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INSTITUTE OF AGRICULTURE AND DEVELOPMENT STUDIES

DEPARTMENT OF SOCIAL WORK

ASSESSMENT ON THE CHALLENGES OF SOCIAL HEALTH INSURANCE IMPLEMENTATION IN AKAKI KALITI SUB-CITY ADMINISTRATION FROM PUBLIC SERVANTS PERSPECTIVE

BY

MUSE KIDANE

ID No. SGS/0674/2011A

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ADDIS ABABA

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SCHOOL OF GRADUATE STUDIES

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A THESIS SUBMITTED TO THE SCHOOL OF GRADUATE STUDIES OF St. MARY'S UNIVERSITY IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR THE DEGREE OF MASTER ARTS IN SOCIAL WORK

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APPROVAL OF BOARD OF EXAMINERS

As a member of the Board of Examiners of the Master Thesis open defense examination, we testify that we have read and evaluated the thesis prepared by MUSE KIDANE and examined the candidate. We recommended that this thesis be accepted as fulfilling the thesis requirements for the degree of Master of Arts in Social Work.

Chair Man (Institute Dean)	Signature
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Internal Examiner	
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DECLARATION

I declared that this thesis, *"*Assessment on the Challenges of Social Health Insurance Implementation in Akaki Kaliti Sub-City Administration from Public Servants Perspective*"* is my own work, prepared under the guidance of my advisor Mossisa Kejela (PhD Candidate). I gave the appropriate acknowledgment for the sources I used in the paper.

Muse Kidane Berhe

ENDORSEMENT

This thesis has been submitted to St. Mary's University, school of graduate studies for examination with my approval as a university advisor.

Advisor	Signature
Mossisa Kejela (PhD Candidate)	……..
St. Mary's University, Addis Ababa	June, 2020

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LIST OF ABBREVIATIONS/ ACRONYMS

AAHB	Addis Ababa Health Bureau
AAHIA	Addis Ababa Health Insurance Agency
BoFED	Bureau of Finance and Economic Development
CBHI	Community-Based Health Insurance
CBO	Community-Based Organizations
CSOs	Civil Society Organizations
EHIA	Ethiopian Health Insurance Agency
EFY	Ethiopian Fiscal Year
EPSA	Ethiopian Pharmaceutical and Supply Agency
FMHACA	Food, Medicines, Health Care Administration and Control Authority
FMoH	Federal Ministry of Health
HC	Health Center
HI	Health Insurance
IDI	In-Depth Interview
KII	Key Informant Interview
LMICs	Low- and Middle-Income Countries
NGO	Non-Governmental Organization
OOP	Out-Of-Pocket
SHI	Social Health Insurance
SSA	Sub-Saharan Africa
WB	World Bank
WHO	World Health Organization
WoHO	Woreda Health Office
WTP	Willingness to Pay
UHC	Universal Health Coverage

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ABSTRACT

Lack of adequate healthcare financing and access to basic health services is still a problem in Ethiopia. To alleviate this, Ethiopia is currently introducing SHI. There is limited information the challenges of SHI implementation. Therefore, this study assess the Challenges of SHI Implementation in Akaki Kaliti Sub-City Administration from Public Servants Perspective. In this study the Akaki Kaliti sub city public servants, Ethiopian pharmaceutical supply agency, Addis Ababa social health insurance director, Addis Ababa health bureau and two Akaki Kaliti Sub-City Administration woreda health centers were participated in the study. Purposive sampling technique and case study employed as a major study tools. The collected data were organized and analyzed through qualitative research approach. Qualitative approach was used that would involve content, in-depth interviews and case study discussion with purposively selected public servants. In the study area in addition, key informant interview was also conducted with stake holders, The study found that, most public servants can't cover their health service expenditure this is result of the health service expensive cost and their low income. Private healthcare service payment is not affordable. Most of the respondents accept on the importance of SHI for them and healthcare financing system. Most of them didn't have any knowledge and clear information about the system of the scheme. Majority of them were voluntary to pay an amount similar to that proposed by the government. SHI implementation is influenced by the poor quality of health service. All of the participants were not satisfied with the availability and quality of health services in public facilities. Some participant was strongly not accepting this to implement, they also have a compliant in the policy, According to the public servant perspective the policy need to revise or correction before implement. The study has a great implication for social work practice in the area of policy formulation, advocacy, community mobilization, assessment and research in the areas of research.

Key words: Social health insurance, Challenge to implement and willingness, Ethiopia.

CHAPTER ONE: INTRODUCTION

1.1. BACKGROUND OF THE STUDY

Social Health Insurance (SHI) is one of the five main ways of financing health care. The others are direct payments by patients (user fees, informal payments and out of pocket Spending); general taxation whereby the health system is funded by taxes such as the United Kingdom's National Health Service (NHS), private (commercial) health insurance which is for profit and is open for those who obtain insurance cover through payment of prescribed premiums;, and community health insurance whose membership is drawn from the grassroots through community based initiatives such as the ones in Ghana. A country may have a mixture of several of these types, even if one may dominate. The mixture, a product of policy, history and the nature of society will have a major impact on the way healthcare is delivered in the country and on future healthcare policies (Nthenya, 2009).

SHI in principle involves compulsory membership whereby all of a country's workers self-employed enterprises and the government are required to make contributions into a social health insurance fund. The basis for workers and enterprises contributions is usually the worker's salary and emoluments. The contributions of self-employed persons are ether at-rate or based on estimated income. Government may make contributions of those who otherwise would be unable to pay, such as unemployed people and low income informal workers. SHI owns its own provider networks, works with accredited public and private healthcare providers, or uses a combination of both. Within SHI, a number of functions such as registration, collection of contributions, contracting and reimbursement of providers may also be executed by parasternal or non-governmental institutions, often referred to as sickness funds (Carrin & James, 2005).

In principle, SHI involves compulsory membership involving the entire population. Every citizen and at times, permanent resident becomes a member of a SHI scheme through enrolment and payment of either monthly or annual subscription or as may be deemed convenient to different socio-economic groups. In this way, SHI steers clear of the pitfalls of health insurance that operates on a voluntary basis. It avoids the chance that certain population groups, such as the poorest and most vulnerable become excluded. Exclusions can however arise in a voluntary

scheme due to lack of political interest in including vulnerable groups or because the poorest simply do not have the capacity or will to pay the proposed health insurance contributions (Nthenya, 2009).

The World Health Organization (WHO, 2000) defines the purpose of health financing as follows: "the purpose of health financing is to make funding available, as well as to set the right public health and preventive health care a well preforming SHI scheme that should have the following targets:

- to generate sufficient and sustainable resources for health
- to use these resources optimally and give incentives to providers through appropriate use of these resources
- to ensure that everyone has financial accessibility to health services

Financial contributions are considered fair when health expenditure is distributed according to ability to pay rather than to the risks of 1llness, and should ensure that everyone IS financially protected from this risk. These final goods of responsiveness and fairness in financial contribution also impact on the primary goal of health, as well as being important in their own right (Carrin & James, 2005).

