ADDIS ABABA UNIVERSITY
COLLEGE OF HEALTH SCIENCES
SCHOOL OF PUBLIC HEALTH

WILLINGNESS TO PAY FOR SOCIAL HEALTH INSURANCE AMONG PUBLIC SERVICE PENSIONERS IN ADDIS ABABA, 2020

BY: YONAS HIZKIYAS (BSC)

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December, 2020
Addis Ababa, Ethiopia

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December, 2020

Addis Ababa, Ethiopia

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ACRONYMS

CBHI Community Based Health Insurance

GDP Gross Domestic Product

LMICs Low and Middle-Income Countries

MOH Ministry of Health

NCDs Non-Communicable Diseases

NHA National Health Account

NHIS National Health Insurance Scheme

OOP Out of Pocket

SHI Social Health Insurance

SPSS Statistical Package for Social Sciences

WHO World Health Organization

WTP Willingness to Pay

AOR Crude Odds Ratio

CI Confidence Interval

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Abstract

Background: In many developing countries, health funding is marked by high levels of out-of-pocket spending on severe diseases, leading to potentially catastrophic health care expenditures for its people. Ageing and the rising burden of non-communicable diseases are key challenges for low-income countries in particular because of their effect on the economy and on measures of growth and competitiveness. In order to achieve universal health care coverage, cost-sharing between beneficiaries and governments through offering financial security and pooling funds to enable cross-subsidization between the rich and the poor and between the healthy and the sick is essential. In order to this, Ethiopia is presently launching social health insurance, but implementation has been postponed due to insufficient awareness of the recipient's demand and ability to join the newly proposed insurance scheme. This study aimed to assess the willingness to pay for SHI among in public service pensioners in Addis Ababa.

Methods: An institutional based quantitative cross-sectional study was conducted to determine willingness to pay for social health insurance and associated factors among public service pensioners, who are living in Addis Ababa and take monthly pension salary at Ethiopian postal service enterprise. A sample was allocated to each cashier payroll list of pensioners and a respondent was selected by systematic sampling method in every k^{th} interval. Structured interviewer administered questionnaire was used to collect data. Data was entered in to Epi-data manager and analyzed by using SPSS version 20 statistical software. Descriptive statistics, bivariate and Multivariate logistic regression analysis was applied.

Result: 398 participants participated in this study. Out of the total sample 307(77.1%) will join the new stated social health insurance and 91 (22.9%) are not. The participants' monthly income, number of dependent family members in the household, history of chronic illness in the family, hearing about health insurance and believe health insurance is beneficial are founded to be significantly associated with WTP for SHI.

Conclusion: The prevalence in this study is higher because of the study participants are not actively working at the time with their age and they are facing different chronic illness. Therefore; the government should be implement social health program for formal sectors parallel to CBHI and creating awareness and education about the benefits of health insurance is essential.

CHAPTER 1: INTRODUCTION

1.1. Background

In many countries, financial constraints are one of the major barriers to access to healthcare for marginalized sections of society. At least half of the world's population is estimated to be unable to obtain essential health services, and large numbers of households are pushed into poverty each year because they have to pay for healthcare out of their own pockets (1). In addition, More than 10 % of their household spending is spent on healthcare by 800 million people, and almost 100 million people are forced into severe poverty each year because of out-of-pocket health costs , and many of those who use services suffer financial hardship or are even impoverished because they have to pay 40 percent or more of 'non-subsistence income' on medical care(1).

With little or no position for out-of-pocket expenses, many developed countries have funded their universal health care spending largely through social health insurance or general taxation. On the other hand, many developing countries have funded their universal health care expenses from public resources, with out-of-pocket expenditures being a higher proportion (2).

Evidence suggests that the poor bear the largest burden of diseases in many sub-Saharan African countries and face high levels of catastrophic health expenditure (3).

As part of established global health policy agendas, which remain focused on reproductive health and infectious diseases, no comparable focus on older people has emerged. There is a tendency to highlight the impact of these conditions on younger age groups even within the growing global focus on non-communicable diseases (many of which are strongly associated with old age) (4).

In high-income nations, including where health services are free at the point of use, personal wealth for all age groups, including older people, is consistently correlated with better health outcomes. There is considerable evidence that groups such as older people, especially in low and middle-income countries (LMICs), may face significant financial barriers to accessing adequate health services. Survey data for the United Republic of Tanzania and Cote d'Ivoire showed that substantially higher proportions of those 50 years of age or older did not seek care while they were sick relative to those in younger age groups. Despite this, per capita expenditure on health care by individuals 50 years of age or older was substantially higher for both countries than for other age groups(4).

There is a clear intuitive logic that old-age pensions can boost the health status of older people, with many other factors depending on this effect. That involves the extent to which pension income is preserved or pooled/appropriated by the older person by other members of the family. There is ample evidence that pension pooling across developing countries is a common activity. However there are also signs that exploitation by pensioners and forced appropriation of benefits are widespread. The ability to turn pension income into better health also depends on the availability and affordability of adequate health care, and this is often very limited, particularly in developing countries (4).

Social health insurance (SHI) is seen as a crucial mechanism for ensuring financial security to achieve universal healthcare. Social health insurance schemes are intended to shield individuals from catastrophic healthcare costs by pooling funds to encourage cross-subsidization between rich and poor and between healthy and sick people (3).

Extreme funding, weak security mechanisms and a lack of risk pooling and cost-sharing activities define the Ethiopian health system, all of which lead to inequalities in access to healthcare (5). In 2011, Health insurance was ratified by the Ethiopian government parliament; the state is struggling to launch social health insurance for formal and community-based health insurance for informal sectors, respectively. Because of resistance from public servants, the implementation of social health insurance was delayed. In order to provide health insurance for workers and pensioners in the formal sector and their families, social health insurance is planned. Active employees will have to pay monthly premiums of 3%, while pensioners are required to pay 1% of their monthly salary for an outpatient and inpatient service, but exclude overseas treatments, treatments with high cosmetic values, teeth implantation and plastic surgeries (6). This is part of the larger health care funding reform plan of the government that seeks to increase the quality and coverage of health services through the identification of alternative healthcare. Therefore, to successful implementation of the program it is essential to assess its feasibility and acceptance within the public service pensioners. Moreover, willingness to pay for social health insurance and related factors among public service pensioners are unidentified that make the program in question sustainable and efficient, thus this study is intended to find out willingness to pay for social health insurance and recognize associated factors among pensioners in the public service.

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1.2. Statement of the Problem

Because of the health services they need many families worldwide suffer needless financial distress. It is estimated at the global level that 808 million individuals have earned out-of-pocket health payments in excess of 10%-25% of overall household spending or income. Of these 150 million people, disastrous spending faces catastrophe, while about 100 million people are disadvantaged due to direct payment of health care (1). Since 2000, both the proportion and the scale of the global population awaiting devastating payments have grown. The area with the highest out-of-pocket payer rate of 14.8 percent was Latin America and the Caribbean. The second-highest rate in Asia was (12.8%). LMICs account for 90% of the global disease burden, paying for just 12% of global health spending (1).

In LMICs direct out-of-pocket payments are a significant health care funding system; such direct payments are inequitable and ineffective in financing health sectors because they have negative consequences for access to health care and expose the public to catastrophic and impoverishing health care costs(7). In Ethiopia, the government purchases a large proportion of health services (61 %),while Out of Pocket expenditure was 35%, which threatens households from catastrophic health expenditure and has a negative effect on access and use of health care (8).

Social health insurance will also be a key focus of initiatives currently under consideration in many developing countries across the globe in order to counter the risk of impoverishment, inequitable access and use of health care. The consensus seems to be that poor people should be subsidized and that citizens should be covered by the substantial financial risk posed by high-cost diseases (9).

