62
Median	81.66	4.66
Mode	134	7.66
Standard deviation	59.65	3.41
Maximum	306	17.49

NB: 1 US\$ = 17.5 ETB

About one fourth of the respondents stated that they would not be willing to pay anything, although they would be willing to join the social health insurance scheme. Out of 60 teachers who were not willing to pay 35 (58.3 %), 17 (28.3) and 8 (13.3 %) stated it was the government's responsibility to finance the programme, out of pocket payment is better and contribution being nonrefundable respectively as reason for not willing to pay.

6.6. Factors affecting willingness to join and pay for social health insurance

6.6.1. Predictors of willingness to join for SHI

Different socio-demographic and health insurance related variables were entered in stepwise regression. As can be seen in (Table 6) below, males were 2 times more likely to be willing to join than females, this was statistically significant even after controlling for possible confounders like age, marital status, educational level (AOR = 2.445, 95% CI. 1.096, 5.450).

Marital status was also found to be significantly associated with willingness to join social health insurance. Married respondents were 21 times more likely to be willing to join as compared to never married (AOR = 21.507, 95 % CI. 9.159, 50.505).

The educational status of the respondents was also found to be predictor of willingness to join. Those who had masters degree were 3 times more likely to be willing to join as compared to those teachers who had first degree (AOR = 3.120, 95 % CI. 1.113, 10.670).

Teachers who heard about health insurance scheme were 24 times more likely to be willing to join the SHI scheme as compared to those teachers who have never heard about health insurance scheme (AOR = 24.185, 95 % CI. 9.982, 58.593).

Furthermore number of service year was also found to have significant association with willingness to join. Accordingly, teachers who had one to two years service were 4 times more likely to be willing to join the SHI scheme as compared to those who served for more than two years (AOR = 4.305, 95 % CI. 1.525, 12.158).

It was found that respondents who experienced problem of paying medical bill over the past 12 months preceding the survey were 3 times more likely to be willing to join the SHI scheme as compared to those who didn't (AOR = 2.831, 95 % CI.1.219, 6.572).

Other socio-demographic characteristics, health status and health insurance related factors like age, working in higher educational institution, having lesser family size, having at least one episode of illness over the past two months, the thought that insurance is an amount paid to get compensation if something bad happens and the perception that insurance premium should be shared among individuals, employers and government were found to be significantly associated with willing to join but the association does not persist after controlling for potential confounders like educational status, sex, age and the like.

Table 5: Logistic regression analysis of predictors of willingness to join social health insurance scheme among teachers in government educational institutions of Wolaita Sodo town, South Ethiopia, February-March 2012 (N = 328)

Variables	WTJ SHI		COR (95 % CI)	AOR (95 % CI)
	yes	No		
Sex				
Females (ref)	59	35	1	1
Males	175	59	1.760 (1.055,2.935)*	2.445 (1.096, 5.450)***
Marital status				
Single (ref)	135	70	1	1
Married	96	22	6.338 (3.345, 12.011)*	21.507 (9.159, 50.505)***
Divorced	2	0		
Widow	1	2		
Educational status				
First degree (ref)	107	33	1	1
Diploma	76	52	0.451 (0.266, 0.763)*	0.932 (0.435, 1.995)
Masters	44	6	2.262 (0.855, 5.778)*	3.120 (1.113, 10.670)***
PhD	1	0		
TTI (certificate)	6	3		
Family size				
≤ 4 (ref)	160	53	1	1
>= 5	74	41	0.598 (0.366, 0.978)*	0.626 (0.295, 1.328)
Service year				
> 2 year (ref)	168	85		
< 1 year	26	1	13.155 (1.775, 98.598)*	14.231 (0.752, 57.981)
1 to 2 year	40	8	2.530 (1.134, 5.645)*	4.305 (1.525, 2.158)***

Table 5: Logistic regression analysis of predictors of willingness to join social health insurance scheme among teachers in government educational institutions of Wolaita Sodo town, South Ethiopia, February-March 2012 continued (N = 328)

Variables	WTJ SHI		COR (95 % CI)	AOR (95 % CI)
	yes	No		
Age				
≤ 25 (ref)	65	9	1	1
26 to 35	92	24	0.531 (0.232, 1.216)*	0.750 (0.224, 2.360)
36 to 45	34	37	0.127 (0.055, 0.294)*	0.586 (0.150, 2.295)
>= 46	43	24	0.248 (0.105, 0.585)*	0.989 (0.226, 4.321)
Episode of illness				
No (ref)	133	65	1	1
Yes	101	29	1.702 (1.024, 2.830)*	0.943 (0.417, 2.132)
Problem of paying medical bills				
No (ref)	156	76	1	1
yes	70	16	2.131 (1.160, 3.916)*	2.831 (1.219, 6.572)***
Don't know	8	2	1.949 (0.404, 9.400)	4.712 (0.651, 26.724)
Heard about health insurance				
No (ref)	95	86	1	1
Yes	139	8	15.729 (7.283, 33.971)*	24.185 (9.982, 58.593)***

N.B * statistically significant at p- Value ≤ 0.25

*** Statistically significant at p – Value ≤ 0.05

6.6.2. Predictors of willingness to pay for SHI

In the final model to identify predictor's of WTP for SHI scheme, sex, age, family size and length of service year did not remain to be significant predictors. On the other hand, variables such as educational status, marital status, awareness on the very basic construct of health insurance, problem of paying medical bills and the perception about who should pay for insurance have maintained their significance after controlling for potential confounders like sex, marital status, age and the like (Table 6).

Respondents who had master's degree were 10.5 times more likely to be willing to pay for SHI scheme as compared to those teachers who were diploma holders (AOR = 10.527, 95

% CI. 2.128, 52.063) . Correspondingly, first degree holders were 3 times more likely to be willing to pay as compared to those teachers who were diploma holders (AOR = 2.982, 95 % CI. 1.398, 6.361).

Those teachers who never married were 2.7 times more likely to be willing to pay for the SHI scheme as compared to married counterparts.

It was also found that respondents who experienced problem of paying medical bill over the past 12 months preceding the survey were 2.5 times more likely to be willing to pay for the SHI scheme as compared to those who didn't (AOR = 2.574, 95 % CI. 1.152, 5.751).

Teachers who have awareness on the very basic construct of health insurance scheme were 2.5 times more likely to be willing to pay for the SHI scheme as compared to their counterparts (AOR = 2.539, 95 % CI. 1.210, 5.326).

Furthermore, the perception about who should pay insurance premium was significantly associated with willingness to pay. Those teachers who suggested shared responsibility among the employers, government and individuals to pay for insurance premium were 3.5 times more likely to be willing to pay as compared to those who suggested the government to pay (AOR = 0.290, 95 % CI. 0.121, 0.695).