A well-designed SHI scheme should be an effective way of realizing the goal of equity in financial contribution, as SHI shares risks and acquires its funds according to ability to pay SHI, as with any kind of health financing scheme, also impacts on both the distribution of resources and the overall health status of a population, by providing resources for health and defining how these resources are used access to healthcare services depends on factors beyond health financing, such as the level of economic development and a number of socio economic and epidemiological characteristics. It cannot be overemphasized that health financing, of which SHI is one model, is a very critical aspect of the health system.

According to (Carrin & James, 2005), describes twenty-seven countries worldwide had established the principle of universal coverage via this method, and several low and middle income countries are currently interested in extending their existing health insurance for specific groups, such as the poor and vulnerable, to eventually cover their entire populations.

In Africa, several countries have spent scarce time, money, and effort on health insurance initiatives. However, many of these schemes both public and private cover only a small proportion of the population, with the poor less likely to be covered (Acharya, 2013). In a country such as Ethiopia where public health care suffers from poor management, poor service quality, and weak finance, development of health insurance is likely to bring improvement in public health care.

Owing to lack of adequate healthcare financing, access to at least the basic health services is still a problem in Ethiopia. With the intention of raising funds and ensuring universal health coverage, a mandatory health insurance scheme has been introduced. The Community Based Health Insurance (CBHI) has been implemented in all regions of the country, while implementation of social health insurance was delayed mainly due to resistance from public servants. This study was, therefore, aimed to assess the challenges of SHI implementation in Akaki Kaliti Sub-City administration from public servants perspective.

1.2. STATEMENT OF THE PROBLEM

SHI is a central focus of the reforms currently being discussed in many countries. The consensus appears to be that the poor should be subsidized and that people should be protected from the large financial risk posed by high - cost illnesses. Public systems go part of the way toward protecting people from large financial risk, but do so with inequities, inefficiency, and inadequate quality (Yeshiwas, Kiflie, Zeleke, & Kebede, 2018).

Challenges of expanding SHI in developing countries have been widely debated. SHI compliance and preferences for private employer-based insurance in the US offers insight into factors that shape a firms' decision to enroll in SHI. Given the growing interest in expanding health insurance towards universal coverage and the scarcity of data on the determinants of enrolment in SHI identifying the factors that are likely to drive or hinder enrolment of firms in SHI is likely to be an important contribution to policymakers and other countries looking to stimulate SHI enrolment (Alkenbrack, Jacobs, & Lindelow, 2013).

World health organization (GHO-WHO, 2020) indicates that Ethiopia has one of the worst health problems in the world. On the demand side, high incidence of poverty, low levels of education,

culture and religion are the main constraining factors of health care utilization. In fact, health care use is highly dependent on one's ability to pay and to access health insurance services. According to the World Bank (WB), the OOP health expenditure in Ethiopia which is the proportion of total health expenditure that is paid privately by individuals and households was measured at 79.87% in 2011.

In Ethiopia, The SHI was intended to cover the employed and their family members, approximately 11% of the population (public servants, permanent employees working in private organizations and pensioners). Enrollment in SHI is compulsory and the proposed contribution is 3% of their salary (Alebachew, Hatt & Kukla, 2014).

By the Proclamation No. 690/2010 Ethiopian established a SHI scheme based on the 3% salary contribution from the formal sector workers. To this end, the Ethiopian SHI scheme was assumed to start its operation in Ethiopian Fiscal Year (EFY) 2008 (2015/16). It was also assumed that SHI would cover the whole country and the strategy was expected to cover the entire formal sector, about 7.77% of the population (6.36million) in three years. The total projected contributions (based on the 3% salary contribution) of SHI in the next 5 years is estimated to be 409 million USD (WHO, 2015).

Despite the government's plan to fully implement SHI by 2014 it has been repeatedly postponed, largely due to strong resistance from public servants (Haile, Ololo, & Megersa, 2014). Nevertheless, on January 11, 2016 a memorandum from the Prime minister office was circulated to all formal sectors to undertake discussion about the SHI scheme. But, the discussion did not take place as planned, and no feedback has been received from the formal sectors. Meanwhile it was rumored that the government has extended the discussion of SHI for unlimited period of time.

The statement of the study can be articulated the SHI option, as a financing alternative in Ethiopia, in terms of the challenges to implement Social Health Insurance in the public servants perspective; crucial problems that have not been properly addressed.

1.3. OBJECTIVES OF THE STUDY

1.3.1. General Objective

The main objective of this study is to assess the Challenges of SHI Implementation in Akaki Kaliti Sub-City Administration from Public Servants Perspective.

1.3.2. Specific Objectives

- To examine the challenges of SHI as a health financing mechanism and its implementation challenges among public servants.
- To assess the readiness of SHI implementation and to draw possible recommendations.

1.4. RESEARCH QUESTIONS

1. What are the challenges to implement SHI? And how to make it possible as a mechanism of healthcare financing?
2. Is SHI scheme ready to be implemented? How to draw possible conclusions and recommendation?

1.5. SIGNIFICANCE OF THE STUDY

This study provides important information to policymakers, for those who have an interest to conduct further research about the challenge to implement SHI and relevant stakeholders including Ministry of Health, EHIA and AAHB and to devise effective strategies and appropriate interventions. It provides evidence about factors that can either deter or encourage to the implementation of SHI in the public servants by their perspective; thereby maintaining the program acceptability and sustainability. The study fills the knowledge gap in the area of the SHI implementation to reduce the challenges.

1.6. LIMITATION

One of the main limitations was the COVID-19 epidemic. Due to that there was exposed to constraints of time to collect the required data, as situational or event on Akaki Kaliti Sub-City administration health sector was burden by pandemic health care. The other limitation was some target group members were not present at their job because of the epidemic. It was also difficult to conduct FGD method as the result of the epidemic.

1.7. SCOPE OF THE STUDY

The study was conducted in Addis Ababa, AkakiKaliti Sub-City public servants rather than the entire city due to limited resource such as human, material, availability of time. Content and geographical wise, the scope of the study was based on challenges of the implementation of SHI in Akaki Kaliti Sub-City administration from public servants perspective. The study captures the varying shades of opinion on implementation of SHI, with a view to presenting a balanced view of SHI in Akaki Kaliti, and an objective picture on the way forward.

1.8. OPERATIONAL DEFINITION OF TERMS

- **Social Health Insurance:** is a form of financing and managing health care based on risk pooling. SHI pools both the health risks of the people on one hand, and the contributions of individuals, households, enterprises, and the government on the other. (WHO, 2003)
- **Customer Satisfaction:** customers are satisfied when they get more benefits than their cost and satisfaction is the extent to which the customers' expectations have been met. (Tian, Tien, Chen, & Liu, 2012)
- **Service Quality:** The quality of service as used in this study was based on the revised SERVQUAL instrument which divides the quality of service into five distinct dimensions of Tangibles, Reliability, Responsiveness, Assurance and Empathy (Alkenbrack, 2013)
- **Healthcare Service Quality**: quality of healthcare as "The degree to which health services for individuals and population increase the likelihood of desired health outcomes and are consistent with current professional knowledge". The institute of medicine (IOM)

1.9. ORGANIZATION OF THE THESIS

This paper is organized into five chapters. The first chapter of the thesis is devoted to introduction, statement of the problem, objectives of the study, research questions, limitation of the study, and operational definitions of key concepts. The second chapter deals with the review of related literature consists of the conceptual review and the empirical studies, health, health systems, financing and insurance, improving healthcare financing in Ethiopia, advantage and disadvantage of SHI, Ethiopian health insurance system and Ethiopian SHI scheme. The third chapter presents and describes the study area, the research design and methods, universe of the study, sampling method, tools and procedures of data collection. In addition, it explains about data processing and analysis, and ethical considerations in the research process. Chapter four presents data analysis, the major findings and interpretation of the study. The fifth chapter, puts together those major findings drawn conclusions and to suggest possible and plausible actions using social work perspectives.

