The Impact of Community-based Health Insurance on Health Service Utilization in Aneded Woreda,

Ermiyas Tesfagiorgis, Debre Markos University

Abstract

The purpose of this research is to assess the impact of community-based health insurance on health service utilization in East Gojjam Zone, Aneded Woreda. The study attempts to: examine the major factors that help establish the scheme in this Woreda; assess client satisfaction on the services provided by the scheme; assess the overall systems of the scheme; and examine the attitudes of households towards the scheme. The researcher used cross-sectional research design and qualitative methods. The qualitative data analyzed through descriptive method of analysis that was collected through interview. The quantitative data, which was obtained through questionnaire, is analyzed in percentages, tables and frequencies. The data was collected from 30 respondents who are members of the scheme in Aneded woreda, specifically kebele 01, and Wonganflam kebele and three key informants from different offices. Finally, the researcher summarized the findings and suggested possible solutions.

Key words: Health insurance, community, scheme, client satisfaction

1. Background of the Study

Community-based Health Insurance (CBHI) is a type of insurance meant for informal sectors through contributing some amount of money that is owned, designed and managed by the members. The scheme is a not-for-profit type of health insurance that has been used by poor people to protect themselves against the cost of seeking medical treatment for illness. It is mainly financed by the contributions or premium regularly collected from its members (Sparrow and others, 2015).

Community-based Health Insurance Schemes are based on the premises of risk-pooling and community solidarity to risks of falling sick and are conceptually designed to provide financial protection and reduce out-of pocket payment for health care. Providing this financial protection, CBHI schemes could potentially increase access and utilization of health service and thus increase antenatal care and institutional delivery. Indeed, in the endeavours of protecting the community against a brutal and unaffordable cost of illness, the CBHI scheme need to make sure that there is no adverse selection or moral hazard in terms of environment. The use of health services or drop-out, the evidence in effectiveness of CBHI schemes has been mixed. Penetration rates (enrolment rate) of CBHI schemes are often low, ranging between 3.1 to 5.1 of the targeted population and rarely 10%, and the effectiveness of CBHI in terms of quality of care or representativeness of members with regard to the targeted population was weak or inexistent (Hounton et.al, 2012).

Providing health care for poor people who work in informal sectors or live in rural areas is considered as one of the challenges that many developing countries face. Despite remarkable efforts being made in addressing these challenges by development agents and states, they remain as serious barriers to economic growth, since illness does not only affect the welfare but also increases risk of impoverishment. This is because of high cost associated with health problems, especially in the absence of any form of health insurance subsequently. Thus, households may decide to live with illness untreated, or opt for use of poor quality

health care or even self-administred medication. It is argued that more than 150 million people face catastrophic health expenditure each year; and most of them fall into poverty worldwide due to out of pocket health payment. This is an indication that health problems and associated costs are the main causes that drive people into poverty, especially in developing countries where the health care payment is still made out of pocket (Gebremeskel, 2014).

According to WHO, health financing in India for 2004, showed that India spent 5.0% of GDP on health with General Government Health Expenditure (GGHE) 0.9%, of the total GDP and private expenditure nearly 4.1% of the total GDP. Out of pocket (OOP) expenditure accounted for 93.8% of the total private health expenditure or 3.84% of the total GDP. Such figures clearly indicate that public health investment has been very low (Indian Institute of Public Health, 2014).

Health care in India is now financed in several ways that include general revenue, Social Health Insurance (SHI), private insurance, private spending, mostly through OOP payments, CBHI and a few state government sponsored schemes like RSBY, Yeshaswini, etc. Such schemes use the principles of CBHI, in the sense of voluntary participation but are really not managed by the community. Hence they are called state-sponsored schemes. But it is not able to raise enough to protect and cover a large population of India because of the Indian government limited ability to raise revenue due to lower tax base and allocation to health (Indian Institute of Public Health, 2014). According to a study in Burkina Faso, factors that affect enrollment of people were: affordability, distantly located health facility, poor quality of health services that included long waiting times, over preserving and differential treatment depending on socio-economic status of enrollee, lack of health seeking behavior, cultural beliefs and practices. In addition to this, the Burkina Faso study found lack of knowledge and past bad experiences with such schemes as the two main reasons that prevented people's enrollment in such schemes (Indian Institute of Public Health, 2014).

The states in most developing countries have not been able to fulfill health care needs of their poor population. Shrinking of budgetary support for health care services, inefficiency in public health provision, unacceptable low quality of public health and the resultant imposition of user charges are reflective of the states in ability to meet health care needs of the poor (World Bank, 1993) coated by Gebremeskel, 2014.

In June, 2011, the Ethiopian government launched the CBHI scheme. By December 2012, it reached 45.5% (Sparrow and others 2015). In the study area: – the Aneded woreda CBHI scheme was introduced in 2005 E.C at one kebele. Now the scheme expanded to one town kebele, and nineteen rural kebeles. It is on the process to include all kebeles found in Aneded woreda.