Table 6: Logistic regression analysis of predictors of willingness to pay for social health insurance scheme among teachers in government educational institutions of Wolaita Sodo town, South Ethiopia, February-March 2012 (N= 234)

Variables	WTJ SHI		COR (95 % CI)	AOR (95 % CI)
	yes	No		
Sex				
Females (ref)	36	23	1	1
Males	138	37	2.383 (1.261, 4.504)*	0.967 (0.396, 2.362)
Marital status				
Single (ref)	86	10	1	1
Married	86	49	0.241 (0.125, 0.465)*	0.370 (0.169, 0.808)***
Divorced	2	0		
Widow	0	1		
Educational status				
Diploma (ref)	41	35	1	1
Bachelor degree	87	20	3.757 (1.958, 7.208)*	2.982 (1.398, 6.361)***
Masters	42	2	18.568 (4.215, 87.791)*	10.527 (2.128, 52.063)***
PhD	1	0		
TTI (certificate)	3	3		
Family size				
≤ 4 (ref)	125	35	1	1
>= 5	49	25	0.549 (0.298, 1.010)*	0.925 (0.402, 2.129)
Service year				
> 2 year (ref)	115	53	1	1
< 1 year	23	3	3.533 (1.016, 12.288)*	1.433 (0.258, 7.972)
1 to 2 year	36	4	4.148 (1.404, 12.151)*	1.154 (0.268, 4.974)
Heard about health insurance				
No (ref)	58	37	1	1
Yes	116	23	3.217 (1.751, 5.912)*	2.539 (1.210, 5.326)***

Table 6: Logistic regression analysis of predictors of willingness to pay for social health insurance scheme among teachers in government educational institutions of Wolaita Sodo town, South Ethiopia, February-March 2012 continued (N= 234)

Variables	WTJ SHI		COR (95 % CI)	AOR (95 % CI)
	yes	No		
Age				
≤ 25 (ref)	58	7	1	1
26 to 35	69	23	0.362 (0.145, 0.904)*	0.865 (0.275, 0.721)
36 to 45	18	16	0.136 (0.048, 0.382)*	0.491 (0.113, 1.818)
>= 46	29	14	0.250 (0.091, 0.687)*	1.401 (0.357, 1.493)
Problem of paying medical bills				
No (ref)	110	46	1	1
yes	56	14	1.673 (0.848, 3.299)*	2.574 (1.152, 5.755)***
Don't know	8	0		
Perception about who should pay insurance premium				
Shared b/n three (ref)	90	20	1	1
Individuals	21	3	1.566 (0.229, 1.355)	1.950 (0.480, 7.915)
Employers	20	10	0.444 (0.181, 1.094)*	0.411 (0.139, 1.221)
Government	22	25	0.196 (0.092, 0.414)*	0.290 (0.121, 0.695)***
Don't know	21	2	2.33 (0.506, 10.767)	4.189 (0.819, 21.435)

N.B * statistically significant P- Value ≤ 0.25

*** Statistically significant at P- Value ≤ 0.05

Chapter Seven: Discussion

High level of awareness and willingness to participate and pay a premium are undoubtedly some of the prerequisite factors, which could contribute to a successful social health insurance scheme.

Despite the fact that, more than half (55.2 %) of teachers in this study have no awareness on the very basic construct of health insurance scheme. This was consistent with the study conducted in Bahraich district, Uttar Pradesh, India and in Uganda, Kampala District's government educational institutions in 2008 and 2009 respectively (52 and 54).

Given that teachers were the majority of formal employees; this was not good news for the proposed scheme. The above further implies that the health insurance scheme was not well publicized and there had been little involvement of the key stakeholders. In spite of the compulsory nature of the scheme, the stakeholders need to understand its basics. Otherwise, their participation will not be full and this affects the success of the scheme.

However, this study revealed that 71.3 % of the respondents were willing to join the newly proposed social health insurance scheme. Of these, 74.4 % were willing to pay for the proposed social health insurance. Moreover, 47.1 % of those willing to pay were willing to contribute greater than or equals to 4 % of their monthly salary as premium.

This was lower than the study done in Accra, Ghana in 2002 where 97 % of the respondents agreed to join the scheme and 62.8 % were willing to contribute 2 % of their income as premium and the study done in Nigeria in 2010 where 83.9 % were willing to join and 76.6 % were willing to pay but, higher than the study done in Kampala district, Uganda, where 41.2 % of respondents were willing to pay and of them 38.8 % were willing to contribute less than 4 % of their monthly salary (32, 52, 56). This disparity might be related to the difference in scenario presented, elicitation technique used and geo-political area and cost of living in both locations.

The median WTP values found in this study was 81.66 ETB (US\$ 4.66) per person per month and WTP per person per year reached 979.92 ETB (US\$ 55.99). This is higher than the overall expenditure for health in Ethiopia which is about US\$ 5 per person per year and even higher than the \$34 per capita recommended by the Commission for Macro Economics and Health (25).

In terms of the experience of method of payment for medical bills, it emerged that 87.7 % of the respondents used out-of-pocket financing to cover their medical bill. This is in line with studies done on government employee in Congo in 2011 (19) and African context (22). The possible explanation might be employees from the public sector are not assisted in organizing their health care. Consequently, they use the out-of-pocket payment system to cover their health bills.

This study uncovered that problem of paying medical bills predicted both the willingness to join and the willingness to pay for SHI scheme. Respondents who experienced problem of paying medical bill over the past 12 months were 2.8 times more likely to be willing to join and 2.5 times more likely to be willing to pay for the SHI scheme as compared to those who didn't. This partly goes in harmony with a study done in rural china that individuals who were in the very worry bracket were 2.51 times more likely to be willing join and 1.60 times more likely to be willing to pay for SHI than those who were not worried about medical expenditure (30).

Furthermore educational status of the respondent was found to be one of the strong predictors for willingness to join and pay for social health insurance. Respondents with higher education were more likely to be willing to join and pay than their lower cadre counterparts. This is more or less comparable with the findings of Barnighausen T et al (10), Zhang L et al (30) and others (31, 32 and 42).

This might be due to the fact that people with higher education were more confident in adjusting to and trusting a new system and could be attributed to a positive relationship between a person's educational level and propensity to acquire skills (62) and knowledge about the advantage of making regular small insurance payments to avoid the risk of catastrophic medical expenditures (39).

This study revealed that the willingness to join and pay for SHI is predicted by the awareness of respondents on the very basic construct of health insurance. Individuals who heard about health insurance scheme were 24 times more likely to be willing to join and 2.5 times more likely to be willing to pay as compared to those teachers who have never heard about health insurance scheme. This finding is consistent with result obtained by Liu and Inke M et al (39, 53). The possible explanation might be the potential of public

information schemes that may change the negative attitude towards health insurance, which this study has not covered.

This study identified that marital status had a statistically significant positive effect on willingness to join social health insurance. Married persons were more likely to be willing to join social health insurance than those who were single. This finding is consistent with the results obtained by Harmon and Nolan (63) and others (38, 39). This might be partly explained due to the need to protect their children (62) and being more averse to the risk of catastrophic health expenditures than those who are single.

In contrary who never married were 2.7 times more likely to be WTP for the SHI scheme as compared to married counterparts. Indeed this finding is intuitively sensible since any increase in the household size while holding the income constant reduces the per capita income.

Sex was found to predict the willingness to join social health insurance scheme. Males were more likely to be willing to join social health insurance than their female counterparts. Results of studies carried out in different African countries were in accordance with the findings of the present study (31-34). However, sex was not found as significant predictor of willingness to pay for the scheme.

This study uncovered that coefficient for service year had a statistically significant negative effect on the willingness to join social health insurance. Teachers with less than two years of service were more likely to be willing to join compared to those more than two years. This finding is intuitively sensible since new employees are more averse to the risk of catastrophic health expenditure.

To increase the validity of contingent valuation studies the test-re-test method should have been used but due to time and other resource constraints this was not done in this study.

The study did not contain insurance-specific attributes like co-payments, deductibles This was a hypothetical willingness to pay study and may not reflect actual practice.

Chapter Eight: Conclusion and Recommendations

8.1 Conclusion

More than half of the teachers in government educational institutions have no awareness on the very basic construct of health insurance. However, 71.3 % of the teachers in government educational institutions were willing to join and about three fourth of those WTJ were willing to pay for the proposed social health insurance scheme. Furthermore, median WTP was 81.66 ETB (US\$ 4.66) per person per month. These give policy-makers an indication of the financial implications of a policy under consideration.

Currently teachers on government educational institutions are not assisted in organizing their health care. Consequently, they were using the out-of-pocket expenditure to pay health care bills.

The willingness to join social health insurance was found to be predicted by sex, marital status, educational status, service year, problem of paying medical bills and the awareness of individuals on the very basic construct of health insurance.