Ageing brings an increased risk of chronic disease and disability growth. In most developing countries, Non-communicable diseases (NCDs) are now the single largest cause of both mortality and morbidity. In low, middle and high income countries, Non-communicable diseases account for almost 90 % of the disease burden for the over-60s, and people over 60 accounted for 75% of the 35 million deaths from NCDs worldwide in 2004, with the majority in low and middle-income countries(4).

Studies conducted in different parts of Africa and Asia have stated that the low level of willingness to pay for SHI is responsible for various socio-demographic and economic factors(10). As the research conducted in Ethiopia shows, formal health insurance coverage is very limited. The government of Ethiopia is currently conducting a range of activities to resolve this problem and

establish an equal funding system to implement SHI with the ultimate objective of achieving universal health coverage and reducing high out-of-pocket expenditure and improving the use of health care, but when public service staff, especially health professionals, are forced to postpone (5, 11).There are social security beneficiaries who have served the public, and those who are more likely to be exposed to a variety of illnesses than other related to aging and socioeconomic problems. Health Service costs will be raised. In fact, they understand the importance of social health insurance and their desire to pay for the program and their associated factors. Since they are unknown, as well as various studies conducted in Ethiopia so far, the study has shown that compared to the active workers and social security beneficiaries at the time of the study. This study was necessary because it focused only on those who were less likely to develop health problems related to aging, socioeconomic problems. Therefore, to fill this gap this study is proposed with aim to determine willingness to pay for the Newly Proposed social health insurance among public service pensioners.

1.3. Significance of the Study

The World Health Organization has advocated the establishment of social health insurance as a key to achieving universal health care coverage and to ensuring access to health services, especially for the vulnerable in developing countries. Therefore, this study undoubtedly will provide the useful data on willingness to pay for SHI and associated factors for researchers, policy makers, decision makers, civil associations and implementers. It will also provide real data to check for the opportunities and obstacles it will face during the implementation process on willingness to pay for SHI and associated factors that will give a factual insight to the successful implementation of the program. The result will be expected for improving willingness to pay for of SHI. and the study will invite and will start further study on the issue in order to Providing details on factors that can either discourage or promote public service pensioners' willingness to pay; ensuring the acceptability and viability of the program.

CHAPTER 2: LITERATURE REVIEW

2.1. Definition of social health insurance

Social health insurance can be set up by pooling premiums over time by pre-payment and risk pooling over people to distribute the financial risk associated with the variation in health care spending (12). The main objective of insurance is to smooth out spending on a good for which the need occurs unexpectedly; over a lifetime, the good is health care with health insurance (12). Another aim is to provide individual subsidies, as certain individuals who pay into a financial pool may not have a clear need. Insurance also offers risk pooling over time and individuals because of risk differentials over time and individuals (13).

2.2. Health care financing and health insurance in low-income countries

Low-income countries face 56% of the global burden of disease, but account for just 2% of global health spending with spending levels ranging about $30 per capita, more than half of it out of pocket, low-income countries face significant challenges in providing their people with a basic package of vital services and a minimum of financial protection against the impoverishing impact of catastrophic illness (14). Catastrophic spending is a challenge for countries at all levels of development in 2010, 97 million people were impoverished by out-of-pocket spending on health at the $1·90 per day poverty line, equivalent to 1·4% of the world's population, At the $3·10 per day and relative poverty lines, 122 million people (1·8% of the world's population) and 103 million people (1·5%) were impoverished by out-of-pocket spending on health (15).

A health care system that provides good health outcomes, affordable services, satisfied customers and suppliers, and medical and financial equity is what every country wants. In low-income countries, where budget constraints are binding at low levels of overall expenditure, particularly in the public sector, these objectives are difficult to achieve (14). Donors are expected to finance most of the scale-up, having reported that health expenditures are largely out of pocket in low-income countries and there is limited capacity to increase domestic public spending. But even though donors make long-term promises, health spending would inevitably have to be absorbed into the domestic resources of each country (14).

In recent decades, it has become increasingly difficult for many low and middle-income countries to sustain adequate funding for health care, especially for the poor, and international policymakers

have been involved in recommending a number of effective steps, including cost-sharing arrangements for conditional cash transfers and a variety of health insurance programs, including social health insurance(13). In 2005, the WHO adopted a resolution that would endorse a strategy to mobilize more health capital, to pool risk, to improve access to poor people's health care and to provide quality health care in all its member States, but in particular in low-income countries (16).

The Ethiopia sixth National Health Accounts (NHA) showed that the total spending on health has been reached 26.5 billion birr which are 5.2% of Gross Domestic Product (GDP)This is an acceptable level since it is above the WHO recommendation of a minimum of 5% of GDP spending on health(OOP but of the 26.5 billion birr 49.9% from donor ,33.7% from house hold (OOP) ,15.6% from government and 0.8 from other source which is Extreme funding, low structures of security for the vulnerable, and a lack of risk pooling and cost sharing strategies.(17). The implementation of community-based health insurance (CBHI) and social health insurance (SHI) for the informal and formal segment of society, respectively, are attempts by governments to resolve the challenge of high out-of-pocket spending (OOP) during the use of health services. The implementation of the CBHI and SHI is seen as a way of advancing towards universal health care (17).

2.3. Ageing and the challenge of non- communicable diseases in developing countries

The World Health Organization's September 2010 Global Status Report on NCDs, which refers to ageing as the first of four drivers of NCD predominance in developing countries, indicates a growing relationship between ageing and NCDs in low- and middle-income countries (4).

It is estimated that two-thirds of the 177 million people with type -2diabetes live in the developing world, and the highest rise in the prevalence of type- 2diabetes in the elderly is projected to occur in Asia and Africa, where the majority of patients are likely to be identified by 2030. In developing countries, there are significant numbers of elderly people suffering from cardio-vascular disease, stroke and diabetes. In older populations of low and middle-income countries, hypertension, sometimes undetected, is normal. Some non-modifiable risk factors will also grow exponentially with ageing. By 2050, 115 million people worldwide will have Alzheimer’s disease or other dementias, 71% of whom will be living in developing countries (4).

2.4. Willingness and decision to pay premium for sustainable SHI

In terms of any indicator of use of health services for treatment, taking up preventive care, avoidance of high one-time spending, and change in health by promoting access to care, the welfare effect of social health insurance should be measured(13).

Study in BahirDar among civil servants shows majority of the respondents 83.2% of respondents perceive that social health insurance will address their unexpectedly higher costs related to health care services and 82.8 percent of the vast majority of study participants perceived that their existing reimbursement mechanism for healthcare was not adequate to cover the full cost of their healthcare needs and that Two-thirds of respondents are able to pay for their registration and 62% are demand for social health insurance (5). Similar study in WolayitaSodo, 71.3% of the teachers were able to enroll in the new social health insurance program of this 74.4 % were willing to pay for the scheme (12). Education status, marital status, difficulties of paying for medical expenses over the past 12 months , level of awareness and Perception about who should pay insurance premium are Predictors of willingness to pay for SHI and significantly associated with it(18). The definition and aspects of health insurance little understood, some principles are not well understood, such as risk pooling and sharing. Health insurance was considered by the study participants as just a prepayment mechanism without risk sharing among member of the scheme. They also have shown standard of care as the most significant consideration with respect to choice for health insurance (19).