1.2. Statement of the Problem

Health is the most sensitive essentials of nature. Everybody wants to save his/her life from any injury that harms. Thus governments and people give much concern. Modern health institutions are health care providers where people attend to get treatment for injury or illness. Therefore people develop the habit of attending health institutions to examine his/her health problem and to get health care services (Gebremeskel, 2014)

The catastrophic nature of health care financing mechanisms for the poor and often rural population has been a source of concern in Africa. According to the WHO, quoted by Adane

et al (2014), 150 million people are pushed in to poverty because of direct payments for health service and suffer financial shocks each year globally. CBHI schemes are becoming increasingly recognized as an instrument to financial health care in developing countries, though with certain weaknesses such as, low capital start-up bases, small size of risk pool, low level of revenue mobilization, limited management capacity; isolation from complete benefit.

The overall objective of CBHI is to promote equitable access to sustainable quality health care, increase financial protection and enhance social inclusion or the majority of Ethiopian families via the health sector. Specific CBHI objectives are to improve financial access, quality of health care services, increase resource mobilization in the health sector, as well as increasing community participation in the management of the health and finally strengthen national capacity for policy development and scale up of health insurance coverage in the rural and urban informal sector (Ethiopian Health Finance and Governance, 2015).

However, CBHI has many problems or challenges on health service utilization. The policy of CBHI is not serving equally for all regions of the country. Contributions vary by region and range from birr 10.50 (US$0.56) to birr 15 (US$0.80) per month per house hold. And also the referral system is very difficult. Beneficiaries are allowed to access hospitals without penalty, with a health center referral members bypass the referral system and are required to pay an overall payment far over 50% (ARSHB, 2012).

According to Tailor (2005), as quoted by Houston et al (2012) there are different problems such as poverty, awareness and covariate risk related to the context in which community based health insurance is designed and implemented.

In Aneded Woreda, CBHI was introduced since September, 2005 E.C. The members utilize health services by contributing annual health service fees. But there are problems such as resistance, the system of membership, the given service satisfaction, etc., observed in the area. But the researcher did not get any study done on the topic. Some researchers did a study in another area on the topic. Zelalem Yilma and others studied the impact of CBHI in relation to the economic welfare of the households, and he came up with positive results. Gebremeskel Tesfaye did a study on the same topic in Tigray, Kilte Awlaelo woreda, and come up with findings that show the effectiveness of the scheme. But the researcher wants to study about community based health insurance in Aneded woreda both the positive and the negative impact of the scheme, because it is a new phenomenon with multiple problems.

1.3. Research Questions

- What are the major factors that help to establish the scheme in Aneded Woreda?
- How is the effectiveness of the scheme in providing better access of health services for the members?
- How does the overall system of the scheme look like?
- How do the attitudes of households towards the scheme look like?

1.4. Objective of the Study

1.4.1 General Objective of the Study

The general objective of this study is an assessment of the impact of community based health insurance on health service utilization.

1.4.2 Specific Objectives of the Study

- To examine the major factors that help to establish the scheme in this woreda.
- To assess clients satisfaction on the service provided by the scheme.
- To assess the overall systems of the scheme
- To examine the attitudes of households towards the scheme.

1.5. Scope of the Study

The study was limited to the study of community based health insurance in Aneded Woreda at one kebele from Amber town, and another from a rural village called Wonganflam kebele. The whole population of the woreda was not target of the study due to financial, budget and a time constraints. Thus time and budget availability limited the number of samples. The study was delimited to the impact of CBHI on health service utilization in the case of Aneded Woreda.

1.6. Significance of the Study

This study will serve as supplementary provision for future investigation of the problem. It will be used as source of knowledge or basic information supply for the scheme providers and the researcher to conduct a wider research in this area regarding the issue. The study may create awareness about the community based health insurance scheme for other readers of this material.

1.7. Conceptual Definition of Terms

- Health: It is a state of complete physical, mental and social wellbeing and not merely the absence of disease of infirmity (WHO, 1948).
- Health Insurance: It is a type of insurance coverage that pays for medical and surgical expenses that are incurred by the insured (WWW. Investopedia. Com/terms/h/health insurance)
- Referral: It can be defined as a process in which a health worker at a one level of the health system, having insufficient resource (drugs, equipments, skills) to manage a clinical condition seeks the assistance of a better or differently resourced facility at the same or higher level of assisting, or take over the system (WWW.whsint/ management/preferable notes. doc)

2. Research Methodology

2.1. Description of the Study Area

The study was conducted in Aneded Woreda in East Gojjam Zone. The Woreda is at a distance of 283 km northwest of Addis Ababa and 282 Kilometer south of Bahirdar; while it is only 20 km from Debre Markos Town. Aneded Woreda is divided in 20 Kebeles. All those Kebeles are incorporated in CBHI scheme. But not all populations of each kebele are incorporated into CBHI scheme.