CHAPTER TWO: LITERATURE REVIEW

2.1. INTRODUCTION

This chapter includes three sections; theoretical, empirical and the conceptual framework. The theoretical frameworks cover of Healthcare financing in general and health insurance system in particular. It is categorized into four parts. The first part deals with relation between health systems, financing and insurance. This is considered as the importance of health financing to achieve system goals, how to Mobilizing funds for the health system, Sharing and managing risk and purchase service provider. The second deals how we can improve health care financing in the context of finding the problem mean that poor health care financing, policy option and the implementation consideration. Third part of theoretical part that deals with the advantage and disadvantage of SHI and the last one is about the Ethiopian SHI System and the regulation. The second section is empirical frame work it cover the data or research done before in the world, Africa and Ethiopia. The last section indicates the conceptual frame work.

2.2. THEORETICAL REVIEW

2.2.1. Health, Health Systems, Financing and Insurance

2.2.1.1. Achieving System Goals

Health financing is an important health system function and should contribute to the overall goals of health systems. Health is the primary or defining goal of a health system, and both the overall health status of the population and the distribution of health among the population are important. However, non-health outcomes are also important. Responsiveness to people's (non-medical) expectations and the fairness in financial contribution are also recognized as important final goals of the health system (charles & alex, 2009).

Thus, any assessment (and design) of health-financing schemes must ultimately relate to the health system goals. Most directly, a well-designed health financing scheme should be an effective way of realizing the goal of fairness in financial contribution, where risks are pooled and shared and resources are acquired according to ability to pay. But a health financing scheme also impacts on both the distribution and overall health status of a population, by providing

resources for health and shaping how these resources are used. Finally, a good health financing scheme can have a positive effect on the responsiveness goal, by altering the incentives faced by health-care providers (charles & alex, 2009).

2.2.1.2. Mobilizing funds for the health system

The specific purpose of health financing is to make funding available, as well as to set the right financial incentives for providers, in order to ensure that everyone has access to effective public health and personal health care. When assessing the performance (and design) of health financing schemes, it is important to do this with respect to these health financing targets (charles & alex, 2009).

2.2.1.3. Purchasing services from providers

Purchasing is the process by which pooled contributions are used to pay providers to deliver a set of health interventions. Purchasing can be either passive or strategic, with passive purchasing simply following predetermined budgets or paying bills when presented. Strategic purchasing is generally preferred, as it involves a continuous search for the best purchase method and source for health services. The key design issues for purchasing are benefit package, organization of services, provider payment mechanisms and operational / administrative efficiency (Charles & Axel, 2009). While mobilizing sufficient public resources and organizing pooling to maximize re-distributive capacity are essential for achieving equitable and affordable health care access for all, it is of equal importance that collected resources be efficiently used in order to maximize and sustain the provision of benefits for the population. Strategic use of the purchasing function is the key health financing instrument for this purpose (Nthenya, 2009).

2.2.2. Improving Health Care Financing In Ethiopia

The problem: Poor health care financing: - FMoH in Ethiopia has developed and implemented a health care financing strategy since 2005 (Health Sector Development Plan III). This strategy focuses mainly on improving the efficiency of allocation and utilization of public sector health resources. Like most African countries the health financing system in Ethiopia is pluralistic, with funds originating and flowing through several sources and mechanisms,

including: the government, grants and loans from bilateral and multilateral donors, private contributions and other sources, including contributions from private employers (FMoH, 2010b). Although health care financing has improved significantly over the years as a result of the health care financing strategy, inadequate health care financing remains a major challenge for the health system of the country (FMoH, 2010b). By addressing this problem, the current system of health care financing can be strengthened and sustainable resource mobilization, allocation and utilization, as well as equitable health system utilization, can be improved.

Size of the problem

Total health spending in Ethiopia has increased from US$1.2 billion in 2007/08 to US$1.6 billion in 2010/11 (FMoH, 2014). The country's overall health care is under–financed both in absolute terms and when compared to Sub-Saharan Africa (SSA) standards. For instance, the per capita national health expenditure for the country was reported to be US$ 20.77 during the year 2011 (FMoH, 2014) while the SSA average was US$ 93.65. This per capita health expenditure for Ethiopia is also well short of the WHO's recommended US$ 30-40 per person needed to cover essential health care in low-income countries (www.tradingeconomics.com).

According to the World Bank, the OOP health expenditure in Ethiopia (i.e., the proportion of total health expenditure that is paid privately by individuals and households) was measured at 79.87% in 2011. This figure is higher than the 62.2 % in SSA during the same period.

Another important indicator of the problem of health care financing is the maternal mortality rate, which has not shown significant improvement since 2005. One of the reasons for this lack of progress is the under-financing of maternal health services, not only compared to other countries but also compared to other services. Total reproductive health expenditure in 2010/11 was US$ 224 million (constituting 14% of total health spending) (FMoH, 2014). During the same period, spending per woman of reproductive age (15-49 years) was not more than US$ 12 not adequate to improve the health status of women nor to improve access and use of reproductive health services (FMoH, 2010b; FMoH, 2014).

The causes of inadequate financing for health care in the country include: low government spending on the health sector; strong reliance on out of pocket expenditure; inefficient and inequitable utilization of resources; and poorly harmonized and unpredictable donor funding.

2.2.3. Policy options

Poor health care financing of the country is the result of various causes. However, this evidence brief seeks to address one of the major causes – high reliance on OOP payments through risk sharing mechanisms. These mechanisms are given emphasis because they are effective health financing techniques that have been used in LMIC and also they are currently under consideration by the government. Risk sharing mechanisms (such as insurance schemes) are strategies to reduce large OOP payments for health care and to overcome financial barriers to accessing health care. Health insurance schemes come in different forms SHI one of these.

SHI is one of the principal methods of health financing globally. It is a form of mandatory HI for formal sector employees, including retirees and pensioners. Most SHI schemes combine different sources of funds: these schemes are usually financed by earmarked payroll and pension contributions (from employer and employees) (FMoH, 2008). In addition, governments often contribute on behalf of people who cannot afford to pay themselves. SHI entitlement is linked to a contribution made by, or on behalf of, specific individuals in the population (Carrin & James, 2004).

Like CBHI schemes, SHI is meant to improve access to health services by removing catastrophic health expenditure at the point of service delivery, particularly for formal sector employees and their families (FMoH, 2008).