2.5. Conceptual frame work

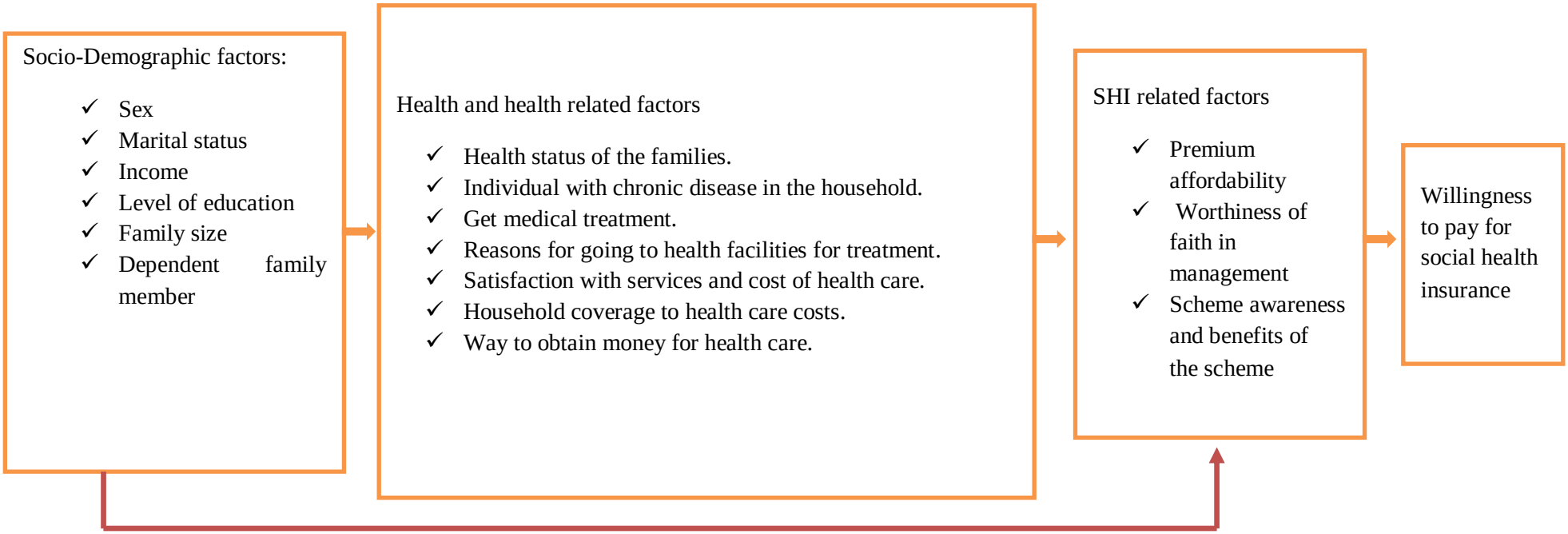

Figure 1. Conceptual frame work of social health insurance willingness to pay changed according to the study aim those variables considered as independent variables and related with the outcome variables (adapted from Belay N.2018).

CHAPTER 3: OBJECTIVES

3.1. General Objective

To assess willingness to pay for social health insurance and associated factors among public service pensioners in Addis Ababa

3.2. Specific objectives

- To assess awareness about the concept of health insurance
- To assess willingness to pay for social health insurance
- To identify factors associated with willingness to pay for social health insurance

CHAPTER 4: METHODS AND MATERIALS

4.1. Study area and period

The study was carried out in Addis Ababa, Ethiopia. Addis Ababa is the federal capital city of Ethiopia. During the study period, 90,500 public service pensioners live in the city, from these 25,800 pensioners collect monthly pension at Ethiopian postal service enterprise. The city has 16 public and referral hospital, 108 public health center, 24 private hospitals and 119 specialty clinics(20).Public health institutions, funded by the government, donors and out-of-pocket spending received from patients during the time they receive health care services .The study was conducted from May, 2020 to June,2020.

4.2. Study design

Institution based quantitative cross-sectional study design was carried out.

4.3. Population

4.3.1. Source of population

The source population is all public service pensioners living in Addis Ababa.

4.3.2. Study population

All Public service pensioners who take monthly pension salary at Ethiopian postal service enterprise head office.

4.4. Inclusion and exclusion criteria

4.4.1. Inclusion criteria

All public service pensioners who are included in the pensioner’s payroll list during the data collection period.

4.4.2. Exclusion criteria

All military, police pensioners, formal representative of pensioner was excluded in the study

4.5. Sample size determination and sampling procedure

4.5.1. Sample size determination

Sample size was calculated using the formula of single population proportion

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

Where n= the required sample size

z= the value that corresponds to 95%confidence level in the standard normal distribution

p= assumed population proportion p=50% (no previous study in the same respondents)

d= margin of error=10%

So, $n = (1.96)^2 \frac{0.5(1-0.5)}{0.05^2} \approx 403$

Since the source population is greater than 10,000 no population correction formula is required.

Therefore, by taking 10% non-response rate, the total sample size becomes 423.

4.5.2. Sampling procedure

Ethiopian postal service enterprise head office pension payment station was purposely selected. The total sample size was allocated to each cashier payroll list of pensioners. Then respondents was selected by systematic sampling method every k^{th} interval (since k=N/n) in each group.

4.6. Variables of the study

4.6.1. Dependent variables

Willingness to pay social health insurance

4.6.2. Independent variables

Socio-demographic factors: Sex, Marital status, Income, Level of education, Family size, Number of dependent family member

Health and health related factor: Health status of the families, Individual with chronic diseases in the household, Get medical treatment and place of treatment, Reasons for going to health facilities for treatment, Services and costs of health care, Household coverage to health care costs, Way to obtain money for health care.

SHI Related Factors: Premium affordability, Worthiness of faith in management, Scheme awareness and benefit of scheme.

4.7. Operational Definition

Willingness to pay: The need to enroll and pay in SHI. Therefore, a respondent will pay for SHI if the responses were 'yes' for both questions that assess need and willingness to pay for SHI and respondent answers a minimum of 1% of his salary to be paid for social health insurance premium.

Public service pensioners: The person with age 60 years and above and previously worked in different public service institutions.

Institution: Governmental institution in this case Ethiopian postal service enterprise.

4.8. Data collection tools and procedures (instrumental and personal)

A structured interviewer administered questionnaire was adopted from previous study to collect information regarding socio demographics, willingness to pay for SHI and associated factor using primary data (from sample individuals). The questionnaire was first developed in English and translated in to Amharic version. Pre-test was conducted to cheek for validity and reliability. Data was collected by four trained health professionals.

4.9. Data quality control/assurance

Filled questionnaires is check for completeness and any incomplete information was excluded from the entry, after the entry of every questionnaire complete, the soft copy of every questionnaire is cross check with its hard copy to see for the consistency clean data is exported to SPSS version 20 software packages for analysis then, it was analyzed using Statistical Package for Social Sciences (SPSS) version 20. Descriptive summary measures were used to describe the socio-demographic data. Data was checked for normality and homogeneity distribution before assessment of association.

4.10. Data processing and analysis

Data was entered in to Epi-data manager and analyzed by using SPSS version 20 statistical software. Descriptive statistics such as frequencies, percentages and medians was computed to describe variables of the study. Crude Odds ratio with 95% CI in bi-variate analysis was computed to see an association between willingness to pay for SHI and independent variable. Variables with p-value <0.25 was included in Multivariate logistic regression analysis model to observe independent effects of associated factors on the demand SHI by controlling the effect of confounders. Finally, P-value less than 0.05 were considered as significantly associated variables.

4.11. Ethical approval and consent to participate

The study was approved by committee of Addis Ababa University School of Public Health research Ethics Review Board, Letter of support was getting from Public Servants Social Security Agency, Addis Ababa Region Office. Oral consent was obtained for study participants in order to collect data.

4.12. Dissemination of results

The result of this study was sent to Addis Ababa University, College of Health Science, School of Public Health for the partial fulfillment of master of public health in health system management. In addition, the result of the survey will be submitted to Ethiopian health insurance agency, Ethiopian public Servants Social Security Agency, Ethiopian pensioner's association and Addis Ababa Health Bureau.