Moreover, educational status, marital status, problem of paying medical bills, awareness on the very basic construct of health insurance and the perception about who should pay insurance premium were found to be predictors of willingness to pay for social health insurance.

The findings also can be applied in a cost-benefit analysis to estimate the benefits of a social health insurance program in relation to its cost. Because, Economic theory argues that the maximum amount of money an individual is willing to pay for a commodity or service is an indicator of the utility or benefit to her of that commodity or service.

8.2 Recommendations

Based on the findings of the study the following recommendations have been forwarded for MoH, federal and regional health policy makers and researchers.

- It is recommended that the federal and regional health policy makers engage key stakeholder categories such as teachers in awareness rising to build their knowledge and should market the scheme so that every employee will be conversant with it for successful implementation. In particular, teachers have a multiplier effect because they have a ready audience of their students who can even serve as an entry point to their families.
- The FDRE, MoH should consider implementing the policy under consideration since, findings are encouraging and the enthusiasm should therefore be sustained because these attributes have been reported as prerequisites for a successful implementation of such a scheme.
- Federal and regional health policy makers and implementers should introduce strategies to win the trust of government employee by facilitating public information schemes in relation to a health insurance system, particularly among those with lower educational status, greater service year.
- A follow up study following introduction of the scheme in the study area would provide very useful information about revealed preferences by including insurance specific attributes like co payments and deductibles.

References

1. International labor organization (ILO). An ILO strategy towards universal access to health care, global campaign on social security and coverage for all. ILO; 2007
2. Carrin G. Community-based Health Insurance Schemes in Developing Countries: Facts, Problems and Perspectives. Department of Health Financing and Stewardship. Geneva: WHO/EIP; 2003
3. Charles N & Axel W. Social health insurance a guidebook for planning. University of Dublin; 2009
4. Tarimo E, Webster E. Adopting PHC for the year 2000 and beyond. Primary Health Care concepts and challenges in a changing world. Alma Ata revisited; 1996
5. Federal Democratic Republic of Ethiopia Ministry of Health. Health Sector Development Program 2010/11 – 2014/15. Ministry of health Ethiopia; 2010
6. World Health Organization. Paying for health services. Geneva, Switzerland; 2007
7. Hsiao W.C and Shaw R.P. Social health insurance for developing nations. Washington: the international bank for reconstruction and development / the World Bank; 2007
8. De Allegri M, Sanon M and Sauerborn R. "To enroll or not to enroll?" A qualitative investigation of demand for health insurance in rural West Africa. Soc Sci Med. 2006; 62: 1520-1527
9. Neil G. Alternative forms of social protection for developing countries social service review. The University of Chicago. 1976; 50(3): 363-387
10. Heidemarie W, Assane D and Timothy E. Social Health Insurance in Development Cooperation. Department of Planning and Development, Germany International conference in developing countries Berlin. 2005; pp. 05-07
11. Federal Ministry of Health. Health Insurance Strategy Planning and Programming Department. Addis Ababa; 2008
12. Charles N & Axel W. Social health insurance a guidebook for planning. University of Dublin; 2009
13. Hengjin D, Bocar K, John C and Rainer S. Inequality in willingness-to-pay for community-based health insurance. Elsevier Ireland. 2004; 72(2): 149-156
14. Barnighausen T, Liu Y, Zhang X and Sauerborn R. Willingness to pay for social health insurance among informal sector workers in Wuhan, China: a contingent valuation study. BMC Health Services Research. 2007; 7:114

15. Kayiba T and Rankhumise E M. Employees' perceptions regarding social health insurance: A case of Kinshasa, Democratic Republic of Congo. *African Journal of Business Management*. 2011; 5(28): 11309-11315
16. Asgary A, Willis K, Taghvaei A.A, and Rafeian M. Estimating rural households' willingness to pay for health insurance. *Eur J Health Econom*. 2004; 5:209–215
17. Guy C. Social health insurance in developing countries. International Social Security Association, World Health Organization. 2002; 55: 2
18. Gertler, P. "On the Road to Social Health Insurance". *World Development*. 1998; 26(4): 717-732
19. Kayiba T and Rankhumise E M. Employees' perceptions regarding social health insurance: A case of Kinshasa, Democratic Republic of Congo. *African Journal of Business Management*. 2011; 5(28): 11309-11315
20. Deutsche Gesellschaft für Technische Zusammenarbeit (GTZ). Elaboration and Introduction of Social Health Insurance Systems in Developing Countries. GmbH, division; 2004
21. Abel-Smith B. An introduction to health Policy. Planning and financing New York: Longman Group; 1994
22. McIntyre D, Lucy G and Vimbayi M. Promoting equitable health care financing in the African context: Current challenges and future prospects. *Global Forum for Health Research*; 2007
23. Damen H. Exploring alternatives for financing health care in Ethiopia: An introductory Review article. *Ethiop. J. Health Dev*. 2001;15(3):153-163
24. Federal Ministry of Health Planning and Programming Department. Health Insurance Strategy. Addis Ababa; 2008
25. Murru M. Ethiopia: the country, the people and their health. *UMU press*. 2005; 5 (1) 59 – 66
26. World Bank. Ethiopia a country status report on health and poverty. Africa Region Human Development & Ministry of Health Ethiopia: The World Bank; 2004
27. Moller V. Researching Quality of Life in a Developing Country. Lessons from South Africa; 2004
28. Creese A, Bennett S. Rural risk-sharing strategies. *Innovations in Health Care Financing*. The World Bank; 1997

29. Detlef S. GTZ GmbH International Services: Towards a national health insurance system in Yemen; 2005
30. Zhang L, Wang H, Wang L and Hsiao W. Social capital and farmer's willingness-to-join a newly established community-based health insurance in rural China. *ELSEVIER health policy*. 2006; 76: 233-242
31. Dong H, Kouyate B, Cairns J, Mugisha F and Sauerborn R. Willingness-to-pay for community-based insurance in Burkina Faso. *Euro Journals*. 2009; 12: 849-862.
32. Dominic E and Francis T. Influence of Biomedical science on National health insurance scheme in Ghana. *Afr. J. Health Sci*. 2002; 9:51-60
33. Bonu S, Rani M, and Bishai D. Using willingness to pay to investigate regressiveness of user fees in health facilities in Tanzania. *Health Policy Plan*. 2003; 18: 370-382
34. Eckhardt M, Forsberg B.C, Wolf D, Crespo-Burgos A. Feasibility of community-based health insurance in rural tropical Ecuador. *Rev Panam Salud Publica*. 2011; 29(3):177–84.
35. Kirigia J, Sambo L.G, Nganda B, Mwabu G.M, Chatora R and Mwase T. Determinants of health insurance ownership among South African women. *BMC health service research*. 2005; 5:17
36. Donfouet H.P.P, Makaudze E, Mahieu P.A, and Malin E. The Economic Value of the Willingness-to-Pay for a Community Based Prepayment Scheme in Rural Cameroon. University of Yaoundé: University of Western Cape-South Africa; 2011
37. Edward N. Cross Sectional Evidence on demand for Health Insurance among Women in Ghana. *International Research Journal of Finance and Economics*. 2009; 33: 1450-2887
38. Trujillo A. J. Medical Care use and Selection in Social Health Insurance with an Equalization Fund: Evidence from Colombia. *Wiley Inter Science Health Economics*. 2003; 12(3):231-246
39. Liu T. and C. Chen. An Analysis of Private Health Insurance Purchasing Decision with National Health Insurance in Taiwan. *Social Science and Medicine*. 2002; 55:755-774
40. Butler, S. *Transcending Employer-Based Health Insurance*, Council on Economic Impact of Health System Change, Washington DC; 1997
41. Savage, E. and D. Wright. *Health Insurance and Health Care Utilization: Theory and Evidence from Australia 1989-90*. Mimeograph. University of Sydney; 1999
42. Shimeles O, Chali J, Yohannes H and Girma B. Indigenous community insurance (Iddirs) as an alternative health care financing in Jimma city, southwest Ethiopia. *Ethiop J Health Sci*. 2009; 19