Current Practice in Ethiopia

The SHI Proclamation was ratified by Parliament in July 2010 (Negarit, 2010); however, it is not implemented to date. There is an initiative to establish an SHI scheme incrementally, gradually expanding its coverage to include all employees in the formal sector (FMoH, 2008), including retirees and pensioners. The potential members of the SHI are formal sector employees of public or private organizations in the country, including the retired and pensioners. The plan is to make

citizens of the country in formal employment beneficiaries through contributions constituting 3% of their salary. A member is eligible to enroll in the SHI program with his or her spouse and children under 18 years of age. Regarding service provider selection, public facilities are planned to be the major service providers. However private facilities that have gone through accreditation process and agreed to provide the service at established tariff can be considered.

2.2.4. Implementation considerations

CBHI and SHI are two potential options for improving health care financing in Ethiopia, in addition to other existing financing schemes. The implementation of these two options includes both opportunities and challenges. It is therefore important to consider possible barriers and enablers, so that benefits arising from enablers can be taken as an opportunity while properly addressing the barriers. Enablers for implementation of these options CBHI & SHI in Ethiopia include:

- Existence of a strong government commitment to improving health care financing so as to enhance the health status of Ethiopians (FMoH, 2008).
- The on-going implementation of the health care financing reforms.
- The existence of high OOP expenditure is an indication of the capacity and WTP for health services, which is a necessary precondition for establishment of health insurance.
- Existence of local institutions like ‘edir’ (community groups that collect funds for funeral costs),
- ‘Equb’ (rotating credit association or a rotating fund) etc. where people contribute a certain amount of money regularly (usually monthly) are important entry points for establishing health insurance.
- The existences of Micro-finance Institutions in all regions, with networks that extend to the community level, offer a good opportunity for expansion of health insurance. They can serve as a means of reaching rural communities particularly to collect premiums.
- The steady economic growth of the country is likely to enhance the capacity of the government to subsidize health insurance schemes

2.2.5. Advantages and Disadvantages of Social Health Insurance

SHI is thus one method of financing health services. It may be the main funding mechanism or a supplementary one. Countries may wish to introduce or scale up an SHI scheme for a number of reasons. In any case it is useful to consider the advantages and disadvantages of SHI. SHI has a number of advantages (Carrin & James, 2004). SHI helps prevent people from falling into poverty due to health care costs. Catastrophic expenditure due to accidents or disease since SHI combines prepayment and risk pooling with mutual support.

- SHI may be more acceptable than tax funding in some countries as a framework for developing risk pooling and social solidarity. This may be the case particularly in countries with a high current dependence on user fees. This is due to the more transparent flows of funds and the link between payments and entitlements. It therefore seems more compatible than tax funding in terms of personal responsibility and compatibility with the wider market economy.
- SHI can mobilize additional resources for the health system, such as funding from employers.
- SHI can provide a stable source of funding for health care, which is separated from the general government budget and independent of budget provision.
- SHI does not compete directly for a share of the public budget.
- SHI is more just and more equitable than OOP spending and commercial insurance.
- SHI can help to strengthen patients' rights as customers of health care providers.
- SHI can improve transparency of prices, costs and expenditure.
- The SHI framework encourages the development of explicit purchasing arrangements and greater provider autonomy, which can increase efficiency in health care.
- Employers and employee representatives have incentives to monitor spending if they are part of the social insurance management setup.

Although risk pooling and purchasing are not exclusive to SHI, the need to provide services to which people are entitled and to be accountable for costs encourages good practice. The extent to which the potential advantages are realized depends on the details of how the SHI is designed and developed. On the other hand, SHI has a number of disadvantages:

- SHI constitutes an administrative challenge, requiring capacities and infrastructure that may be in short supply.
- People may not understand and accept the concept of health insurance. Thus health insurance needs to be explained to many people, especially in developing countries and among poorer and less educated communities.
- There may be limited enthusiasm for solidarity and mutual support.
- It may require more administrative effort to register workers in the informal sector and to collect contributions from them.
- Functional responsibilities for pooling and purchasing may be duplicated, unless there are synergies with other schemes and mechanisms.
- The capacity to provide services of appropriate quality is required.
- SHI schemes may worsen existing inequalities in financial protection, especially during their initial development, if formal-sector employees are covered first.
- Special mechanisms may be needed to cover the poor who are unable to pay contributions.

2.2.6. The Ethiopian Social Health Insurance System

Ethiopian SHI "Social Health Insurance Proclamation No.690 /2010" (Negarit, 2010) as stipulated in the proclamation the definition and objectives of SHI is stated hereunder.

Ethiopian SHI Proclamation

Attention of the Ethiopian government has been turned to universal and sustainable health care services with decentralized financing. The government has recognized health care financing reforms, including health insurance, as part of the strategy for improving access to quality health services in an "*equitable"*, efficient and sustainable way. The SHI is established in accordance with Article 55 (1) of the constitution of the FDRE, under proclamation no. 690/2010. According to the SHI strategy justification, the existence of high OOP expenditures is an indication of the capacity and WTP for health service, which is believed to be a necessary precondition for the establishment of health insurance. So, the SHI is established to provide a basic package of essential health services to all Ethiopians at reduced OOP spending at the point of service

delivery through collection of premiums to increase the resources for health facilities and utilize accountably (Wondie, 2018).

Insurance coverage

The SHI Scheme Council of Ministers Regulation No. 271/2012, Article 3 provides a list of health services a beneficiary will have the right to, from health facilities. These are:-

- outpatient care and inpatient care;
- delivery services and surgical services ;
- Diagnostic tests and generic drugs included in the drug list of the agency that will be prescribed by the medical practitioners.

2.3. EMPIRICAL REVIEW

Globally, SHI in developed countries has universal formal coverage and effective access to health services. The main health financing mechanisms still being used are contribution-based social health insurance and the tax- based National Health Service. These countries only have a small share of health expenditure by private for-profit insurance companies and an OOP share of about 10% of total health expenditure and the use of health financing mechanisms based on risk pooling and prepayment. However it is important to note that levels of health expenditure and formal social health protection coverage vary greatly based on the national level of income. This indicates that there is considerable policy space for countries wishing to introduce social protection financing to cover healthcare risks.

Respondent's age is found to have a positive effect on WTP in some studies, while in others it is the opposite. Likewise, distance to the nearest health facility has been found to have a positive effect on WTP in some cases, in the sense that short distance increased the likelihood of WTP, while in others it has had a negative effect. Some studies have shown that household or income has a positive effect on WTP, while others have not found such an effect. Other factors that have been found to significantly influence WTP for SHI programmers include education, household size, level of trust that households have in the management of the insurance program, sex,

knowledge of the SHI program and place of residence (Gidey, Gebretekle, Hogan, & Fenta, 2019).

A study conducted in national health policy Nepal challenge implementation health insurances Demand for health insurance membership cannot be delinked from the quality of health services which the scheme gives access to. Membership will be less attractive if services are of poor quality. Currently Inefficiency of health services is a particular problem, as 20-40% of resources spent in health are wasted which could rather be used in achieving universal coverage.