CHAPTER 5: RESULT

5.1. Socio demographic

423 participants were expected to include in the study but only 398 were participated making the response rate of 94.1%. Among, this 216 (54.3%) were male and the remaining 182 (45.7%) were female. Most of the respondents were between the ages of 60-70 years (55.3%), and a majority of the respondent were married 260 (65.3%).From the total respondents, 191 (48.0%) and 115 (28.9%) were previously worked elementary occupation and clerical and support worker, respectively. Most of households have a family size of 4-6 person per household 271 (68.1%) and number of dependent family greater than or equal to two 147(36.9%). Most of the respondents were complete primary education 147(36.9%) and majority of the respondent monthly income is between 2000-2499 143(35.9%) and the majority household income is between 2501-3500 132(33.2%).

Table1, Socio-demographic characteristics of the study respondents December,2020.

Variables	Details	Frequency (n)	Percentage (%)
Gender	Male	216	54.3%
	Female	182	45.7%
Age	60-70	212	53.3%
	71-80	171	43.0%
	Over 80	15	3.8%
Marital status	Single	9	2.3%
	Married	260	65.3%
	Divorced	15	3.8%
	Widowed	114	28.6%
Previous occupation	Profession	23	5.8%
	Technical and associated profession	69	17.3%
	Clerical and support worker	115	28.9%
	Elementary occupation	191	48.0%

House hold family size	Less than or equal to 3	38	9.5%
	4-6	271	68.1%
	Greater than or equal to 7	89	22.4%
Dependent family size	Less than or equal to 2	185	46.5%
	Greater than 2	213	53.5%
Educational status	No formal education	55	13.8%
	Attend elementary school	147	36.9%
	Certificate	97	24.4%
	Diploma holder	78	19.6%
	Degree and above	21	5.3%
Respondents' income	Less than 1500	63	15.8%
	1500-1999	109	27.4%
	2000-2499	143	35.9%
	Greater than or equal to 2500	83	20.9%
Household income	Less than or equal to2500	9	2.3%
	2501-3500	132	33.2%
	3501-4500	129	32.4%
	4501-5499	73	18.3%
	Greater than or equal to 5500	55	13.8%

5.2. Health care utilization information

Among 398 respondents, 238 (59.8%) respondents or their family members have chronic illness also 216(53.3%) were recent illness episode over the last twelve months preceding the survey. Majority of the participants medical fee was covered by the government 62 (41.6%) and self (out of pocket) 51 (34.2%) more than half of the respondents said that the price was unaffordable 76(50.7%) and most of the pensioners said that their health care fee was covered by their relatives 101(70.6%) and the majority were neutral to comment about the health service satisfaction 220 (55.3%).

Table 2, Health care utilization information of the study participants December,2020..

Variables	Details	Frequency (n)	Percentage (%)
Chronic illness	Yes	238	59.8%
	No	160	40.2%
Recent illness with In the last 12 months	Yes	216	54.3%
	No	182	45.7%
Illness episode occurred	Between 6 and 12 months ago ,	28	7.0%
	Between 3 and 6 months ago ,	104	26.1%
	Between 1 and 3 months ago ,	37	9.3%
	Within 1 month	47	11.8%
Duration of sickness	Number of days	Mean = 7.74	SD = 3.432
Seek care for the recent episode	Yes	144	64.0%
	No	81	36.0%
Where did you get treated?	Traditional healer	10	6.7%
	Local drug vender	11	7.3%
	Private health facility	64	42.7%
	Public health facility	65	43.3%
Why did you go there?	Considering the illness is self-limiting	6	4.0%
	Easily accessible and convenient	14	9.3%
	Not expensive	40	26.7%
	Not too crowded	2	1.3%
	It is more effective	65	43.3%
	Didn’t have money to go elsewhere	23	15.3%
How did you pay your medical care costs?	Government(free)	62	41.6%
	Self(out of pocket)	51	34.2%
	Family	36	24.2%
How did you see finding	Affordable	74	49.3%

money to pay for the health care?	Unaffordable	76	50.7%
If paying for a medical expense was difficult, how did you get it?	Drawn from savings	6	4.2%
	Borrowing	7	4.9%
	Assisted by relatives	101	70.6%
	Undertaken extra work	1	0.7%
	Cut back on other things: food, cloth	28	19.6%
What is your satisfaction level with governmental health facility service and cost?	Very satisfied	1	0.3%
	Satisfied	30	7.5%
	Neutral	220	55.3%
	Dissatisfied	144	36.2%
	Very dissatisfied	3	0.8%

5.3. Awareness of health insurance

More than half of the respondents are heard about health insurance 235 (59.0%) the main source of information for the respondents is mass media and friends 93 (39.9%) and 89 (38.2%) respectively. Most the respondents believe that having health insurance is beneficial 235(59.0%) and they believe the main reason benefit is it prevents from unexpected health expenditure 135(57.9%). 341(85.1%) of the respondents think the government should set up the health insurance stated. There is no single respondent that took part in any kind of health insurance which covers the health expenditure.

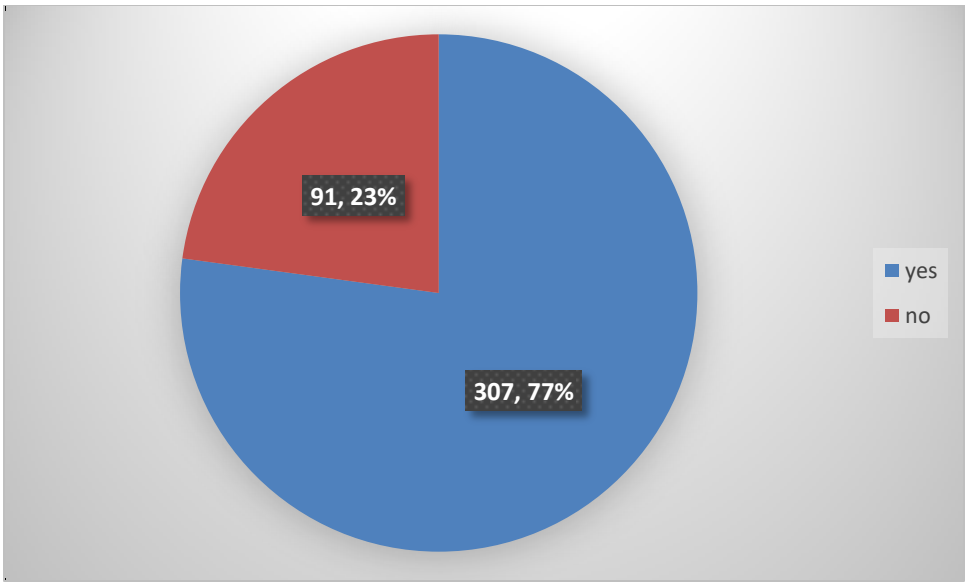

Figure 2, Participant's willingness level of social health insurance

5.4. Willingness to participate in social health insurance

Among 398 respondents who are participated in the study, 307(77.1%) will join the new stated social health insurance and 91 (22.9%) are not. The major reason for the participants to join health insurance is they are facing health problem frequently 140(46.2%) and quality of health service in government health facility is mentioned as the major barrier for joining social health insurance 49(53.8%). Majority of the respondents 290(72.9%) will pay if the insurance premium will be 1% of their monthly pension and the respondents will pay a maximum of 2% of their pension 30(7.5%) and 18 (4.5%) of the participant are not willing to pay any percent of their pension. The major reason mentioned by these entire respondents 18 (100%) is the government should have pay for such programs.

Table 3, Participation of the respondents related to health insurance, December, 2020.