43. Mathiyazhagan k. Willingness to pay for rural health insurance through community participation in India. *Int J Health Plann Mgmt.* 1998; 13: 47±67
44. Walraven G. Willingness to pay for district hospital services in rural Tanzania. *Health Policy Plan.* 1996; 11: 428-437
45. Asfaw A and Jacques v. Willingness to Pay for Health Insurance: An Analysis of the Potential Market for New Low Cost Health Insurance Products in Namibia. *Social science and medicine.* November 2009; 69 (9): 1351-1359
46. Lwambo N.J.S, Siza J.E & Mwenda G.C. Community's willingness to pay for a school-based chemotherapy programme. National Institute for Medical Research, Mwanza Tanzania; 2005
47. Brown W, Churchill CF. Insurance Provision in Low-income Communities. Part II: Initial Lessons from Micro-insurance Experiments for the Poor. *Micro-enterprise best practices, Development Alternatives Inc.* Bethesda; 2000
48. Jutting J. Do community-based health insurance schemes improve poor people's access to health care? Evidence from rural Senegal. *World Dev.* 2004; 32(2): 273–288
49. Carrin G, Waelkens MP, and Criel B. Community-based health insurance in developing countries: A study of its contribution to the performance of health financing systems. *Trop Med Int Health.* 2005; 10: 799–811
50. Pagán, J. Puig A, and Soldo B. J. Health insurance coverage and the use of preventive services by Mexican adults. *Health Economics.* 2007; 1359-1369
51. Lofgren C, Thanh N, Chuc N, Emmelin A and Lindholm L. willingness to pay for health insurance in rural Vietnam. Umea international school of public health, Umea University, Sweden: Biomed central; 2008
52. Byabashaija A.A. The knowledge and views of teachers in government educational institutions in Kampala district on the proposed social health insurance scheme in Uganda. *UMU Press.* 2009; 7(1) 1-9
53. Mathauer I, Schmidt J and Wenyaa M. Extending social health insurance to the informal sector in Kenya. An assessment of factors affecting demand. *Int J Health Plann Mgmt.* 2008; 23: 51–68
54. Constella Futures, New Delhi. Health insurance needs awareness and assessment in the Bahraich district, Uttar Pradesh. USAID/India; 2008

55. Mathauera I, Doetinchema O, Kirigiab J and Carrina G. Report of the technical support mission for the Feasibility assessment and financial projection results for a Social Health Insurance Scheme in Lesotho. World Health Organization, Geneva; 2007
56. Osungbade KO, Olumide A, Balogun O, Famakinwa EO and Jaiyeoba O. Social Health Insurance in Nigeria: Policy Implications in a Rural Community. Nigerian Medical Practitioner. 2010; 57(5-6): 90 - 95
57. Mathauera I, Muango L, Carrina G and Mthethwa K. Report of the technical support mission for the Feasibility assessment and financial projection results for a Social Health Insurance Scheme in Swaziland. World Health Organization, Geneva; 2008
58. Karen G, Fleischman F and James R. Willingness to pay surveys for setting prices for reproductive health products and services a user's manual. U.S. Agency for International Development (USAID): Population Council; 2004: 5-6
59. WHO. The World Health Report Health Systems: improving performance. The World Health Organization; 2000
60. Wedgwood A and Sanson K. willingness to pay surveys: streamlined approach. WEDC, Loughborough United; 2003
61. Federal Ministry of Health. Essential health services package for Ethiopia. Ethiopia; 2005
62. Grossman M. On the concept of health capital and the demand for health. Journal of Political Economy. 1972; 80(2):223-255.
63. Harmon C, Nolan B. Health insurance and health service utilization in Ireland. Health Economics. 2001; 10:135-145.

Annexes

Annex I: Questionnaires

1.1. Questionnaire (English version)

Questionnaire for a research on willingness to join and pay for social health insurance among teachers in government educational institutions of Sodo town, Wolaita zone SNNPR, February-March, 2012

Individual Consent Form

Dear Participant,

Hello, my name is _____; I am one of the data collectors in this study. We are conducting a survey to learn about the willingness to join and pay for social health insurance scheme.

Confidentiality and consent

You have been chosen to participate in the study. This survey is currently taking place in Sodo town government educational institution, Wolaita zone. The interview will take approximately 20 minutes. I will ask you questions about your willingness to join and pay for social health insurance.

The information you provide is totally confidential and will not be disclosed to anyone. It will only be used for research purposes. Your name, address, and other personal information will be removed from the questionnaire, and only a code will be used to connect your name and your answers without identifying you. The survey team may contact you again only if it is necessary to complete the information at a later point in time. You can also stop the interview at any time if you wish, or skip any questions that you don't want to answer. There is no right or wrong answers. Your participation is completely voluntary but telling about your experiences as part of this survey could be very helpful. Would you be willing to participate?

If yes, proceed. If no, thank and stop here

Signature of the interviewer certifying that respondent has given informed consent verbally

If you have something to ask concerning the study, at any time you can contact the principal investigator by Phone No. 0912425757, Tesfamichael Alaro.

**Questionnaire for a research on willingness to join and pay for social health insurance
in Sodo town, Wolaita zone SNNPR, January 2012**

Interviewer's Name _____

Supervisor's Name _____

Date of interview _____

Questionnaire No _____

Part I: Socio-demographic and economic characteristics of teachers in government educational institution in Sodo town, Wolaita zone, 2012.

No	Question	Response code	Skip
101	Level of educational institution	1= primary level <input type="checkbox"/> 2= secondary level <input type="checkbox"/> 3= higher educational institution <input type="checkbox"/>	
102	Age in completed years	_____years	
103	Respondent's Sex	1 = male <input type="checkbox"/> 2= female <input type="checkbox"/>	
104	What is your religion?	1= Orthodox <input type="checkbox"/> 2= Protestant <input type="checkbox"/> 3= Catholic <input type="checkbox"/> 4= Muslim <input type="checkbox"/> 5=others (specify)_____ <input type="checkbox"/>	
105	What is your Ethnicity?	1= Wolaita <input type="checkbox"/> 2= Amhara <input type="checkbox"/> 3= Oromo <input type="checkbox"/> 4= Tigre <input type="checkbox"/> 5= others (specify)_____	
106	What is your marital status?	1= Never Married <input type="checkbox"/> 2= Currently Married <input type="checkbox"/> 3= Divorced, Separated <input type="checkbox"/> 4= Widow/Widower <input type="checkbox"/>	

107	Total number of family members	In number _____	
108	What is your educational status?	1= Diploma <input type="checkbox"/> 2= Bachelor's Degree <input type="checkbox"/> 3= Masters <input type="checkbox"/> 4= PhD <input type="checkbox"/> 5= others (specify) _____	
109	How much is your monthly salary?	In ETB _____	
110	How long have you been employed?	1= Less than one year <input type="checkbox"/> 2= One to two years (including 2 years) <input type="checkbox"/> 3= More than two years <input type="checkbox"/>	

Part II: Health status and health care utilization of the individuals

No	Question	Response code	Skip
201	Did you have any episode of illness over the past two month?	1= yes <input type="checkbox"/> → 2= no <input type="checkbox"/> →	Go to 202 Go to 206
202	How many episodes of illness over the past two month?	1= 1 to 2 episodes <input type="checkbox"/> 2= Above 2 episodes <input type="checkbox"/>	
203	How serious was the illness?	1= Not serious <input type="checkbox"/> 2= Quite serious <input type="checkbox"/> 3= very serious <input type="checkbox"/> 4= Not sure/Don't know <input type="checkbox"/>	
204	Where did you first seek treatment	1= Go to public health facility <input type="checkbox"/> 2= Go to private health facility <input type="checkbox"/> 3= Traditional medicine <input type="checkbox"/> 4= other please specify _____	
205	How did you cope with the payment?	1= government/ free <input type="checkbox"/>	