2.2. Study Population

The study populations of this research include 1,528 households who became members of CBHI scheme at Aneded Woreda and 3 other key informants of the scheme's office. The informants are those expected to have deep knowledge about CBHI scheme.

2.3 Sample Size and Sampling Technique

To undertake this research, the researcher used non-probability sampling techniques and both convenience and purposive sampling for the respondents and key informants. Among the 20 kebeles, the researcher selected only two kebeles i.e. kebele (01) from Amber Town and Wonganflam kebele from the rural villages by using convenience sampling techniques. The researcher expected that there is an attitudinal difference between the rural and the village town people. From (1528) households of both kebeles the researcher selected 30 respondents and three key informants.

2.4. Research Design

The research design used in this study was cross-sectional community-based survey to assess the impact of the CBHI on health service utilization, because the data was collected at one point in time.

2.5. Data Collection Method

The data was collected through both qualitative and quantitative tool. The qualitative data was collected through interview form CBHI officials and the quantitative data collected from households who are the members of the scheme by means of questionnaire.

2.6. Data Collection Instrument

Questionnaires: the researcher prepared questions containing both close-ended and open-ended questions and reads out the questions for the respondents' one at a time, and put their answers properly. The researcher used researcher-administered questionnaire, because most of the respondents are illiterate. Gathering data by using questionnaires are very important to save time and to gather large information in a short period of time.

Interview: The researcher prepared interview guide questions to get relevant information from key informants.

2.7. Source of Data

The necessary data for this study collected from both primary and secondary sources. The primary data was obtained from respondents through interview and questionnaires whereas the secondary data was obtained from unpublished and published materials as well as from the internet.

2.8. Method of Data Analysis and Interpretation

The primary and secondary data were analyzed and interpreted through qualitative and quantitative methods. The qualitative data have been analyzed and interpreted by using narrative sentences. The quantitative data were interpreted through percentage, table and frequency.

2.9. Ethical Consideration

All information was gathered based on the free-will of respondents. In every interaction the researcher respected his respondent's right and dignity. There was no need of naming the respondents that involved in the study. The respondents have free choice to decide whether to deliver required information or not.

2.10. Limitation of the Study

At the time of conducting this study the researcher encountered the following limitations.

- The sample of the research may not be truly representative because of limited respondents sample size.
- The type of the village settlement is very difficult to collect the data. Because of this the researcher used convenience sampling technique. This does not make the researcher free from bias.
- Some respondents were not interested to give the information openly because of misconception.
- The lack of updated documents to refer to the experience of the members of the scheme before and after engaging in to the scheme on health service utilization.

3. Data Analysis and Interpretation

This chapter deals about data analysis and interpretation on the impact of CBHI on health service utilization. The data was collected from three key informants, who held different positions. The first was a health officer from Amber Town Ethiopian Health Insurance Agency, the second interviewee was the kebele administrator in Amber Town; and the third interviewee was from the main branch of Ethiopian Health Insurance Agency at Debre Markos Town, who was a recording and monitoring officer. After the collection of data through questionnaires and interviews simultaneously, they responses were analyzed and interpreted, separately.

3.1. Attitudes of Households towards the Scheme

Table 1: The Helpfulness of the Scheme

Item	Households response	Frequency	Percentage (%)
The Scheme is helpful to utilize health services	Strongly agree	4	26.7
	Agree	2	13.3
	Partially agree	9	60
	Disagree	-	-
	Strongly disagree	-	-
	Total	15	100
	Data from Kebele 01		
	Strongly agree	5	33.3
	Agree	3	26.7
	Partially agree	4	20
	Disagree	-	-
	Strongly disagree	3	20
	Total	15	100

Source: Primary data from respondents 2016

The data from Wonganflam kebele on the above table 1 shows that 4 (26.7%) of the respondents replied strongly agree that the scheme helps them to utilize health services. The next 2 (13.3%) of the respondents agree whereas 9 (60%) of them responded partially agree. The remaining choice, i.e., disagree and strongly disagree are left by all respondents. The data from kebele 01 shows that 5 (33.3%) of the respondents replied that they strongly agree as the scheme helps them to utilize health services. Three (26.7%) of responded that they

agree, 4 (20%) respondents answered that they partially agree, and 3(20%) of them responded that they strongly disagree. Generally, the rural informants have negative attitudes towards the helpfulness of the scheme than the town respondents.