Variables	Details	Frequency (n)	Percentage (%)
Have you heard about health insurance?	Yes	235	59.0%
	No	163	41.0%
What are the sources of information?	Mass media	93	39.9%
	Family	41	17.6%
	Friends	89	38.2%

	Insurance agency	10	4.3%
Do you believe having health insurance is beneficial?	Yes	235	59.0%
	No	163	41.0%
Which of the following do you expect the benefits of health insurance?	Prevent from unexpected health expenditure	135	57.9%
	To have timely cared in times of illness	92	39.5%
	Improve health services quality	6	2.6%
Do you have any kind of health insurance that covers your health expenditure?	Yes	0	0.0%
	No	398	100.0%
What type of health insurance do you have	Private insurance	0	0.0%
	employment based insurance	0	0.0%
	Others	0	0.0%
	None	398	100.0%
How many members of household (including you) covered by a health insurance?	None	398	100.0%
Amount paid for the health insurance	0%	398	100.0%
Do you think the government should set up the health insurance stated?	Yes	341	85.7%
	No	57	14.3%
Are you willing to join the insurance?	Yes	307	77.1%
	No	91	22.9%
What is your reason for your answer, yes?	It provides free access to medical care at point of service	85	28.1%
	For security and peace of mind in times of ill-health	78	25.7%
	I am facing health problem frequently	140	46.2%
What is your reason for your	I do not have enough money to pay	4	4.4%

answer no?	Insurance package doesn't cover all health services	2	2.2%
	Lack of trust in government programs	13	14.3%
	Lack of trust in the insurance scheme	10	11.0%
	Poor quality of health service in government health facility	49	53.8%
	Contributing money for sickness in advance is a taboo	13	14.3%
If the insurance premium will be 1% of your monthly pension, are you willing to join the insurance?	Yes	290	72.9%
	No	108	27.1%
If your answer is yes, would you pay the above specified amount?	Yes	287	96.0%
	No	12	4.0%
Maximum how much percent of your pension are you willing to pay?	None	91	22.9%
	0	18	4.5%
	1	259	65.0%
	2	30	7.5%
	3	1	0.2%
If your answer is 0%, what is your reason?	Other reach members of the society should pay for the program	0	0.0%
	Because of Luck of money	0	0.0%
	I doubt the management of the fund	0	0.0%
	It is the responsibility of the government to pay for such a program	18	100.0%

5.5. Factors associated with willingness to pay for Social health insurance

Five independent factors are associated with WTP for SHI with P value of less than 0.05. These are participants' monthly income, number of dependent family members in the house hold, history of chronic illness in the family, hearing about health insurance and believe health insurance is beneficial. In multivariate analysis, these five independent variables are found to be significantly associated with P value of less than 0.05 with WTP for SHI. The model fitting test was conducted using the likelihood ratio test, and using variance inflation factor, multi co linearity diagnosis was performed and none was detected. In the study the first variable is participants monthly income, as a family income gets decrease WTP for SHI is also gets decrease ,which is respondents who got a monthly income of $\leq$ 1500 (AOR = 0.145, 95% CI (0.054, 0.384) are 85% less likely WTP for SHI than for reference category monthly income of $\geq$ 2500 and respondents who have dependent family less than or equal to 2 are 73.6% higher WTP for SHI than that of the counter group which have several dependent family greater than to 2 (AOR = 1.736, 95% CI (1.035,2.912). A house hold or a family member which have chronic illness are almost two times more likely WTP for SHI than those who have not chronic diseases (AOR = 1.906, 95% CI (1.114, 3.262). Study participants who were heard about SHI preceding the study are twelve times more likely to have a WTP for SHI (AOR = 12.686, 95 % CI (1.262,127.556). Finally, these study participants who believe health insurance is beneficial are sixteen times more likely to have WTP for SHI (AOR =16.307, 95 % CI (1.599, 166.298).

Table 4, Bivariate and multivariate analysis of factors associated with willingness to pay for SHI. December, 2020.

Variables	Details	Frequency (%)		COR with 95 % CI and p value	AOR with 95% CI and p value
		Willing to pay			
		yes	no		
Respondents' income	≤ 1500	55(13.8%)	8(2.0%)	0.149(0.063, 0.351) P value (0.000)	0.145 (0.054, 0.384) P value 0.000
	1500-1999	97(24.4%)	12(3.0%)	0.127(0.061, 0.265) P value (0.000)	0.126 (0.054, 0.290) P value 0.000
	2001-2499	113(28.4%)	30(7.5%)	0.272(0.151, 0.490) P Value (0.000)	0.282 (0.148 ,0.538) P value 0.000
	≥ 2500	42(10.6%)	41(10.3%)	1	1
Dependent family size	≤ 2	133(33.4%)	52(13.1%)	1.744(1.087, 2.798) P value (0.021)	1.736 (1.035,2.912) P value 0.037
	> 2	174(43.7)	39(9.8)	1	1
Chronic illness	Yes	198(49.7%)	40(10.1%)	2.316(1.440, 3.726) P value 0.001.	1.906 (1.114,3.262) P value 0.031
	No	109(27.4%)	51(12.1%)	1	1
Have you heard about health insurance?	Yes	169(42.5%)	66(16.6%)	2.156 (1.292,3.598) P value 0.003	12.686(1.262,127.556) P value 0.019.
	No	138(34.7%)	25(6.3%)	1	1
Do you believe having health insurance is beneficial?	Yes	172 (43.2%)	63(15.8)	1.766,(1.072,2.909) P value 0.025	16.307(1.599,166.298) P value 0.010
	No	135(33.9%)	28(7.0%)	1	1

CHAPTER 6: DISCUSSION

The aim of this study was to determine the level of willingness to pay for the newly stated social health insurance and factors that are determine willingness to pay for this program among public service pensioners. The result of the study showed that 307(77 %) of the respondent have willingness to pay for newly stated social health insurance. This finding is lower than studies conducted in different parts of world and Ethiopia.

A study conducted in Iran show that the willingness to pay for SHI is 98% (21) and also studies conducted in Nigeria and Ghana also have higher prevalence of willingness than this study which is 82% (22) and 98.7% (23) of the respondents are willing to pay for social health insurance, respectively. The level of willingness to pay found in the present study is also very low when compared to a study conducted in Addis Ababa on formal sector employees, which showed that 90% of the respondents were will to pay (19).also a study which is conducted in Mekele, Ethiopia among public servants show that WTP for SHI is 85% (24).This difference is may occur because of the difference between the population segment included in the study's because all the above study's are including active working respondents but in this study passive workers are included.

The finding in this study is higher than one study in South Sudan and two separate studies conducted in Addis Ababa, Ethiopia among St, Paul's hospital millennium medical college among health workers and health care providers, which is 68% (25),17% (11) and 29% (26) respectively also a study conducted among teachers worked in wolaita sodo town, south Ethiopia shows that the prevalence of willing to pay for SHI is around 71.3 % (18) the reason raised for the lower prevalence in the above two study's in Addis Ababa, is due to medical expenditure for health care givers is covered by the government.

In this study, respondent income, number of dependent family members, chronic illness, awareness about SHI and believing having SHI is beneficial are the main predictors of WTP for SHI.

Respondent income is the first predictor for WTP for SHI, which is people who got a monthly income of $\leq$ 1500, 1500-1999 and 2000-2499 are less likely willing to pay for SHI than the

reference category monthly income of ≥ 2500 thus finding is similar with the study conducted in Nigeria and South Sudan it shows that income is directly related with willingness to pay for SHI which is also a study's done in Addis Ababa and Mekelle, Ethiopia, respondent income is the main predictor of willingness to pay for SHI.

The second predictor is the number of dependent family. When a number of dependent family is get increased willingness to pay for SHI will decrease, it is because of the peoples have faced challenges to handle the house hold expenditure this finding is in line with a study done Iran, Nigeria and South Sudan when the number of family members in the house hold increase willingness to pay will be decreased, however, because the participants in this study were older, their dependent families may be less likely to be under the age of eighteen. Peoples with chronic illness in the house hold are 2 times willing to pay for SHI. Similar study conducted in Vietnam showed that chronic illness is directly related with WTP for SHI(27) .