		2= Own money <input type="checkbox"/>	
		3=Borrowed money <input type="checkbox"/>	
		4= Sold household movable assets <input type="checkbox"/>	
		5= Others (specify)_____	
206	During the last 12 months, were there times when you had problems paying or were unable to Pay for medical bills?	1=Yes <input type="checkbox"/>	
		2= No <input type="checkbox"/>	
		3= Don't know <input type="checkbox"/>	
207	How confident are you that if you become ill to afford the care you need	1=Very confident <input type="checkbox"/>	
		2 =confident <input type="checkbox"/>	
		3 =Not at all confident <input type="checkbox"/>	
		4=Don't know <input type="checkbox"/>	

Part III: Exposure and Perception regarding insurance

No	Question	Response code	Skip
301	Have you ever heard about health insurance scheme?	1= yes <input type="checkbox"/> 2= no <input type="checkbox"/>	
302	Who do you think should pay for insurance?	1= Individuals <input type="checkbox"/> 2=Employers <input type="checkbox"/> 3= The government <input type="checkbox"/> 4=Shared by individuals, employers and the government <input type="checkbox"/> 5=Don't know <input type="checkbox"/>	
303	Believe that insurance is similar to monthly thrift/savings	1= yes <input type="checkbox"/> 2= no <input type="checkbox"/> 3= don't know <input type="checkbox"/>	
304	Think Insurance is an amount you pay to get some compensation if something bad happens	1= yes <input type="checkbox"/> 2= no <input type="checkbox"/> 3= don't know <input type="checkbox"/>	

Part IV: Willingness to pay survey part

Enumerator read:

CVM Scenario

Most of the time when people fall sick, they tend to adopt various ways of coping with such an event this includes selling off personal belongings like electronic gadgets, and if intense, land and landed property. Sometimes also, households tend to resort to borrow money from their neighbors, religious organization or friends. This is because there is always a desire to get better again and if possible, quickly. If the individual or household fails in obtaining financial help, often times the sick individual has no option than to remain in the state and begin to deteriorate. Others decide at this point to go for cheaper alternatives, which might not be efficacious such as the use of traditional healers and medical practitioners. The scenario is also worse if the family finally obtains financial assistance only to discover at that point that the sick individual has died.

With the nature of out-of-pocket health care financing and the increasing burden of diseases facing the people in Ethiopia, the government of Ethiopia has proposed a social health insurance scheme to the formal sector worker in Ethiopia.

Introduction to health insurance: Health insurance is a program that pools the risk of several people in an effort to decrease the amount that is paid by an individual at the time health care services are needed. Ill-health occurrence is largely unpredictable for individuals, as such, the need for health-care is often highly unpredictable and very costly for most individuals; however, it is predictable for large groups. Health insurance provides an opportunity to spread the financial burden of payment over several people thus making health care more affordable for individuals. **[Enumerator: Ask whether respondent has any question].**







Iddirs are indigenous community associations established primarily to provide mutual aid in burial matters but also to address other community concerns. Households become members of the associations and pay fixed contributions monthly. Whenever death occurs among members, the association raises an amount of money (depending on the specific bylaws) and handles the burial and related ceremonies. In addition, certain members are assigned to stay at the house of the bereaved for two to three days to assist the household, similar to Iddirs Social Health Insurance (SHI) is a non-profit type of health insurance for the formal sector, formed on the basis of an ethic of mutual aid and the collective pooling of health risks, in which members pay premiums on a regular basis to offset the risk of needing to pay large health care fees upon falling sick. However, unlike many insurance

schemes, SHI schemes are typically based on the concepts of mutual aid and social solidarity and are useful for people in the formal sectors and even those informally employed who are unable to get adequate public, private, or employer-sponsored health insurance. **[Enumerator: Ask whether respondent has any question and has understood the subject matter]**

The objective of the social health insurance scheme shall be to provide quality and sustainable universal health care coverage to the beneficiary through pooling of risks and reducing financial barriers at the point of service and prevents people from falling in to poverty due to health care costs since SHI combines prepayment and risk pooling with mutual support. Organization will be managed by a board of directors consisting of key stakeholders both from employers, employees and health providers. They will be accountable to the MOH. Services will be delivered through accredited public and private health facilities. Quality indicators will be developed and quality of care will be built into the contracts with the health care providers. An autonomous health insurance agency/institution will be established at the federal level to manage the health insurance fund, provide overall guidance and undertake monitoring and evaluation & capacity building activities. The agency will establish local offices in all regions. The board of directors will supervise the autonomous health insurance agency. Health facilities will be monitored in terms of best practices and standard treatment protocols, waiting time, medical records, and drug stock outs.

To be eligible, individual is expected to pay a specified amount (premium) monthly. Once individual has paid into the scheme, s/he will be given a membership card that identifies her/him with all personal information and the same membership number for the household which then entitles them to benefits that includes essential health services like Family health (ante-natal care; delivery and newborn care; post-natal care; family planning; child health – Integrated Management of Childhood Illness (IMCI); growth monitoring and essential nutrition actions; immunization; adolescent reproductive health), Communicable diseases control (TB and leprosy; HIV/AIDS and sexually transmitted infections), Basic curative care and treatment of major chronic conditions, Hygiene and environmental health, Health education and communication and includes critical curative service which includes inpatient and outpatient service. **[Enumerator: Ask whether respondent has any question]**

No	Question	Response categories	Skip
401	Would you be willing to join Social Health insurance scheme?	1=yes <input type="checkbox"/> → 2= no <input type="checkbox"/> →	Go to 403 Go to 402
402	Reason for not willing to join the social health insurance scheme	1= I am always in good health <input type="checkbox"/> 2=does not cover needed <input type="checkbox"/> 3= fear of poor implementation <input type="checkbox"/> 4= Others (specify)-----	Terminate
403	Would you be willing to pay for Social Health insurance?	1= yes <input type="checkbox"/> → 2= no <input type="checkbox"/> →	Go to 405/411 Go to 404
404	Reason for not willing to pay for social health insurance scheme?	1=The government responsibility to finance the program <input type="checkbox"/> 2= Out-of-pocket payment is better <input type="checkbox"/> 3= Contribution being nonrefundable 4 = Other (specify) _____ <input type="checkbox"/>	
Enumerator; make respondents to randomly select the starting point (4% or 5% of the monthly salary)			
A. 4% → Go to 405			
B. 5% → Go to 411			
Starting with 4% of the monthly salary			
405	Would you be willing to pay 4% of Monthly salary for SHI?	1= yes → 2= no →	Go to 406 Go to 408
406	Would you be willing to pay 5% of Monthly salary for SHI?	1= yes → 2= no <input type="checkbox"/>	Go to 407 Accept 405 and terminate
407	Would you be willing to pay 6% of Monthly salary for SHI?	1=yes → 2= no <input type="checkbox"/>	Go to 410 Accept 406
408	Would you be willing to pay 3% of Monthly salary for SHI?	1= yes <input type="checkbox"/> 2= no →	Accept 408 and terminate Go to 409
409	Would you be willing to pay 2% of Monthly salary for SHI?	1 =yes <input type="checkbox"/> 2= no →	Accept 409 and terminate Go to 410

410	How much you would be willing to pay for the scheme?	In percent _____	
Starting point with 5% of the monthly salary			
411	Would you be willing to pay 5% of Monthly salary for SHI?	1= yes  2= no 	Go to 412 Go to 414
412	Would you be willing to pay 6% of Monthly salary for SHI?	1= yes  2= no <input data-bbox="917 828 1005 884" type="checkbox"/>	Go to 413 Accept 411 and terminate
413	Would you be willing to pay 7% of Monthly salary for SHI?	1= yes  2= no <input data-bbox="869 1019 957 1075" type="checkbox"/>	Go to 416 Accept 412 and terminate
414	Would you be willing to pay 4% of Monthly salary for SHI?	1= yes <input data-bbox="869 1176 957 1232" type="checkbox"/> 2= no 	Accept 414 and terminate Go to 415
415	Would you be willing to pay 3% of Monthly salary for SHI?	1= yes <input data-bbox="869 1388 957 1444" type="checkbox"/> 2= no 	Accept 415 and terminate Go to 416
416	How much you would be willing to pay for the scheme?	In percent _____	

Thank you for the information you gave us!!!