Government expenditure on health in sub – Saharan Africa has severally been described as being inadequate, insufficient, inequitable and unsustainable. The burden of paying for health care has been a performance indicator for assessment of national health systems according to the World Health Report. Social health insurance in Nigeria has been characterized by a lot of misconceptions, fears about workability of the scheme, concerns as regards workers financial contribution to the scheme overtime and the sincerity of government in financing workers in the formal sector among others.

A cross-sectional study conducted in St. Paul's Hospital Millennium Medical College Addis Ababa, Ethiopia showed that 17% of the study participants were willing to pay for SHI. In addition lack of adequate information on the SHI scheme (9%) and lack of confidence in health institutions giving health insurance service (6.1%) were among the reasons for not willing to pay for SHI (Lasebew, Mamuye, & Abdelmenan, 2017).

The study done in central Vietnam identified reason for unwillingness to join SHI as; no enough money to buy the scheme (70.1%), complicated SHI administration (3.6%) and poor health care quality (0.6%) (Nguyen & Hoang, 2017).

In generally although literature of the challenge to implement SHI in developing countries like Ethiopia in thus for quite scant, available studies show economic, socio cultural and variable as important correlation of enrolment in health insurance. This study will try to examine the challenge to implement SHI.

2.4. CONCEPTUAL FRAMEWORK

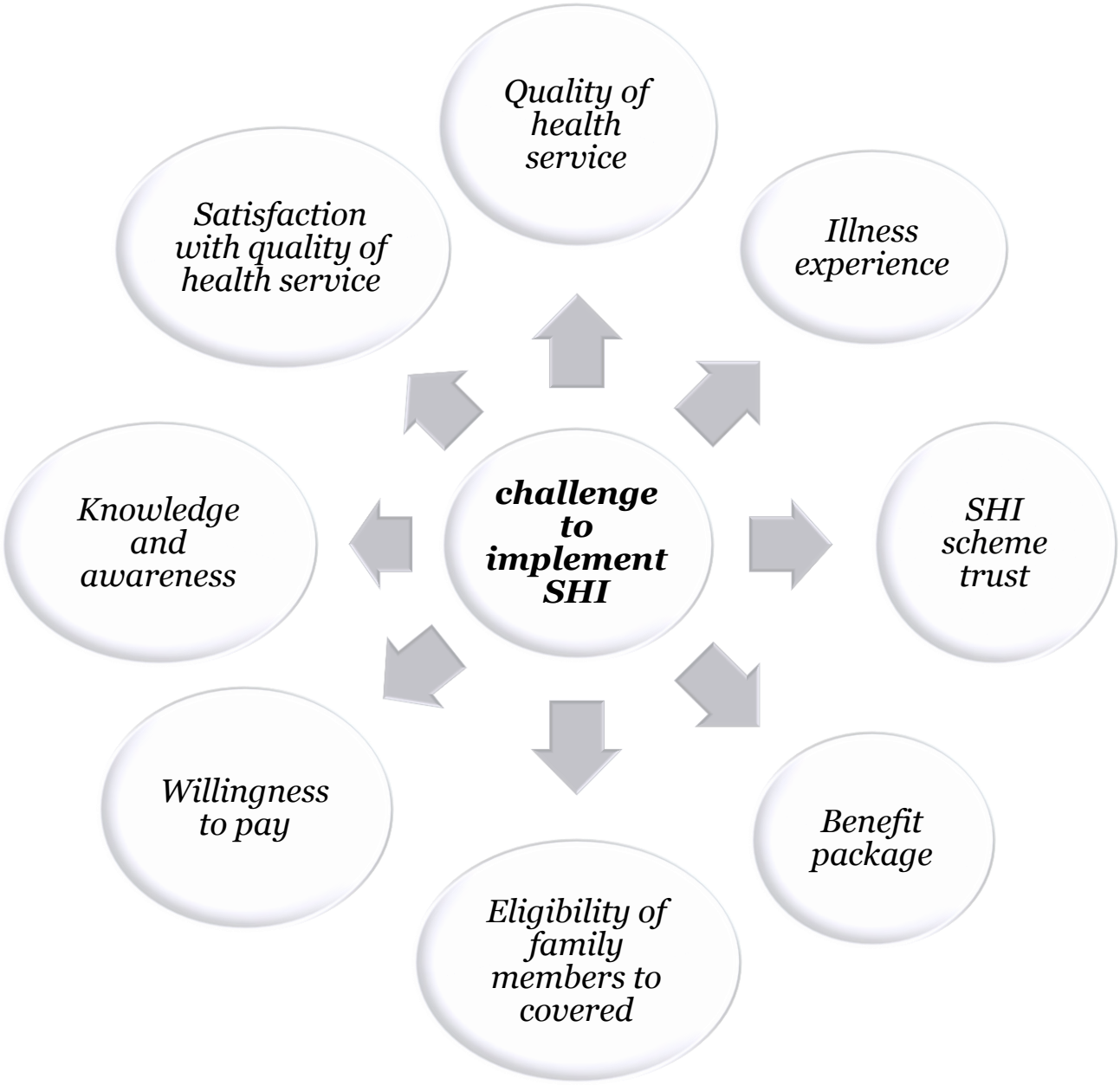

Figure 1: Conceptual framework of challenge to implement SHI in public servants adapted from different literatures (Alkenbrack, 2013)

CHAPTER THREE: RESEARCH DESIGN AND METHODOLOGY

Introduction

This chapter describes the study area, discusses study design, approaches and methods, universe of the study, sampling method, sample size, data sources, and tools or instruments and procedures for data collection, data processing and analysis, as well as ethical considerations.

3.1. DESCRIPTION OF STUDY AREA

The research is conducted in Akaki Kaliti sub city administration public servants. Akaki Kaliti is one of the 10th sub cities of Addis Ababa. The sub-city is located in the southern parts of the city. According to the data obtained from the Addis Ababa City website, Retrieved on June, 2020). Its population is estimated to 195,273 of these 99,715 are females and 95,558 are males. The sub city has an area of 12,300 hectares. The sub city is divided in to 13 administrative Woredas (districts) and eight governmental health centers with one general hospital. The total population of the public servants in this sub city administration is 528 (317 females and 211 males). (Akaki Kaliti sub city, human resource data of 2012 E.C.)