Hearing about health insurance and believing having health insurance is beneficial are the main predictors for willingness to pay for social health insurance peoples who were heard about social health insurance preceding this study is 12.7 times more willing to pay than those who are not, also peoples believing having health insurance is beneficial is 16 times willing to pay for SHI than the counter group and this factor is the main predictor for willingness to pay for social health insurance in different studies conducted in the world and Ethiopia.

In this study from the study participants 59% of the respondents are heard about health insurance the finding in the study is higher than a study finding in South Sudan and lower than a study in Addis Ababa which is the prevalence of awareness about health insurance is 54%(25) and 63.0%(26).This deference may due to in socio demographic difference between the studies participants.

A study conducted in South Sudan show that awareness will increase the WTP for SHI by 2 times (25). A study conducted in Addis Ababa show that peoples who are aware about health insurance are 4.4 times WTP for SHI than the counter group(26).Also different studies conducted in Ethiopia such as studies in Wolaita sodo and Mekele support the claim stated above

CHAPTER 7: CONCLUSION AND RECOMMENDATION

7.1. CONCLUSION

Direct out-of-pocket payments for healthcare services increases the financial burden of households and expose impoverishing health care expenses. Aging causes an increased risk of developing Non-communicable diseases in most developing countries. The aim of this study was to determine the level of willingness to pay for the newly stated social health insurance and factors that are determine willingness to pay for this program among public service pensioners. In this study more than half (77%) of the respondents are willing to pay for this newly stated social health insurance.

The prevalence in this study is higher because of the study participants are not actively working at the time they are pensioners and related with their age they are facing different chronic illness .so they had financial problem to cover their health expenditure because of their low income, also the government is reject their application for CBHI because they are considered as a formal sector, according to Ethiopian social health insurance agency proclamation No.690/2010. Due to such reason they are highly willing to join this social health insurance

The WTP for SHI was correlated positively with income, peoples with chronic illness in the family, awareness about social health insurance and believe having health insurance is beneficial each family. On the other hands, dependent family numbers had a negative influence on the WTP. It should be remembered that these factors have greatly impacted the willingness of the household to pay for social health insurance.

The results suggest that to increase enrollment, it is important to create awareness and inform the population about the benefits of SHI and the government should implement of social health insurance for formal sector (especially for pensioners) as soon as possible.

7.2. RECOMMENDATION

For Ethiopian Health Insurance Agency

To providing various awareness-raising activities for social security beneficiaries who have been providing public service, the program should also be implemented.

For Ethiopian public Servants Social Security Agency

In view of the health, social and economic burden of social security beneficiaries, Public service social security agency and other concerned stakeholders should facilitate trainings and seminars regarding to social health insurance program.

For Ethiopian public service pensioner's Association

Consumers of the social services who are part of the association should be pressured to ensure the implementation of the program, taking into account the wide range of health problems and desire to benefit from social health insurance.

For Addis Ababa Health Bureau

It should organize and strengthen existing health facilities and professionals in a way that is conducive to the implementation of social health insurance program.

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CHAPTER 8: ANNEXES

8.1. Consent form

Dear "respondent", I extend my greeting to you. We are here to collect data for the purpose of research from Addis Ababa University, College of Health Science, School of Public Health. The purpose of this study is to determine willingness to pay for social health insurance and associated factor in public service pensioners. Nowadays, the prevalence of non-communicable diseases such as diabetes, hypertension and others is increasing worldwide, and the spread of these diseases is also evident in developing countries, such as Ethiopia. Studies show that increasing prevalence of these diseases has a direct link to old age and lifestyles. Therefore, as you are older, there are preventive measures to prevent these diseases (simple physical activities), but these and other health problems can be avoided if you do not feel that you are eligible for social health insurance. We are requesting your Permission in order to fill the questionnaire on issues related to willingness to pay for social health insurance and associated factor. This information will help the policy makers and other responsible bodies as background to improve the health status of the public service pensioners. We assure you that whatever information you provide will only be used for the purpose of this research and will not be made available to anyone outside of the research team. Your willingness and support to interview the questionnaire is very much appreciated. We also assure that the information which you give for us will not bring any harm to you and your family. It is also your right to withdraw any time from the process when your feeling is uncomfortable with it.

Please mark (✓) to indicate the respondents' decision regarding participation in the study. The purpose of the study and confidentiality procedures has been explained to me and I on my own consent:

a) Agree _____ b) Disagree_____

Date _____Time started_____ Time completed_____

Code _____

Place of your previous work _____

8.2. English Version Questionnaire

Willingness to pay for social health insurance and its Associated factor among public service pensioners in Addis Ababa. ***/adapted from previous study/***

Part I: Socio demographic information		
Q.NO	Questions	Response Category
1	Gender	1. Male 2. Female
2	Age (in years)	_____
3	Marital status	1. Single 2. Married 3. Divorced 4. Widowed
4	Previous Occupation	1. Profession 2. Technical and associated profession 3. Clerical and support worker 4. elementary occupation
5	Respondents net income per month	_____birr
6	Household income per month	_____birr
7	Household family size including you	
8	Dependent family size	_____
9	Educational status	1. No formal education 2. Attend elementary school 3. Certificate 4. Diploma holder 5. Degree and above
Part II: Health Care Utilization Information		
10	Do you or other member of the household have chronic illness (eg.DM, asthma, hypertension…)?	1. Yes 2. No
11	Do you or family member's encountered illness during the last 12 Months?	1. Yes 2. No
12	If yes when did the latest illness episode occur?	1. Between 6 and 12 months ago 2. Between 3 and 6 months ago 3. Between 1 and 3months ago 4. Within 1 month
13	For how many days were you sick during the recent episode?	
14	Did you seek care for the recent episode?	1. Yes

		2. No
15	If yes for Q14 where did you get treated?	1. Traditional healer 2. Local drug vender 3. Private health Facility 4. Public health facility 5. Others (specify)
16	Why did you go there?	1. Considering the illness is self-limiting 2. Easily accessible and convenient 3. Not expensive 4. Not too crowded 5. It is more effective 6. Didn't have money to go elsewhere 7. Didn't have time to go elsewhere 8. Others (specify)_____
17	How did you pay your medical care costs?	1. Government (free) 2. Self (out of pocket) 3. Family 4. Private insurance 5. Other_____
18	How did you see finding money to pay for the health care?	1. Affordable 2. Unaffordable
19	If paying for a medical expense was difficult, how did you get it?	1. Drawn from savings 2. Borrowing 3. Assisted by relatives 4. Undertaken extra work 5. Cut back on other things, food, school fees6. Others (specify)_____
20	What is your satisfaction level with governmental health facility service cost?	1.Very satisfied2.satisfied 3.Neutral 4. Dissatisfied 5.Very dissatisfied
Part III: Information related to participation in health insurance		
21	Have you heard about health insurance?	1. Yes 2. No
22	If yes to Q21, what are the sources of information?	1. Mass media 2. Family 3. Friends 4. Insurance agency 5.Other _____
23	Do you believe having health insurance is beneficial?	1. Yes

		2. No
24	If yes which of the following do you anticipate the benefits of health insurance?	1. Prevent from unexpected health expenditure 2. To help others who can't afford their medical cost 3. To have timely care in times of illness 4. Improve health services quality 5. Other (specify)_____
25	Do you have any kind of health insurance that covers your health expenditure?	1. Yes 2. No
26	If yes for Q 25 which type of health insurance coverage do you have?	1.Privateinsurance 2.privious employment based insurance 3.others (specify)_____
27	If yes to Q25, how many members of your household (including you) covered by a health insurance?	
28	If yes to Q25, what is the amount of money you pay for health insurance per month for the whole family?	