1.2. Questionnaire Amharic Version

መጠይቅ (በ አማርኛ)

**በ ጂማ ዩኒቨርሲቲ የሕብረተሰብ ጤና ና የሕክምና ሳይንስ ኮሌጅ
በደቡብ ክልል ወላይታ ዞን ሶዶ ከተማ የማሕበረዊ ጤና መድሀን አባል የመሆንና የ
አባልነት መዋጮ ክፍያ
የ ፍቃደኝነት ሁኔታ የ ጥናት መጠይቅ
የካቲት /2004 ዓ.ም**

ወደ ተሳታፊዎች

ጤና ይስጥልኝ ስሜ _____ይባላል። የማሕበረዊ ጤና መድሀን አባል የመሆንና የ አባልነት መዋጮ ስለመክፈል የ ፍቃደኝነት ሁኔታ ጥናት ከጂማ ዩኒቨርሲቲ ጋር በመተባበር እያካሄድን ነዉ። ለዚህ ጥናት መረጃ ሰብሳቢ ነኝ።

የሚሰጥር አጠባበቅና የተጠያቂዉን ስምምነት ማረጋገጫ

በዚህ ጥናት የእርስዎን እንዳንድ ግለሰባዊ ጉዳዮች የሚመለከቱ ና የማሕበረዊ ጤና መድሀን አባል የመሆንና የ አባልነት መዋጮ የ ፍቃደኝነት ሁኔታ ጥያቄዎች ይጠየቃሉ። የሚሰጡን ምላሽ ግን ፍቃድም በእኔና በእርስዎ መካከል የሚቀር ና ለጥናት ጥቅም ብቻ ሲሆን ከእርስዎ ስም ተዛማጅነት ባለዉ መልኩ ለማንም አይነገረም።

ማንኛዉንም ምላሽ ሲሰጡ የማየፈልጉትን ጥያቄ አለመመለስ ይችላሉ። ቃለ ምልልሱንም በፈለጉት ጊዜ ሊያስቆሙ ይችላሉ። የእረስዎ እዉነተኛ ምላሽ የለዉን ትክክለኛ ሁኔታ እንድንረዳ ያስችላል። በቅድሚያ ለጥናቱ ምላሽ ለመስጠት ፍቃደኛ ቢሆኑ እናመሰግናለን። ጥናቱን በተመለከተ ለ ማንኛዉም ጥያቄ በ ስልክ ቁጥር 0912425757 የ ጥናቱን መሪ ተስፋሚካኤል አላሮ ን ማግኘት ይችላሉ።

በጥናቱ ለመሳተፍ ፍቃደኛ ነዎት አዎ—————> ይቀጥሉ

አይደለሁም —————> አመስግነዉ ያቁሙ

መረጃ ሰብሳቢዉ የተጠያቂዉን ፍቃድ መጠየቁንና ማግኘቱን ወይም አለማግኘቱን የሚያረጋግጥ ፊርማ _____

ቀን _____

የመረጃ ሰብሳቢዉ ስም _____

የተቆጣጣሪዉ ስም _____

መጠይቁ የተሰበሰበበት ቀን _____

የመጠይቅ ቁጥር _____

ክፍል አንድ: የማሕበራዊና ኢኮኖሚያዊ ጥያቄዎች፡፡

ተራ ቁጥር	ጥያቄ	መልስ	ዝላል
101	የሚያስተምርበት የትምህርት ተቋም ደረጃ	1= አንደኛ ደረጃ <input type="checkbox"/> 2= ሁለተኛ ደረጃ <input type="checkbox"/> 3= ከፍተኛ ትምህርት ተያም <input type="checkbox"/>	
102	ዕድሜ	_____ ዓመት	
103	ፆታ	1 = ወንድ <input type="checkbox"/> 2= ሴት <input type="checkbox"/>	
104	የሐይማኖት ሁኔታ	1= ኦርቶዶክስ <input type="checkbox"/> 2= ፕሮቴስታንት <input type="checkbox"/> 3= ካቶሊክ <input type="checkbox"/> 4= ሙስሊም <input type="checkbox"/> 5= ሌላ <input type="checkbox"/>	
105	ብሔረሰብ	1= ወላይታ <input type="checkbox"/> 2= አማራ <input type="checkbox"/> 3= ኦሮሞ <input type="checkbox"/> 4= ትግራይ <input type="checkbox"/> 5= ሌላ _____	
106	የጋብቻ ሁኔታ	1= ያላገባ/ች <input type="checkbox"/> 2= ያገባ/ች <input type="checkbox"/> 3= በፍቺ የተለያየ/ች <input type="checkbox"/> 4= ባል የሞተባት/ ሚስት የሞተችበት <input type="checkbox"/>	
107	ጠቅላላ የቤተሰብ አባላት ብዛት	በቁጥር _____	

108	የትምህርት ደረጃ ሁኔታ	1= ዲፕሎም <input type="checkbox"/> 2= የመጀመሪያ ዲግሪ <input type="checkbox"/> 3= ማስተርስ ዲግሪ <input type="checkbox"/> 4= ዶክተሬት ዲግሪ <input type="checkbox"/> 5= ሌላ _____	
109	የ ወር ደመወዝ	በ ብር _____	
110	የአገልግሎት ዘመን ስንት ነው?	1=ከ አንድ አመት በታች <input type="checkbox"/> 2= ከ አንድ እስከ ሁለት ዓመት(ሁለት ዓመት ጨምሮ) <input type="checkbox"/> 3=ከሁለት ዓመት በላይ <input type="checkbox"/> 4= አላውቅም (አታንብበው) <input type="checkbox"/>	

ክፍል ሁለት: አጠቃላይ የጤና ሁኔታ ና የጤና አገልግሎት አተቃቀም

ተ.ቁጥር	ጥያቄ	መልስ	ዝላል
201	በለፈው ሁለት ወር ውስጥ በሽታ አሞ/ሽ ያወቃል?	1= አዎ <input type="checkbox"/> 2= አይ <input type="checkbox"/>	<input type="checkbox"/> → ወደ <input type="checkbox"/> → 202 ወደ 206
202	በለፈው ሁለት ወር ውስጥ ስንቴ ነው የታመምከው/የታመምሽዉ?	1= ከ አንድ እስከ ሁለቴ <input type="checkbox"/> 2= ከ ሁለቴ በላይ <input type="checkbox"/>	
203	የበሽታው ሁኔታ?	1= ከባድ አልነበረም <input type="checkbox"/> 2= ከባድ ነበር <input type="checkbox"/> 3= በጠም ከባድ ነበር <input type="checkbox"/> 4= እርግጠኛ አይደለውም <input type="checkbox"/>	
204	የህክምና አገልግሎት የት ተከታተልክ/ሽ?	1= በመንግስት ጤና ተቋም <input type="checkbox"/> 2= በግለሰብ ጤና ተቋም <input type="checkbox"/>	