Table 2: The Bitterness of the Health Service Provision

Item	Households response	Frequency	Percentage (%)
The Scheme provided a better health services	Strongly agree	2	13.3
	Agree	6	40.0
	Partially agree	5	33.3
	Disagree	2	13.3
	Strongly disagree	-	-
	Total	15	100
	Data from Kebele 01		
	Strongly agree	-	-
	Agree	4	26.7
	Partially agree	4	26.7
	Disagree	3	20.0
	Strongly disagree	4	26.6
	Total	15	100

Source: Primary data from respondents 2016

In table 2 the Wonganflam kebele households response shows that 2 (13.3%) of the respondents strongly agree on the access of better health services of the scheme, while 6 (40%) responded that they partially agree on the issue. Again, 5 (33.3%) of the respondents replied that they agree and the remaining 2 (13.3%) responded that they disagree. The responses of kebele 01 respondents shows that 4(26.7%) agree, and 4(26.7%) partially agree, while 3(20%) said they disagree and 4 (26.6%) strongly disagree. The first choice, "strongly agree", is left out by all respondents. The above result indicated that most respondents of Wonganflam kebele accept that the scheme provides a better health services. On the contrary, respondents from kebele 01 express bitterness about the health service provided by the scheme as they most of the time in the clinic there is no sufficient amount of drug. Because of this they complained that they are enforced to buy drugs out of the clinic by using the prescription. In addition to this, there is no adequate number of health professionals at all levels of health institutions.

Table 3: The Consent of the Households to Establish the Scheme

Item	Households response	Frequency	Percentage (%)
The Scheme was established by the consent of the people	Strongly agree	3	20
	Agree	4	20
	Partially agree	3	26.6
	Disagree	4	26.6
	Strongly disagree	1	6.7
	Total	15	100
	Data from Kebele 01		
	Strongly agree	2	13.3
	Agree	2	13.3
	Partially agree	1	6.7
	Disagree	6	40
	Strongly disagree	4	26.7
	Total	15	100

Source: Primary data from respondents 2016

Table 4 reveals that 3(20%) of the respondents replied both strongly agree and partially agree, the next group 4(26.6%) replied agree and disagree in the same way, while the remaining 1(6.7%) responded on the position of strongly disagree on the establishment of the scheme based on their consent. The above table 4 reveals that 2(13.3%) of respondents replied both strongly agree and agree equally. The next group of respondents 1(6.7%) of them replied on partially agree and also 6(40%) of the participants of the study replied disagree. The remaining 4(26.7%) respondents react to strongly disagree. Both disagree and strongly disagree together absorb more than half of the respondents. On the contrary key informant's information reveals that the scheme was established by conciliating the community through continuous meetings. Therefore, based on the above information we can conclude that the establishment of the scheme was not with popular participation of the whole community.

Table 4: The Balance of the Scheme Fee and the Utilized Services

Item	Households response	Frequency	Percentage (%)
The Scheme fee is balanced with that of the service we have.	Strongly agree	6	40
	Agree	3	20
	Partially agree	6	40
	Disagree	-	-
	Strongly disagree	-	-
	Total	15	100
	Data from Kebele 01		
	Strongly agree	3	20
	Agree	6	40
	Partially agree	4	26.6
	Disagree	1	6.7
	Strongly disagree	1	6.7
	Total	15	100

Source: Primary data from respondents 2016

In the above table 4, the data from Wonganflam kebele shows that 6 (40%) of the respondents replied that they strongly agree with the balance of their fee and the service they utilize, the other 6 (40%) of respondents partially agree on the same issue. The remaining 3 (20%) of the households agree the service utilization and the fee. The data from kebele 01 indicates 3 (20%) of respondents answered that they strongly agree with the balance of both the service fee and its utilization while the other 6 (40%) of respondents also respond that they agree and 4 (26.6%) of the participants out of 15 respondents replied that they partially agree. The remaining 1 (6.7%) replied on disagree and strongly disagree for each respectively. On the other hand the key informants reveal that the cost of the scheme that the members contribute is not sufficient but the government subsidized it at different level. The woreda and regional subsidy is called target subsidy, because it was meant for "the poor of poor". But the federal subsidy depends on the coverage of a woreda's membership cotta. The woreda must reach more than 80% household membership registration and the new one 50%, unless otherwise they are not subsidized. Therefore, more than half of the respondents from both kebeles are satisfied by the amount of their payment and the service they utilize.

Table 5: The Perception of the Major Aim of the Scheme

Item	Households response	Frequency	Percentage (%)
The major aim of the scheme is to allocate health services for all citizens	Strongly agree	7	46.6
	Agree	3	26.7
	Partially agree	4	20
	Disagree	1	6.7
	Strongly disagree	-	-
	Total	15	100
	Kebele 01		
	Strongly agree	7	46.6
	Agree	6	40
	Partially agree	1	6.7
	Disagree	-	-
	Strongly disagree	1	6.7
	Total	15	100

Source: Primary data from respondents, 2016

The above table indicates that 7 (46.6%) of the respondents replied that strongly agree with the aim of the scheme. 3(26.7%) of respondents replied they agree. The next 4(20%) of respondents also replied that partially agree. Only 1 (6.7%) respondent answered that they disagree. The data from kebele 01 shows that 7(46.6%) of respondents replied strongly agree with the major aim of the scheme. The next 6(40%) of participants also respond agree, and 1(6.7%) the same way equal amount of respondents also replied that partially disagree and strongly agree. Generally, the majority of both kebele's respondents approve the major aim of the scheme. In addition to this, the key informants replied that the main purpose of the scheme is preserving the community from accidental health service cost. Therefore, the researcher concludes that the major aim of the scheme is clear for most members of the scheme.