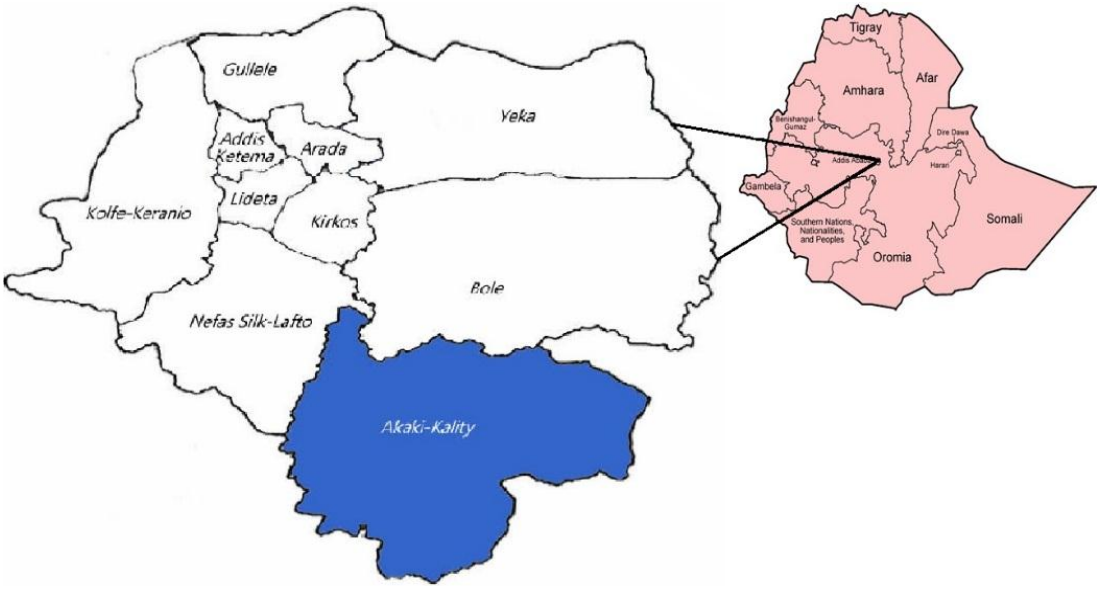

Figure 2: Administrative map of Addis Ababa, Ethiopia Source: (www.addisababa.gov.et., Retrieved on June, 2020)

3.2. RESEARCH DESIGN

In this study qualitative research approach was used. Qualitative research paradigm is best to explore new issues with the perspectives of study participants themselves. The goal of qualitative research is to look for meaning and stress is laid on socially constructed nature of reality (Creswell, 1997). A case study design was chosen to examine the public servant perspectives. According to Kothari, (2004), through case study method a researcher could obtain a real and lived personal experiences which would reveal man's inner strivings, tensions and motivations that drive him to action along with the forces that direct him to adopt a certain pattern of behavior.

3.3. SOURCES OF DATA AND TYPES OF DATA

The population of this study was the public servant of Akaki Kaliti sub city who were have 5 year experience being a civil servant, Semi-structured interviews were selected to carry out this research study. It was helped to maximize the reliability and validity of the service the public servant perspective. It was also more semi structured because the researcher had a clearly specified set of research questions that was to be identified. The semi structured interviews were conducted with the Akaki Kaliti sub city administration public servants. The main purpose of the interview items were to gather information from future members of SHI on the extent to which the SHI scheme how to reach at grass root level. The semi-structured interview questionnaires was developed from previous studies and modified to fit the study. The questionnaires were comprised of questions related to challenges of SHI implementation. The questionnaires was first prepared in English and back translated to local language (Amharic) and re-translated to English to ensure its consistency of meaning. Based on used purposive sampling techniques, study participants was appropriate selected tool. Observation provided the researcher to yield direct information about the nature of the health center service in the health center environments. The health canter observation helped the researcher to watch and understand the availability of basic health services.

3.4. SAMPLING TECHNIQUE AND SAMPLE SIZE

The study participants consist of all the public servant who has been working in the Akaki Kaliti sub city administration in Addis Ababa, Ethiopia. There were a total of thirty three (33) sectors under the sub city and there are 528 public servants. Thus who were have more than 5 year experience and which qualify the inclusion criteria was 175. The participant was 20% of the population, a total of 34 Public servants were purposively selected from the entire population of the study.

The researcher used non- probability sampling technique for undertaking qualitative study to generate qualitative data using semi-structured interviews, in depth interview, observations and document analyses, purposive sampling non- probability sampling method was used to select these public servants whose working in the sub city. This purposive sampling technique was used in that the study required on the part of the familiarity with the area under investigation and their ability to furnish information readily since the researcher also required specific, accurate and appropriate information. The purposive sampling technique was employed because the Akaki Kaliti Sub City public servants needed to be specifically targeted for conducting interviewing and for administering the interview schedules. In qualitative research the quality of percipients is important than large number target group. Thus, 34 participants were selected based on selection criteria, availability, convenience of time and money, and complexity of data analysis.

Participant Selection Criteria

The selection of participant was based on eligibility criteria set for each target participant. To generate relevant data the researcher set criteria's based on which participants were incorporated age, period of service, language proficiency and willingness were the criteria used to select public servants (Creswell, 1997). All public servants with at least five years working experience in the selected organizations, who participate in January 11, 2016 discussion of SHI scheme in the formal sectors, which was led by Prime minister office, and the quality of the participant's knowledge about the area also included in the study. All temporary workers and have less than five year experience were excluded from the study.

3.5. DATA COLLECTION TOOLS/INSTRUMENT

The qualitative data were collected by different method these are interviews, observation and collection of documented material such as letters, diaries, and by open ended questions in questionnaires. The techniques for collecting data were through observation writing descriptions and audio recording. KII and IDI had been employed for this study.

In-Depth Interviews (IDI):

Interviews were conduct using Amharic language as a medium of instruction. Venue for IDI with public servants was in their office and in the compound of their environment as per their preferences. The researcher conducted face to face interview with participants by employing semi structured and open ended questions.

Key Informant Interviews (KII):

It was a type of interview with individuals who have been taken especial knowledge, experts and talent about the issue under investigation. KII sampling IDI was used and the interview would continue until saturation is reached. The interviews are semi-structured, relying on a list of issue to be discussed. KII resemble a conversation among acquainted, allowing a free flow of ideas information (USAID, 1996). Key informants data were collected from six stake holders, they are EHIA, AAHB, AAHIA, EPSA and two Akaki Kaliti woreda health centers. The researcher conducted face to face interview with participants by employing semi structured, open ended and probing questions in Amharic language as a medium of instruction.

3.6. DATA ANALYSIS

The qualitative analysis of qualitative data was employed in this study for it is best suited to achieve the objectives of the study by analyzing oral accounts of residents based on their lived experiences. In order to analysis the textual data, first the audio taped interviews was been transcribed. As far as the presentation is concerned, making the selected thematic areas to is the focus point of data presentation, the relevant data presented in a way related to the thematic areas. Thematic analysis was a method for identifying (categorizing), analyzed, and reporting

patterns (themes) within data. To achieve this, all the recorded data and field notes through interviews and key informant interview including the nonverbal communication first transcribed to English language. In the second step repetitive reading of all the transcription was put into practice in order to grasp the general idea to develop coding of ideas and to extract significant statement. In the third step develop categories along with the content of interview which is important to avoid repetition of ideas. Fourth, the researcher was developed themes and merges themes of similar ideas to come to the objectives of the study. In the discussion session a cross case synthesis was employed as a major analytical technique which was found important in analyzing multiple cases.

3.7. ETHICAL CONSIDERATIONS

Ethical clearance was obtained from St. Mary's University institutional ethical committee and Addis Ababa public research and emergence management directorate. In addition, permission letter was obtained from the Sub-city.

As far as the ethical issues are concerned, the researcher first explained about the purpose of the study, the obligation of keeping confidential information including delegating pseudonyms. The participants had given the right to interrupt the interview process at any time when they feel discomfort, so that they have the right to self-determination.

Participants would be ask for their informed consent to participate in the study after informed them the importance of participation, risks and benefit associated with the study. They were assured that they had a right to with draw at any point without consequences. Once consent was obtained, participants were allocated a study number obtaining informed consent. So that the researcher collected a sign document of consent form the participants to confirm their willingness to take part in the study.