		3= ባሕላዊ ሕክምና <input type="checkbox"/> 4= ሌላ ካለ _____	
205	የህክምናውን ወጪ ማን ሸፈነው?	1= መንግስት/አሰሪዎ <input type="checkbox"/> 2= የግል/የኪስ ገንዘብ <input type="checkbox"/> 3= በ ብድር ገንዘብ <input type="checkbox"/> 4= ንብረት ሸጬ <input type="checkbox"/> 5= ሌላ ካለ _____	
206	ባለፈው አስራ ሁለት ወር ውስጥ የሕክምና ወጪ መክፈል ያቃተ ጊዜ ነበር?	1=አዎ <input type="checkbox"/> 2= አይ <input type="checkbox"/> 3= አለውቅም <input type="checkbox"/>	
207	እነበልና በድንገት እርሶ ወይም ከቤተሰቦ በታመም የ ሚዩስፊልገውን የጤና አገልግሎት ወጪ ሁሉ ለመሸፈን ምን ያህል እርግጠኛ ነዎት?	1=በጣም እርግጠኛ <input type="checkbox"/> 2 = እርግጠኛ <input type="checkbox"/> 3 = እርግጠኛ አይደለውም <input type="checkbox"/> 4=አላውቅም <input type="checkbox"/>	

ክፍል ሶስት: ስለ ጤና መድሀን ያለ አመለካከት

ተ.ቁጥር	ጥያቄ	መልስ	ዝልል
301	ስለ ጤና መድሀን ሰምተክ/ሽ ታወቃለህ/ቂያለሽ?	1= አዎ <input type="checkbox"/> 2= አይ <input type="checkbox"/>	
302	የ መድሀን ክፍያ ማን መክፈል አለበት ብለው ያስባሉ?	1= ግለሰብ <input type="checkbox"/> 2= አሰሪ <input type="checkbox"/> 3= መንግስት <input type="checkbox"/> 4= ግለሰብ አሰሪ እና መንግስት በጋራ <input type="checkbox"/> 5= አለውቅም <input type="checkbox"/>	
303	መድሀንና ወራዊ ቁጠባ ተመሳሳይ ናቸው ብሎ ያምናሉ?	1= አዎ <input type="checkbox"/> 2= አይ <input type="checkbox"/> 3= አላውቅም <input type="checkbox"/>	
304	መድሀን ችግር ሲደረስ ማካካሻ ለማግኘት የሚከፈል ክፍያ ነው ብለው ያስባሉ?	1= አዎ <input type="checkbox"/> 2= አይ <input type="checkbox"/> 3= አላውቅም <input type="checkbox"/>	

ክፍል አራት: የማሕበረዊ ጤና መድሀን አባል የመሆንና የ አባልነት መዋጮ ክፍያ የ ፍቃደኝነት ሁኔታ መጠይቅ

መረጃ ሰብሳቢ አንብብ: አሁን የማህበራዊ ጤና መድሀን አባል የመሆንና ወራዊ ክፍያ ስለ መክፈል የፈቃደኝነት ጥያቄ ጠይቅለዉ።

ካህ በፊት ስለ መሀበራዊ ጤና መድሀን ና ጤና መድሀን መረጃ እሰጥሃለዉ/እሰጥከለዉ።

ሰዎች ሲታመሙ የህክምና ወጪን ለመሸፈን የግል ንብረታቸውን ብለውም የተለያዩ ቋሚ ንብረቶችን ሊሸጡ ይችላሉ። አንድ አንድ ጊዜ ከጎረቤት፣ ከጉዋደኛ እና ከመስሪያ ቤት ይበደራሉ። ይህም ከተቻለ ከበታወ ወዲያው ለማገገም ሲሆን የህክምና ወጪ መሸፈኛ ገንዘብ ከልተገኘ ወርቃማ የሆኑ የህክምና ሳዓቶች ሊቃጠሉና ታማሚዉም አስከፊ ደረጃ ለይ ሊደርስ ይችላል።

ስለ ጤና መድሀን መግቢያ:-

ጤና መድሀን ማለት የብዙ ሰዎችን ድንገተኛና ያልተገመቱ የጤና አገልግሎት ወጪን አንድ ላይ በማድረግ አንድ ግለሰብ ብቻውን ለጤና አገልግሎት የሚያወጣውን ከፍተኛ የሆነ ወጪን የጤና አገልግሎት በሚጠቀምበት ጊዜ መቀነስ ነዉ። በመሰረቱ የጤና አገልግሎት መች እንደሚያስፈልግ ና አንደ ሰዉ በሽታ መች እንደሚያመወ ቀድሞ ማወቅ አይቻልም። ስለዚህ ጤና መድሀን የአንድን ሰዉ የህክምና ወጪ ጫናን ለብዙ ሰዉ በማካፋፈል የጤና አገልግሎትን ለሁሉም ተደራሽ እንዲሆን ያደርጋል።

(መረጃ ሰብሳቢዊ: ተሳታፊዎች ጥያቄ ካለቸዉ ጠይቅ)

ለምሳሌ እድር በህብረተሰብ ዉስጥ ነባር የሆነ ማህበራዊ ተቆም ነዉ። አላማዉም አንድ ሰዉ ላይ እክል ከደረሰ በጋራ የመተባበርና የተለያዩ ድጋፎችን በማድረግ ግለሰቦችን ማገዝ ነዉ። አባላቶችም ወራዊ ክፍያ በቋሚነት ይከፍላሉ። ከአባላቶች መካከል እክል ለደረሰበት የእድር ተቋሙ በህግ ና ደንብ መሰረት የገንዘብና የተለያዩ ድጋፎችን ያደርጋል። ልክ እንደ እድር የማህበራዊ ጤና መድሀን ለትርፍ ያልቆመ ነዉ። የማህበራዊ ጤና መድሀን በመደበኛ ስራ ላይ ላሉት ለቋሚ ሰራተኞች የሚደረግ የጤና መድሀን አይነት ሲሆን በዚህም ስራት ዉስጥ አባላቶች በቋሚነት የተወሰነ ወራዊ ክፍያ በመክፈል ድንገተኛ ና ከፍተኛ ከሆነ የጤና አገልግሎት ወጪ ና ተዛማጅነት ካላቸዉ ችግሮች ይከለላሉ። ማህበራዊ ጤና መድሀን እንደሌሎች መድሀኖች ሳይሆን የተመሰረተዉ እርስ በእርስ መደጋገፍና መተጋገዝ በሚል እሳቤ ሲሆን የማህበራዊ ጤና መድሀን በመደበኛ ስራ ላይ ላሉት እና በመደበኛ ስራ ለይ ለሌሉትም ሁሉ የሚጠቅም የጤና መድሀን ዓይነት ነዉ።
















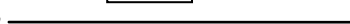
(መረጃ ሰብሳቢዎቹ ተሳታፊዎች ጥያቄ ካለቸው ጠይቅ)

የማህበረሰብ ጤና መድሀኒት ማሰባሰቢያ ጥራት ያለውና ዘላቂ የሆነ የጤና አገልግሎት ለሕጻን መስጠት ነው። ይህም ግለሰቦችን ለድህነትና ላልተፈለገ ኪሳራ የሚዳርገውን ክፍተት የሆነ ድንገተኛ የጤና አገልግሎት ወጪን ወደ ዝቅተኛ ቅደመ ክፍያ በመቀየር በግለሰብ ደረጃ መች እንደሚከሰት የማይታወቀውን የጤና አገልግሎት ወጪን ለብዙሃን በማከፋፈል ተደራሽ የሆነ የጤና አገልግሎት መስጠት ነው። የማህበራዊ ጤና መድሀኒት ድርጅት በደይሬክተሮች ቦርድ የሚመራ ሲሆን የሚቋቋመው ከሰራተኛው፣ ከአሰሪውና ከመንግስት ነው። እንዲሁም ተጠሪነቱ ለጤና ጥበቃ ሚንስትር ይሆናል። በማህበራዊ ጤና መድሀኒት ወሰን የሚገኙ የጤና አገልግሎቶች በታወቁ መንግስታዊና የግለሰብ ጤና ተቋማት የሚሰጡ ሲሆኑ ለሚሰጡት አገልግሎቶች የጥራት መለኪያ ተዘጋጅቶላቸው ይፈተሻሉ። በተጨማሪም የጤና ተቋማቱ በጥሩ ተመክሮ፣ በሚሰጡት ቋሚ የሕክምና እቅድ እና ተግባር፣ በመዳሀኒት ክምችትና በህክምና መረጃ አያያዝ ለይ ክትትል የደረግበቸዋል። ለማህበራዊ ጤና መድሀኒት እንዲከፈል የሚወሰነውን ወራዊ የአባልነት ክፍያ እኩሌታውን አሰሪውና መንግስት ይሸፍናል።