Table 6: Attitudes towards the Profitability of the Scheme

Item	Households response	Frequency	Percentage (%)
The Scheme is not established for profit	Strongly agree	3	20
	Agree	5	33.3
	Partially agree	6	40
	Disagree	-	-
	Strongly disagree	1	6.7
	Total	15	100
	Data from Kebele 01		
	Strongly agree	1	6.7
	Agree	-	-
	Partially agree	7	46.6
	Disagree	4	26.7
	Strongly disagree	3	20.0
	Total	15	100

Source: Primary data from respondents, 2016

According to the data from Wonganflam kebele, as it is apparently shown in table 6, 3 (20%) of the respondents strongly agree that the scheme is not established for profit. The next 5(33.3%) of the respondents also replied that as they agree on the non-profitability of the scheme. The other 6 (40%) group of respondents also partially agree on the given issue but the remaining 1(6.7%) respondents also strongly disagree on the establishment of the scheme without profit. In the same way data from kebele 01 shown in table 6, 1(6.7%) of respondents strongly agree on the scheme is not established for profit. The next 7(46.6%) respondents replied that partially agree and 4(26.7%) of respondents also replied that they disagree and the remaining 3(20%) also respond they strongly disagree. Generally, almost all respondents from Wonganflam kebele and half of kebele 01 believe as the scheme is not established for profit. Additionally key informants said the scheme is not established for profit rather it established based on the principle of supporting each other i.e. the majority cover the health service cost for the minority. Therefore, the above data indicated that the non profitability of the scheme.

Table 7: About the Referral System

Item	Households response	Frequency	Percentage (%)
The referral system of the scheme is good.	Strongly agree	3	20.0
	Agree	-	-
	Partially agree	2	13.3
	Disagree	5	33.4
	Strongly disagree	5	33.4
	Total	15	100
	Kebele 01		
	Strongly agree	3	20.0
	Agree	1	6.7
	Partially agree	1	6.7
	Disagree	4	26.6
	Strongly disagree	6	40
	Total	15	100

Source: Primary data from respondents 2016.

In table 8, 3(20%) of them strongly agree to the referral system of the scheme being good. 2(13.3%) responded partially agree while equal percentage of respondents i.e. 5(33.4%) each replied on both disagree and strongly disagree. The data from kebele 01 reveals that 3(20%) of respondents replied that they strongly agree and 1(6.7%) respondent each responded for partially agree and agree. The next 4 (26.6%) of respondents replied they disagree. The remaining 6 (40%) of respondents also replied they strongly disagree on the referral system of the scheme. This indicates that the referral system of the scheme did not satisfy the needs of the members because the majority of respondents replied their disagreement and strongly disagree. As we have seen on the table above, more than half of the respondents from both kebeles placed on disagree and strongly disagree. In addition to this the respondents explain that when they referred to referral hospital their list of membership disappears then they are instructed to bring a new referral letter from the clinic again. Therefore, this indicated that there is some problem related to the referral system of the scheme.

Table 8: The Helpfulness of the Scheme to Poor People

Item	Households response	Frequency	Percentage (%)
The scheme is established to help the poor people	Strongly agree	3	20
	Agree	3	20
	Partially agree	6	40
	Disagree	2	13.3
	Strongly disagree	1	6.7
	Total	15	100
	Data from Kebele 01		
	Strongly agree	3	20
	Agree	8	53.3
	Partially agree	2	13.3
	Disagree	-	-
	Strongly disagree	2	13.3
	Total	15	100

Source: Primary data from respondents 2016

In the table above, 3 (20%) of the respondents answered strongly agree that the scheme is established to help poor people. The next 3(20%) of respondents replied that they agree on the helpfulness of the scheme. The remaining 6(40%), and 2(13.3%), and 1(6.7%) respondent replied partially agree, disagree and strongly disagree respectively. The data from kebele 01 on the above table indicate that 3(20%) of the respondents answered that they strongly agree on the helpfulness of the scheme for poor people and 8(53.3%) of the respondents replied they agree. The next 2(13.3%) of the participant group respond that agree and no one has replied on disagree and 2(13.3%) of respondents respond strongly disagree. Based on the above data we can conclude that most respondents agree about the helpfulness of the scheme for poor people. As key informants added to this, one of the main purpose of the scheme is to access health services for all segments of the society.