Scenario B: Compulsory health insurance: All pensioners are compulsorily obliged to pay and contributed a monthly premium of 1% to a health care fund. There are not either exemption cards. The fee is based on deducting specified percentage of their monthly pension determined by insurance agency. There by the employees spouse and family members of less than 18 years are entitled to free health care at a nearby health center and free medicine if prescribed by a doctor. The fund will be managed through an independent health care fund. If care at a higher level is needed, the insured patient will be supported and entitled to free health service in these facilities.

29	Do you think the government should set up the type of health insurance stated?	1. Yes 2. No
30	Are you willing to join the insurance?	1. Yes 2. No
31	If yes to Q30, what is your reason for your answer?	1. It provides free access to medical care at point of service 2. I need to help others who can't afford their medical costs 3. For security and peace of mind in times of ill-health 4. I am facing health problem frequently 5. Other(specify)_____
32	If your answer is no to Q30, what is your reason for your answer?	1. I do not have enough money to pay 2. insurance package doesn't cover all health services 3. OOP charge is better 4. Lack of trust in government programs 5. Lack of trust in insurance scheme 6. poor quality of health service in government health facility 7. Contributing money for sickness in advance is a taboo 8. others (specify)
33	If the insurance premium will be 1% of your monthly pension, are you willing to join the insurance?	1. Yes 2. No
34	If your answer is yes for Q33 would you pay the above specified amount?	1. Yes 2. No
35	Maximum how much percent of your pension are you willing to pay?	_____% of your monthly salary

36	If your answer is 0% for Q35 what is your reason?	1. I doubt the management of the fund 2. It is the responsibility of the government to pay for such a program 3. Because of lack of money 4. Other rich members of the society should pay for the program 5. Other (specify) (specify)_____

8.3. Amharic Version Consent Form

ውድ ተጠያቂያችን እንደምን ኖዎት? ከአዲስአበባ ዩኒቨርሰቲ ጤና ሳይንስ ኮሌጅ የህብረተሰብ ጤና ትምህርት ቤት ለጥናትና ምርምር መረጃ ለመሰብሰብ የመጣን ሲሆን የጥናቱ አላማ የህዝብ አገልግሎት ሲሰጡ የነበሩ የማህበራዊ ዋስትና ተጠቃሚዎች ለማህበራዊ ጤና መድህን የመክፈል ፍላጎት እና ተያያዥ ምክንያቶች ማወቅ ነው ።አሁን ባለንበት ወቅት ተላላፊ ያልሆኑ በሽታዎች እንደ ስኳር ፣ደምግፊት ወዘተ ያሉ በሽታዎች ስርጭት በአለም ላይ በከፍተኛ ሁኔታ እየጨመረ ይገኛል የዚህ በሽታ ስርጭትም እንደ ኢትዮጵያ ባሉ በማደግ ላይ በሚገኙ ሀገሮች ላይም ይታያል ። ጥናቶች እንደሚያሳዩትም የእነዚህ በሽታዎች ስርጭት መጨመር ከእድሜ መግፋትና ከአኗኗር ዘይቤዎች ጋር ቀጥተኛ የሆነ ግንኙነት እንዳለው ያረጋግጣሉ ። ስለሆነም እርስዎም በእድሜ ገፋ እንደማለትዎ እነዚህን በሽታዎች ለመከላከል የሚረዱ ቅድመ ጥንቃቄዎች ማድረግ (ቀለል ያሉ የአካል እንቅስቃሴዎችን) እንዳለ ሆኖ እነዚህና ሌሎችም የጤና ችግሮች ቢጋጥምዎ የማህበራዊ ጤና መድህን አገልግሎት ተጠቃሚ መሆንዎካልታሰበ የጤና አገልግሎት ወጪ ያድናል። የዚህን ጥናት መጠይቅ እንዲጠየቁ(እንዲሞሉ) ፍላጎቶን በአክብሮት እየጠየቅን ይህ መረጃ ለፖ/ሊሲ አውጪዎች ለጤና ቢሮ እንዲሁም ለኢትዮጵያ ጤና መድህን ኤጀንሲ የማህበራዊ ዋስትና ተጠቃሚዎችን ጤና ለማሻሻል እንደ ግብዓት የሚያገለግል ሲሆን የሚሰጡንን መረጃ ለጥናትና ምርምር የምንጠቀም መሆኑን እናረጋግጥሎታለን እንዲሁም ከጥናት ቡድኑ ውጪ ለማንኛውም ሶስተኛ አካል አይሰጥም ።መጠይቁን ለመሙላት(ለመጠየቅ) ያሎትን ፍቃደኝነቶንና እርዳታዎን እያደነቅን ለሚሰጡት ማንኛውም መረጃ በእርሶም ላይ ሆነ በቤተሰቦ ላይ ምንም አይነት ችግር የማይደርስቦት መሆኑን ልናረጋግጥሎት እንወዳለን በተጨማሪም መጠይቁን ሲሞሉ ማንኛውም አይነት የማይመች ነገር ካጋጠሞት መተው/ትተው መውጣት ይችላሉ ።

የጥናቱ አላማና ሚስጥራዊነት በስምምነት ቅፅ ላይ የተገለፀልኝ በመሆኑ በጥናቱ ላይ ለመሳተፍ

1) ተስማምቻለሁ____2) አልተስማማሁም _____

ቀን _____የተጀመረበት ሰዓት_____ የተጠናቀቀበት ሰዓት_____

መለያ ቁጥር _____

ቀድመው ሚሰሩበት ቦታ/ መስሪያ ቤት _____

8.4. Amharic Version Questionnaire

የጡረተኞች ለማህበራዊ ጤናመድህን የመክፈል ፍላጎት እና ተያያዥ ምክንያቶች ለማጥናት የተዘጋጀ መጠይቅ

ክፍል 1 ማህበራዊና ስነ-ህዝባዊ መረጃ		
ተ.ቁ	**መጠይቅ**	**የምላሽ አማራጭ**
1	**ፆታ**	1.ወንድ 2. ሴት
2	**እድሜ**	_____
3	**የጋብቻ ሁኔታ**	1. ያላገባ 3. በፍቺ የተለያየ 2. ያገባ 4.የትዳር ጓደኛውን በሞት የተለየ
4	**ሥራ**	1. የሙያ ስራ 2. ቴክኒካል እና ተያያዥነት ስራ የሚሰሩ 3.ሴክሬተሪ እና ድጋፍ ሰጪ ሰራተኞች 4.የመጀመሪያ ደረጃ ስራ
5	**ወርሃዊ የተጣራ ጡረታዎ ስንት ነው**	_____ብር
6	**የቤተሰብዎ የተጣራ ገቢ**	_____ብር
7	**የቤተሰብ ብዛት**	
8	**ጥገኛ/ በኢኮኖሚ/ የቤተሰብ ብዛት**	_____
9	**የትምህርት ሁኔታ**	1.ምንም አይነት መደበኛ ት/ት ያልተማረ 2.የመጀመሪያ ደረጃ ት/ት 3.ሰርተፍኬት 4. ዲፕሎማ 5.ዲግሪና ከዚያ በላይ