Personal information and sensitive issues were kept in secret. In order to ensure confidentiality of the information the audio records was handled with utmost care and not transferred and used for other purpose other than the research objectives. Pseudonyms were used to protect the anonymity of participant and the study had no harm with any potential participant.

Finally the study participant would have access to some of the narratives to check whether confidentiality and privacy is ensured. In sum, all information were collected from respondents and key informants with their consent and willingness all information obtained from the sources was kept confidentially the data was analyzed and interpreted without naming any of the respondents and informant finally, The different assumptions and theories that are utilized from other books, journals and researches are properly cited and acknowledged.

CHAPTER FOUR: DATA ANALYSIS AND DISCUSSION

4. Introduction

This chapter presents the data description and analysis. More specifically, the chapter begins with providing the general profiles of key informants in this study then it continues with providing the background focusing on the socio-demographic characteristics of the study participants. The data presentations were provide the profiles of the thirty-four participants involved in the study. The profile is presented on the basis of gender and age, marital status, religion, number of children and physical and health conditions. It also shows various themes and sub themes of the study. The next section presents the challenges of SHI implementation.

4.1. General Profiles of key Informant

There were key informants those involved in this study. KII were undertaken based on their lived experience and profound knowledge in the area. Key informants in the study were drawn from AASHIA, AAHB, EPSA and health centers in the Akaki Kaliti Sub City. Director of the AASHIA, team leaders of AAHB, EPSA and medical director of health centers in the Akaki Kaliti Sub City were interviewed.

4.1.1. Demographic Characteristics of the participants

A total of 34 participants were involved in this study. Table 1 provides the profiles of the informants who participated in this study. There relevant demographic information such as age, sex, educational status, marriage status, source of income and religious backgrounds are indicated. According to Ethiopian public servant retirement age limit the lowest is 55 and the highest is 60 (Public Servant's Pensions Proclamation, No. 345/2003). And in the data collection the participant lower age was 34. So the age was categorized 33-60, by divided by four equally. Out of the thirty-four participants, eleven of them were have a chronic disease; five have faced acute disease in the last one year and the other eighteen have well health condition.

Table 1: Demographic background of the participants

No	Variable item	Categories	Distribution	
			Frequency	Percent (%)
1	Age	33 – 39	4	11.8
		40 – 46	18	52.9
		47 – 53	9	26.5
		54 – 60	3	8.8
2	Religion	Orthodox	21	61.8
		Muslim	5	14.7
		Protestant	6	17.6
		Catholic	2	5.9
3	Sex	Male	23	67.6
		Female	11	32.4
4	Education	First degree	29	85.3
		Master's degree	5	14.7
5	Marital status	Single	5	14.7
		Married	26	76.5
		Divorced	2	5.9
		Widowed	1	2.9
6	No of children	No	6	17.6
		1 - 4 children's	26	76.5
		5 and above	2	5.9
7	Health status	Well	18	52.9
		Chronic disease	11	32.4
		Acute disease	5	14.7

Source: Own Survey in Akaki Kaliti Sub City Administration, 2020

In this study the numbers of interview participants were thirty four (34) public servants who had work experience for at least 5 years by being civil servant. Each and any informant interviewed once time interviewed in individual case in the study area. Among these, four (11.8%) of

participants were aged in the range 33 – 39 years. The other eighteen (52.9%) participants were in the age ranging from 40-46 years. In addition, the remaining nine (26.5%) of the informants were aged in the range 47-53 years, while the remaining three (8.8%) of participants were between 57-60 years old. Among the participants, one of them were physically disable with one leg, the other participant were physically well.

In terms of gender composition, twenty three (67.6%) of the study informants were males respondents, and the remaining eleven (32.4%) of them were females. All participants of the study have first degree and master's level education. Twenty nine (85.3%) of the participants have got there first degree furthermore the others five (14.7%) of participant they have their master's degree by government and self-sponsorship. Regarding their marital status two (5.9%) of the interviewed informants reported that they broke their previous marriage and the other twenty six (76.5%) were currently married and the other one (2.9%) participant was widow, her husband was died of car accident. Such as in terms of the religious denominations of the informants were twenty one (61.8%) are Orthodox Christianity, five (14.7%) the informants were follows of Islamic, six (17.6%) are protestants and the other two (5.9%) of theme were follow catholic religion.

In this particular study, the participants of the study were asked to provide their family and kin situation. As a result, six (17.6%) participant reported that they have no any children yet, the other twenty six (76.5%) participants were having a children's from 1- 4 and the two (5.9%) rest of them were have five and more children's. And they also mentioned that they haven't any other income out of these. Lastly, the health status of the participants eleven (32.4%) are have a chronic disease and the other five (14.7%) have faced an acute disease in this year, and the rest 18 (52.9%) of them were healthy.

4.2. The Major Challenges of SHI Implementation

A total of thirty four participant interviews, the key informant in-depth interviews were conducted and six major themes were emerged from the thematic analysis: affordability of health services, service quality of governmental health centers, participant's awareness of SHI, factors influencing volunteer for participate in SHI scheme, readiness to implement SHI scheme and

policy gap of SHI. The service quality of governmental health centers and policy gap of SHI will have sub themes.

4.2.1. Lack of awareness and knowledge of SHI in implementation

The majority of participant had a good knowledge regarding what SHI means, how it works, its concepts and purpose. Most of the participant believes that everyone can get benefit from SHI but a few of them strongly argued that only the poor are beneficiaries of the scheme. This was illustrated by one participant:

"I think SHI is about a risks sharing or helping each other in the time that our health affected because none of us is certain about our health status, it is important to have a guarantee for everyone: all people whether rich or poor may not have money at hand in times of emergency health conditions. I always didn't understand our concentration about keeping our health safe, all people have insurance for their materials but they don't have health insurance for our precious life." (Male, 49 year, Social Worker)

On the other hand, some of participant didn't have any awareness about SHI means, how it works, its concept, and also purpose. This was illustrated by one participant:

"I have heard about SHI many times, but I just only know the name not the detail information what it means, I didn't understand the benefit, purpose and also the system how it runs. I was tried to know about the Ethiopian social health insurance scheme but I didn't get any information or who can gave clear information about the scheme." (Male, 37 years old, civil engineer)

One of the key informants also supports the previous participant idea. The SHI scheme awareness creation has a weakness. One of the main challenges to implement is the weakness of awareness creation. This was illustrated by AASHIA director:

"As an institution we believe that the awareness about the SHI *in the public servant is not enough, even some of them have no any information about the system and the purpose. Before we start implementing the* SHI *scheme in the public servant the first assignment of our agency will*

be creation awareness. This may done by regular medias (television or radio), by organizing conferences of awareness creation or by social medias. If it successfully create awareness the implementation will be easy than now. So before anything starting awareness creation is the main thing." (AASHIA)

A few participant also indicate that they have false information, misunderstanding and didn't have clear information about the SHI scheme. The main gap of their awareness is they are thinking SHI and community based health insurance (CBHI) have the same purpose and system, so they want to participate in the CBHI.