Table 9: The Quality of the Service

Item	Households response	Frequency	Percentage (%)
The main objective of the scheme is to provide quality health services with balanced cost and the scheme provide standardized medication for its members.	Strongly agree	2	13.3
	Agree	4	26.6
	Partially agree	5	33.4
	Disagree	3	20.0
	Strongly disagree	1	6.7
	Total	15	100
	Data from Kebele 01		
	Strongly agree	2	13.3
	Agree	2	13.3
	Partially agree	5	33.4
	Disagree	2	13.3
	Strongly disagree	4	26.6
	Total	15	100

Source: Primary data from respondents 2016

Table 10 shows that among the 15 respondents of this study, 2 (13.3%) respond that they strongly agree and 4 (26.6%) replied agree about the existing health service quality provided by the scheme. The other respondents 5 (33.4%), 3 (20) and 1 (6.7%) of the respondents replied partially agree, disagree and strongly disagree, respectively. And among the 15 respondents of kebele 01, 2(13.3%) respondents each respond for strongly agree, agree and disagree. That means the three choices have got equal replies by respondents. The following 5(33.4%) responded that they partially agree. Then the remaining 4(26.6%) replied that strongly disagree. On the other hand, the data obtained from key informants reveals that providing quality health service is the other purpose of the scheme. But this is not achieved. Because there are many unqualified health service delivery institutions in terms of quality, equipment, skillful health service delivery professionals, etc. Therefore, the researcher infers that even though, more than half of the respondents of both kebeles have positive attitudes about the quality of the service provided by the scheme there are some problems they unconsciously encountered.

3.2 The Overall Systems of the Scheme

Table 10: Choice Question

No	Items	Households choice	Frequency	Percentage (%)
1	What is the basic reason that hinders households to renew their membership?	Lack of money	7	46.7
		Low standard of medication	3	20
		Poor reception for members	3	20
		Negative attitudes towards the scheme	2	13.3
		Total	15	100
		Data from Kebele 01		
		Lack of money	4	26.7
		Low standard of medication	2	13.3
		Poor reception for members	3	20
		Negative attitudes towards the scheme	6	40
		Total	**15**	**100**
2	What is the major factor affecting some households have never joined the scheme?	**Households choice**	**Frequency**	**Percentage (%)**
		Lack of many	4	26.7
		Low awareness about the scheme	8	53.3
		Large household members	1	6.7
		All	2	13.3
		Total	**15**	**100**
		Data from Kebele 01		
		Lack of many	1	6.7
		Low awareness about the scheme	4	26.7
		Large household members	7	46.7
		All	3	20
		Total	15	100

3	What does the reception given for the members of the scheme by health service professionals look like?	**Households choice**	**Frequency**	**Percentage (%)**
		Very good	7	46.7
		Good	2	13.3
		Poor of bad	6	40
		Total	15	100
		Data from Kebele 01		
		Very good	1	6.7
		Good	4	26.7
		Poor of bad	7	46.7
		Somehow good	3	20
		Somehow good	-	-
4	What do you think of the quality of drugs?	**Households choice**	**Frequency**	**Percentage (%)**
		Good	7	46.7
		Low quality	8	53.3
		Poor or bad	-	-
		Total	15	100
		Data from Kebele 01		
		Good	9	60
		Low quality	5	33.4
		Poor or bad	1	6.6
		Total	**15**	**100**
5	How do you see the benefit received by an insured client?	**Households choice**	**Frequency**	**Percentage (%)**
		Very good	5	33.4
		Good	1	6.7
		Poor	7	46.7
		I don't know	2	13.3
		Total	15	100
		Data from Kebele 01		
		Very good	2	13.3
		Good	1	6.7
		Poor	9	60
		I don't know	2	13.3
		Total	**15**	**100**
6	What do you say about the current fee of the scheme	**Households choice**	**Frequency**	**Percentage (%)**
		Cheap	9	60
		Expensive	2	13.3
		Too cheap	4	26.7
		Total	15	1oo
		Data from **Kebele 01**		
		Cheap	7	46.6
		Expensive	3	20
		Too cheap	5	33.4
		Total	**15**	**100**
7	In general what do you feel about the	**Households choice**	**Frequency**	**Percentage (%)**
		Very good	3	20

	scheme?	Good	10	66.5
		Poor	2	13.3
		Total	15	100
		Data from Kebele 01		
		Very good	6	40
		Good	6	40
		Poor	3	20
		Total	**15**	**100**

Source: primary data from respondents 2016,

The data obtained from both kebeles are similar as shown in table 11, and the upper data is from Wonganflam rural kebele while the lower is from Amber town kebele 01. For item number one in table 9 (53.4%) of respondents from both kebeles replied lack of money being the major reason hindering households from renewing their membership. The same number of respondents from each kebele, i.e., 8 (53.3%) also respond that low standard of medication and 1 (6.7%) of respondents replied poor reception as well as the remaining 2 (13.3%) respond that negative attitudes towards the scheme. Based on the above data the researcher infers that lack of money and low standard of medication is the major factors that hinder households to renew their membership.