የማህበራዊ ጤና መድሀኒት አገልግሎት ተጠቃሚ ለመሆን የተወሰነውን ወራዊ መዋጮ አበላቶች ይከፈላሉ። ለአባላቶች በማህበራዊ ጤና መድሀኒት በኩል የሚደረጉ የጤና አገልግሎቶች የሚከተሉትን ያከተቱ ናቸው። እነሱም የቤተሰብ ጤና አገልግሎት(ቅደመ ወሊድ እንክብካቤ፣ የወሊድ አገልግሎት፣ድህረ ወሊድ እንክብካቤ፣የቤተሰብ እቅድ አገልግሎት፣ የህጋዊ ሕክምና፣ ክትባት፣ የወጣቶች የሥነ ተዋልዶ ጤና አገልግሎት)፣ ተላላፊ በሽታዎችን ማከምና መቆጣጠር፣ መሰረታዊ የሆኑ የሕክምና አገልግሎት፣ ንግድና የአካባቢ ጥበቃ እና ተመላላሽ ሆነ ተኝተው የሚሰጡ አገልግሎቶችን ያጠቃልላል።

(መረጃ ሰብሳቢዊ፡ ተሳታፊዎች ጥያቄ ካለቸዉ ጠይቅ)

ተ.ቁ ጥር	ጥያቄ	መልስ	ዝላል
401	የማህበራዊ ጤና መድሀን አበል ለመሆን ፍቃደኛ ነዎት?	1=አዎ <input type="checkbox"/> → 2= አይ <input type="checkbox"/> →	ወደ 403 ወደ 402
402	የማህበራዊ ጤና መድሀን አበል ለመሆን ፍቃደኛ ያልሆኑበት ምክንያት	1= ሁል ጊዜ በጥሩ ጤንነት ስላለው <input type="checkbox"/> 2= የሚያስፈልገዉን የጤና አገልግሎት ስላልሸፈነ <input type="checkbox"/> 3= ተግባራዊነቱን ስለምጠራጠር <input type="checkbox"/> 4= ----- <input type="checkbox"/>	አቁም
403	የማህበራዊ ጤና መድሀን አገልግሎት አባልነት መዋጮ ለመክፈል ፍቃደኛ ነዎት?	1= አዎ <input type="checkbox"/> → 2= አይ <input type="checkbox"/> →	ወደ 405/411 ወደ 404
404	የማህበራዊ ጤና መድሀን አገልግሎት የአባልነት መዋጮ ለመክፈል ፍቃደኛ ያልሆኑበት ምክንያት	1= የፕሮግራሙን ወጪ መገፈን ያለ <input type="checkbox"/> መንግስት ነዉ 2= ከኪስ መክፈል ይላል <input type="checkbox"/> 3= ሁል ጊዜ በጥሩ ጤንነት ነኝ <input type="checkbox"/> 4 =ሌላ ካለ _____ <input type="checkbox"/>	
ለመረጃ ሰብሳቢዉ; ዕጣ በማስነሳት የመነገ ነጥብና አስመርጥ (4% or 5% ከወራዊ ደመወዝ)			
<p style="text-align: center;"> A. 4% → ወደ ተ.ቁጥር 405 B. 5% → ወደ ተ.ቁጥር 411 </p>			
መነሻ 4% ከ ጠራዋ ደመወዝ በሰጣ ለደረሰችጠ			
405	ለማህበራዊ ጤና መድሀን ከ ወር ደመዘ 4% ለመክፈል ፍቃደኛ ነዎት?	1= አዎ _____ → 2= አይ _____ →	ወደ 406 ወደ 408
406	ለማህበራዊ ጤና መድሀን ከ ወር ደመወዝ 5% ለመክፈል ፍቃደኛ ነዎት?	1= አዎ _____ → 2= አይ <input type="checkbox"/>	ወደ 407 405 ተቀብለ ጨርስ

407	ለማህበራዊ ጤና መድሃኒት ከ ወር ደመወዝ 6% ለመክፈል ፍቃደኛ ነዎት?	1=አዎ  2= አይ 	ወደ 410 406 ተቀብለ ጨርስ
408	ለማህበራዊ ጤና መድሃኒት ከ ወር ደመወዝ 3% ለመክፈል ፍቃደኛ ነዎት?	1= አዎ  2= አይ 	408 ተቀብለ ጨርስ ወደ 409
409	ለማህበራዊ ጤና መድሃኒት ከ ወር ደመወዝ 2% ለመክፈል ፍቃደኛ ነዎት?	1 =አዎ  2=አይ 	409 ተቀብለ ጨርስ ወደ 410
410	ለማህበራዊ ጤና መድሃኒት ከ ወር ደመወዝ በ Tረስንት ምን ያህል ለመክፈል ፍቃደኛ ነዎት?	በ Tረስንት _____	
መነሻ 5% ከ ወራዊ ደመወዝ በዕጣ ለደረሰኛል			
411	ለማህበራዊ ጤና መድሃኒት ከ ወር ደመወዝ 5% ለመክፈል ፍቃደኛ ነዎት?	1= አዎ  2= አይ 	ወደ 412 ወደ 414
412	ለማህበራዊ ጤና መድሃኒት ከ ወር ደመወዝ 6% ለመክፈል ፍቃደኛ ነዎት?	1= አዎ  2= አይ 	ወደ 413 411 ተቀብለ ጨርስ
413	ለማህበራዊ ጤና መድሃኒት ከ ወር ደመወዝ 7% ለመክፈል ፍቃደኛ ነዎት?	1= አዎ  2= አይ 	ወደ 416 412 ተቀብለ ጨርስ
414	ለማህበራዊ ጤና መድሃኒት ከ ወር ደመወዝ 4% ለመክፈል ፍቃደኛ ነዎት?	1= አዎ  2= አይ 	414 ተቀብለ ጨርስ ወደ 415
415	ለማህበራዊ ጤና መድሃኒት ከ ወር ደመወዝ 3% ለመክፈል ፍቃደኛ ነዎት?	1= አዎ  2= አይ 	415 ተቀብለ ጨርስ ወደ 416
416	ለማህበራዊ ጤና መድሃኒት ከ ወር ደመወዝ በ Tረስንት ምን ያህል ለመክፈል ፍቃደኛ ነዎት?	በ Tረስንት _____	

ለሰጡት መረጃ እናመሰግናችኋለን!!

1.3 Opinion Discussion points

- What do you think about the current health service provision?
- How you are paying for health care service you are using?
- Who do you think should pay for social health insurance and how should pay?
- What benefit package do the SHI scheme should include?
- What percent of monthly salary should be enough to cover the benefit packages in social health insurance?

Declaration

I, the undersigned , declare that this thesis is my original work, has not been presented for a degree in this or any other University and that all sources of materials used for the thesis have been fully acknowledge.

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Date of submission 14/09/2004 E.C

This thesis has been submitted for examination with my approval as University advisor

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