ክፍል 2 የጤና አገልግሎት ተጠቃሚነት መረጃ		
10	እርሶ ወይም የቤተሰብዎ አባል ስር የሰደደ ህመም /የቆየ/ አሎት/አለ ?	1.አዎ 2.የለም
11	ባለፉት 12 ወራት እርስዎ ወይም የቤተሰብዎ አባል ታመው ያውቃሉ?	1.አዎ 2.የለም
12	ምላሾ አዎ ከሆነ በቅርብ ጊዜ የተከሰተው ህመም መቼ ነው?	1. ከ6 እስከ 12 ወር 2. ከ3 እስከ 6 ወር 3. ከ1 እስከ 3 ወር 4. ባለፈው ወር
13	በቅርብ ጊዜ ባጋጠምዎት የጤና መታወክ ለምን ያህል ጊዜ ታመመ/ህመሙ ምን ያህል ጊዜ ቆየ?	----------
14	በቅርብ ጊዜ ባጋጠሞት የጤና መታወክ ህክምና አግኝተዋል? /ታክመዋል /	1. አዎ 2. አልታከምኩም
15	ለጥ14 መልሶ አዎ ከሆነ የት ታከሙ?	1.የባህል ህክምና 2.በአካባቢ በሚገኝ መድኃኒት መደብር 3.የግል ጤና ተቋም 4.የህዝብ ጤና ተቋም 5.ሌላ ----------
16	ወደእዛ ለመሄዶት ምክንያቶት ምንድነው	1. ህመሙ በራሱ ጊዜ የሚድን ስለሆነ 2.በቀላሉ ስለሚገኝና ስለሚመች 3. ውድ ስላልሆነ 4.በጣም የተጨናነቀ ስላልሆነ/ወረፋ ስለሌለው / 5.ፍቱንና ጥሩ ስለሆነ 6.ሌላ ቦታ ለመሄድ ገንዘብ ስለሌለኝ 7. ሌላ ቦታ ለመሄድ ጊዜ ስለሌለኝ 8.ሌላ ምክንያት ካሎት ይፃፉ _____
17	የህክምናውን ወጪዎን እንዴት ከፈሉ	1/. በመንግስት ነፃ ህክምና 2. ከራሶ አውጥተው 3. በቤተሰብ 4. በግል የጤና መድህን 5. በመዋጮ 6 በሌላ _____

18	ለጤና አገልግሎት /ህክምና የሚከፈለውን ገንዘብ እንዴት አዩት/አገኙት	1.ተገቢ ነው 2. ተገቢ አይደለም
19	የህክምና ወጪዎን ለመክፈል አዳጋች ከሆነ/ካልቻሉ እንዴት ከፈሉ?	1.ከቁጠባዬ በማውጣት 2.በብድር 3. በዘመዶቼ እርዳታ 4.ተጨማሪ ስራ በመስራት 5. ከሌሎች ወጪዎቼ በመቀነስ... ከምግብ ... 6. ሌላ ካለ _____
20	በመንግስት የጤና ተቋማት አገልግሎት አሰጣጥ እና ዋጋ የእርካታ መጠኖ?	1. በጣም እረክቻለሁ 2.እረክቻለሁ 3. ገለልተኛ 4. አልረካሁም 5.በጣም አልረካሁም
ክፍል 3 ስለጤና መድህን ተሳትፎና ተያያዥ ነት ያላቸው መረጃ		
21	ስለጤና መድህን ሰምተው ያውቃሉ	1.አዎ 2.ሰምቼ አላውቅም
22	መልሶ አዎ ከሆነ ለጥ21 መረጃውን ከየት ሰሙ	1. ከመገናኛ ብዙሃን 2. ከቤተሰብ 3. ከጓደኞቼ 4. ከጤና መድህን ኤጀንሲ 5.ሌላ ካለ _____
23	የጤና መድህን መኖሩ ይጠቅማል ብለው ያምናሉ	1.አዎ 2.አላምንም
24	መልሶ አዎ ከሆነ ከሚከተሉት የጤና መድህን ጠቀሜታ ውስጥ የቱን ተስፋ አድርገው ነው?	1.ካልተጠበቀ ወጪ ስለሚያድን 2.ሌሎች የህክምና ወጪያቸውን መሸፈን የማይችሉትን ስለሚያግዝ 3. በታመሙበት በፍጥነት ህክምና እንዲያገኙ ስለሚረዳ 4. የጤና አገልግሎት ጥራት ስለሚያሻሽል

		5. ሌላ ካለ _____
25	የጤና ወጪዎን/የህክምና ወጪዎን የሚሸፍነሎት አንዳች የጤና መድህን አሎት ?	1. አዎ2.የለኝም
26	ለጥ25 መልሶ አዎ ከሆነ የትኛው አይነት የጤና መድህን ነው ያሎት	1. የግል የጤና መድህን 2.መንግስታዊ መድህን 3. ሌላ ካለ ይፃፉ_____
27	ለጥ25 መልሶ አዎ ከሆነ እርሶን ጨምሮ ምን ያህል የቤተሰብዎ አባላት በጤና መድህኑ ተጠቃሚ ናቸው?	
28	ለጥ25 መልሶ አዎ ከሆነ ለቤተሰብዎ በጠቅላላ የጤና መድህን ለመግዛት በወር ምን ያህል ገንዘብ ይከፍላሉ ?	----------ብር

29	መንግስት ከላይ የተገለፀውን አይንት የጤና መድህን ማቋቋም አለበት ብለው ያስባሉ?	1. አዎ 2. አላስብም
30	አባል ለመሆን ፍቃደኛ ኖት ?	1.አዎ 2.አይደለሁም
31	ለጥ30 መልሶ አዎ ከሆነ ምክንያትዎ ምንድነው ?	1.የህክምና አገልግሎቱን በምጠቀምበት ጊዜ በነፃ ስለምጠቀም 2.ሌሎች የህክምና ወጪያቸውን መሸፈን የማይችሉትን መርዳት ስለምፈልግ 3. ለደህንነቱ እና ለሰላማዊ አፅምሮ 4.በተደጋጋሚ የጤና እክል ስለሚያጋጥመኝ 5.ሌላ ካለ ይፃፉ_____

32	ለጥ30 መልሶ አይደለሁም ከሆነ ምክንያትዎ ምንድነው ?	1.ለመክፈል በቂ ገንዘብ የለኝም 2.የጤና መድህን ሁሉንም የጤና አገልግሎት ስለማይሸፍን 3.ከኪስ አውጥቶ መክፈል የተሻለ ስለሆነ 4.በመንግስት ፕሮግራም እምነት ስለሌለኝ 5.በጤና መድህን ፕሮግራም ላይ እምነት ስለሌለኝ 6. የመንግስት የጤና ተቋማት አገልግሎት ጥራት ስለሌለው 7.ለህክምና ቀድሞ ገንዘብ ማስቀመጥ መዓት መጥራት ነው 8. ሌላ ካለ ይፃፉ ----------
33	የጤና መድህኑ ክፍያ ከወር ጡረታዎ ላይ 1% ቢሆን አባል ለመሆን ፍቃደኛ ኖት?	1. አዎ 2. ፈቃደኛ አይደለሁም
34	ለጥ33 መልሶ አዎ ከሆነ የተጠቀሰውን መጠን ይከፍላሉ ?	1. አዎ 2.አልከፍልም
35	ከጡረታዎ ምን ያህል ፐርሰንት ለመክፈል ፍቃደኛ ኖት?	_____% የወር ጡረታ
36	ለጥ35 መልሶ 0% ምክንያትዎ ምንድነው ?	1. በመዋጮው ማኔጅመንት ላይ ጥርጣሬ ስላለኝ 2. እንደዚህ አይነት ፕሮግራሞችን የመክፈል ሀላፊነት የመንግስት ስለሆነ 3. ገንዘብ ስለሌለኝ 4.ሌሎች ሀብታም የሆኑ የማህበረሰብ ክፍሎች ለፕሮግራሙ መክፈል አለባቸው 5.ሌላ ካለ ይፃፉ_____

8.5 Declaration

ASSURANCE OF PRINCIPAL INVESTIGATOR

The undersigned agrees to accept responsibility for the scientific and ethical and technical conduct of the research project and for provision of required progress reports as per terms and conditions of the research publications Office in effect at the time of Grant is forwarded as the result of this application.

Name of the student: Yonas Hizkiyas

Date. _____ Signature _____

Approval of the Advisor

Name of the advisor: Dr**.** Anagaw Derseh

Date. _____ Signature _____