From both kebeles for item number two 14 (93.4%) of respondents replied lack of money hinder households to join the scheme. The next 6 (40%) of respondents also replied low awareness about the scheme and the same number of respondents also replied as all choices are contributing factors. This implies that why some households do not join the scheme is the problem of affordability of the scheme fee. On the contrary key informants said that, the first great problem is lack of trust on the scheme. As they said most households did not believe as they get appropriate health services with this minimum cost and some households who have a better income resist the scheme and key informant express that no affordability because the major factor that helps to established the scheme is the income potential of the community. They prefer out of pocket health service. Some members also need to have double registration in a single payment. That means if they are not observed in the clinic last year, they consider their payment serves them for the next.

From the total number of respondents from both kebeles 14 (93. %) replied very well about health professionals reception. The next 4 (26.6%) also respond well. The remaining 12 (80%) respondents replied that poor or bad, but no one respondent replied on somehow good.

Therefore, health professional's reception for members is very good but on the contrary, in the open-ended question most respondents replied that it is very poor as well as data obtained from key informants reveal that most problems of the scheme are related with unethical conduct of health professionals towards members of the scheme.

In table 11, among the total respondents of both kebeles, 14 (93.4%) of respondents replied good and 16 (56%) respondents also replied low about the quality of drugs provide by the scheme. This implies that more than half of the households are not satisfied by the quality of drugs the scheme provide.

The data obtained from both kebeles show that for question number five on the above table 10 (33.4%) of respondents replied very good and 2 (6.7%) also replied well. On the other hand 14 (46.7%) of respondents replied poor. The remaining 4 (13.3%) respondents respond

I don't know. Therefore, the researcher concludes that more than half the members of the scheme are not satisfied with the benefit of the scheme.

About the current fee of the scheme 18 (60%) of respondents replied that it is cheap. The remaining 4 (13.3%) and 8 (26.7%) respondents replied as expensive and too cheap respectively for each kebele. This data indicated that the current fee of the scheme is balanced with their service.

Concerning utilization respondents explained in the open ended question that they pay low membership fees and thus they get low health services. According to key informants response the major importance of the scheme is to provide quality health services with a minimum cost.

Both kebeles respondents for the last question of the above table 6(20%) replied very good and 20(66.5%) of respondents also respond good, but 4(13.3%) responded poor. In general most respondents accepted the current fee of the scheme as good and nearly all of the respondents have good perception about the overall systems of the scheme.

3.3 Client's Satisfaction on the Service of the Scheme

Table 11: Overall Schemes Satisfaction to Clients

No	Variables	Indication		
		Households	**Frequency**	**Percentage (%)**
1	Do you think that the scheme reduce your health service cost?	Yes	12	80
		No	3	20
		Total	15	100
		Kebele 01		
		Yes	13	86.7
		No	2	13.3
		Total	**15**	**100**
2	Do you think that your fee and your service utilizations balanced?	Yes	12	80
		No	3	20
		Total	**15**	**100**
		Kebele 01		
		Yes	7	46.6
		No	8	53.3
		Total	**15**	**100**
3	Have you satisfied by the service of the scheme?	Yes	9	60
		No	6	40
		Total	**15**	**100**
		Kebele 01		
		Yes	8	53.3
		No	7	46.6
		Total	**15**	**100**
4	Did you renew your member ship in this year?	Yes	13	86.7
		No	2	13.3
		Total	**15**	**100**
		Kebele 01		
		Yes	14	93.3
		No	1	6.7

		Total	**15**	**100**
5	Are you observe the clinic the quaintly?	Yes	6	40
		No	9	60
		Total	**15**	**100**
		Kebele 01		
		Yes	8	53.3
		No	7	46.6
		Total	**15**	**100**
6	Have you been referred to a referral hospital?	Yes	2	13.3
		No	13	86.7
		Total	**15**	**100**
		Kebele 01		
		Yes	3	20
		No	12	80
		Total	**15**	**100**
7	Can you go straight to hospital?	Yes	1	6.7
		No	14	93.3
		Total	**15**	**100**
		Kebele 01		
		Yes	1	6.7
		No	14	93.3
		Total	**15**	**100**
8	Is it good registration by household?	Yes	14	93.3
		No	1	6.7
		Total	**15**	**100**
		Kebele 01		
		Yes	13	86.7
		No	2	18.3
		Total	**15**	**100**

Source: Primary data from respondents 2016

Table 11 shows that among 15 respondents of this study 12 (80%) respondents from Wonganflam kebele and 13 (86.7) from kebele 01 replied that the scheme reduces their health service cost, while 3 (20%) and 2 (13.3) replied no. That indicated the scheme reduced their health service cost.

According to the respondents from Wonganflam kebele their cost and their health service utilization are balanced. This reveals that the payments of households are parallel to their health service utilization. The data from the respondents of both kebeles shows more than half are satisfied from the services provided by the scheme. The researcher too concludes that members of the scheme are satisfied by the service. Almost all respondents from Wonganflam and kebele 0, i.e., 13 (86.7%) and 14 (93.3) of them renewed their member ship this year. On the other hand, 2 (13.3%) and 1(6, 7%) respondents from Wonganflam kebele and kebele 01, respectively did not renew their membership. Yet, nearly all renewed their member ship. The implication is the sustainability of the scheme to be in a good manner. On the contrary, key informants data shows that still there is the problem of renewal of membership especially from recently engaged households.

Item number five on table 11 shows that 14 (93.3%) and 8 (53.3%) both from Wonganflam and kebele 01 responded yes respectively, as they observe the clinic frequently. The key informants explained that one of the positive changes of the scheme observed is the

increasing flow of patient specially women and children. The scheme helped these social sectors to have access to health services since they could not get out of pocket payment for their health treatment, because the household type is patriarchal, and they are under the control of the male head household. So to go to the clinic they must get his permeation. Therefore, the researcher concludes that the scheme helps the household to observe the clinic frequently. The above data shows that nearly all respondents from both kebeles are not referred to a referral hospital. Those who were referred to a referral hospital do not get the service on time and they get bored in addition their membership documents mostly do not exist or found at the hospital level. Because of this they can't get the service on time. This data shows that the referral system on the scheme is not satisfactory. In addition, respondents replied that they cannot go to hospital directly to get better treatment without referral paper. The key informants accepted the problem in the referral system; such as lack of human resource, equipment, well organized documents of the members because the system is very new to the country.

4. Conclusion and Recommendations

4.1 Conclusion

The aim of this study is assessing the impact of CBHI on health service utilization at Aneded woreda. CBHI scheme is a type of health insurance for informal sector workers and for rural agricultural communities. It is not established for profit. It is used by poor people to protect them from accidental health seeking cost. Based on the results of this study the researcher concludes that community based health insurance increases the flow of patients' both clinical and hospital level. And it increases the opportunity of women's and children's health service utilization and health seeking behavior. However, the scheme has many challenging circumstances from the very beginning. Most of these challenges are related with the awareness of the community and the system of health service delivery that is providing by the scheme. The community considers the scheme as profit making rather than helping poor people, and some members of the scheme expect double registration in a single payment. For example, if one of the members of the household does not observe any treatment throughout the year they consider last year's fees to be used for the next year. In addition to this most members of the scheme are not committed to pay their fees on time and they did not take the identity card until they get ill. Health service delivery system provided by CBHI scheme is not satisfactory in terms of quality, referral system, human resource and building facility.

The scheme provides less quality medication for members of the scheme and most of the time the members are forced to buy from private pharmacies. This is a major challenge; because members face unexpected cost and they may not have money in their hands in time. Members are not preserving for accidental health service costs.

The referral system of the scheme is not organized. There is no strong coordination between health centers or clinics and the referral hospitals. Some households explain that they return home without any treatment at referral hospitals frequently because of non-existence of their list at hospital level. And even if they get the chance of treatment, there are no skilled health professionals. There is also shortage of equipment's specially laboratory services not available at a clinic level. Some health professionals are not ethical and have negative attitudes towards the members of the scheme. They considered the members of the scheme as free health service users and sometimes they commit verbal attack because they believe members of the scheme may come for miner illness since it is free.

Generally, unqualified health institutions and lack of skilled health professionals and shortage of medicines at clinical and hospital level collectively contributed for membership sustainability and level of satisfaction of the scheme members.

4.2 Recommendations

- The community need understand that the scheme increases their social cohesion and sense of belongingness. Because the majority collectively helps the poor minority;
- The government, especially the Ministry of Health must encourage community participation or create popular participation before the establishment of the scheme;
- The referral system of the scheme should be improved; that means, it is important to create strong connection between referral hospitals and health centers or clinics as well as prepared well organized membership documents;
- The government must improve quality of medication and drugs as well as professional skills of health service providers;
- Before the implementation of the scheme, necessary health service facilities must be fulfilled such as equipments, drugs, skilled professionals, building facilities, etc;
- Health service professionals should serve members of the scheme based on professional ethics;
- Awareness creation strategies of the scheme must be strengthened to increase membership continuity;
- The implementation strategies of the scheme should be uniform throughout the country;
- The government must create large scale promotion programs through the use of different stockholders such as health extension workers kebele's and woreda's administrators, agricultural extension workers, rural teachers, religious leaders as well as mass media; and
- The scheme fees also must affordable for the poor people.

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