4.2.2. The effect of less willingness to pay in the implementation of SHI

Once health expenditure and knowledge of SHI was explored; the principle, purpose and benefit packages of SHI were explained. Perceived need and factors affecting participants' willingness to pay were then discussed. Almost half of the participant have the WTP for SHI scheme, and they also believe the important of the scheme in both was means that for their health expenditure and for the health service financing method to improve the health system also. They also believe these schemes support the participant and the health system one another. This was illustrated by one health professional.

"I am ready to pay for SHI; I believe this health insurance system has multidirectional benefits. As a human being we can't predict in my health status what gone happen tomorrow, so the health insurance may support me from expensive health expenditure. In the other hand when all public servants contribute these 3% of their monthly payment, it can finance for a health system. I believe our today contribution may change or upgrade tomorrow health system of our country." (Female, 41 years old, human resource)

On the other hand, few of participant didn't want to participate or willing to pay for SHI. They indicated that the SHI scheme is working with the public health sector. So they don't want to go the pubic than the private health sector. As a reason they said that, the quality of health service and also the equity of the service. This was illustrated by one participant:

"I don't want to pay for the SHI, it's because I don't believe in the public health sector services quality than the privet sector. I want always to go the private health sector so I don't want to be a member until it improves the service quality or it participate the private sectors."(Female, 36years old, accountant)

Some of them also don't want to pay in this time, they rose as a reason they are to young, they have no illness experience and also they are living alone it means they didn't form their family. Because of this reason they only want to focus on the protecting their health by exercising and eating healthier foods than pay for health service. This was illustrated by one participant:

"I am not willing to pay in this time, because I am to young, living alone and the main thing I didn't have an illness experience. I always focused on preventing my health states. I always waste my time and money by physical exercise and eating healthy food. So I don't want to be a member now but I may participate after some years." (Male, 38 years old, textile engineer)

4.2.3. The effect of Policy gaps in the implementation of SHI

This theme will have two sub themes. According to the public servant perspective they try to indicate the policy gap some of it was the benefit package and the Family members' eligibility.

Benefit packages

Half of participants argued that the list benefits included in the package don't deserve a 3% contribution. Despite their agreement about excluding some services such as dentures and cosmetic surgery, most of them wanted chronic dialysis be included. A few participants agreed that out of country referrals for rare conditions should not be included as it contradicts the intention of health insurance to ensure access to basic health services for all citizens. One health professional supported this idea:

"I do agree on the services excluded from the benefit package, because these disease conditions can consume a large amount of the budget for few patients that would have been used to save more lives. It is rational first to focus on conditions that affect a majority of the people." (Male 39 years, Health professional)

Another participant stated that:

"Personally I think from the excluded services mainly the chronic dialysis has to be involved. And if the service gave in this country public health sector any service have to be included. The SHI *scheme didn't have to be business oriented/ didn't think only the profit it has to also think the members benefit." (Male 48 years, Health professional)*

Family members' eligibility

Children above 18 years are not entitled to their parents' health insurance benefits. The participants were not happy with this age limit as it does not consider the economic situation of the child. Eligibility should not be based on age but individual income. In Ethiopia, most children of 18 years are the 11th or 12th grade, and some may go on to post-secondary education. Thus, coverage under their parents' benefits should continue until approximately 24 years. And also the number of the family has to increase to 6 at least. One participant stressed that:

"If the scheme excludes my family member above 18 years, I don't support this program. This doesn't consider society's real situation, I mean the chance of getting work is low and even at this age most of them are high school students. So, it should not only consider age but also it should consider level of income. Or if the government decided to exclude above 18 years, there should be a means to create work for all citizens in that category and the other is the number of family is only include 4 but even in this time I have 5 children's so it's not also considerable." (Male, 58 years, lawyer)

4.2.4. The effect of poor Quality of governmental health services

This theme will have six sub themes. According to the public servant perspective they try to indicate the effect Quality of governmental health services in the implementation some of it was the supply (medical instruments, medications and reagents), Health Care Providers and clients Relationship (Privacy, listen and respect), Shortage of man power, Lack of training for the professional's, Long wait time (medical card room) in the public health sectors and Loss of documentation (patient medical card).

Shortage of Supply (medical instruments, medications and reagents)

Most participants rated private health facilities quality of health service is better than public health facilities when they compared it. Almost all participants revealed their dissatisfaction with the current services which are characterized by a chronic shortage of medications and diagnostic supplies. Thus, all participants suggested current health services must be improved prior to implementation of the SHI. This was illustrated by one participant:

"The current quality of health services is not optimal; there are challenges in receiving timely healthcare services. Again, we contribute to get services free of charge but from my experience medicines are frequently out of stock in public facilities and that means we will be forced to purchase them privately, as the private health facilities are not part of the scheme. It is frustrating if you paid and get nothing. It is better to improve the quality and availability of services prior to implementation, otherwise it might fail and it ultimately erodes public trust and will have unexpected repercussions." (Male, 58 years old, lecturer)

Poor Health Care Providers and clients Relationship (Privacy, listen and respect)

Both public servants and the governmental health service providers means the health center medical directors interviewed explained that the importance of patients and health care providers relation building process as a time investment involving getting to know the patient, building trust with patient, and understanding the problem of them. All these events bring the good relationship between patients and health care providers and also have a great benefit for adherence to give good or quality of health service to the patients.

This was illustrated by one male public servant said:

"The health care providers who are working in the governmental health center are also like mom, brother, sisters or dad. Two years ago, I was in the hospital intensive care room, because of car accident but recently I've have been back to my job being in normal health status. This result was come by the endeavor of the health professional's specially nurses. They were following me succession of time. Generally, health professionals have good empathy."(Male, 41 year's old, sociologist)

The medical director of the woreda health center in depth-interview believed about the relationship between the patients and health care providers as:

"The health workers must be sympathetic to the patients. The patients should get care from their doctor or nurse. The patients can come to the health center if we give care and treatment following the rules and principles of ethics of a health worker. We must listen to the patients appropriately. There could be good adherence. If the health worker doesn't show good treatment, the patients may choose staying at home or trying traditional way. In this situation the patient may die or if the case is communicable disease like covid-19, HIV, Cholera and so on, controlling it will be costly as a country. So in order not to bring this challenge, we should treat the patients ethically and appropriately." (Female 38 years old, medical director of the woreda health center)

In the other hand, there is also impoliteness of health care providers: Some public servants who were participated in the interview pointed out that the health care providers in the health center are impolite while providing care to patients. The attitude of a few health care providers are not good in terms of respecting, understanding, treating, and keeping the privacy of the patient. And a few in number are also business oriented, it meant that they suggest for a better service their clients to their own or their relatives health center. This was illustrated by a female public servant who had an experience of surgery before; in the interview she stated that:

"Once a time, I was referred from the health center to the hospital for the better treatment. When I started following my case in the hospital, I met one doctor for my medical treatment. He was famous in the hospital and he was considered as a model. I heard about his personality in the hospital. He asked me one by one about my health problem and he told me that I have to do a surgery, my health problem was appendicitis. Then, he suggested me to go other private health center; unless, to have a surgery in the public one I have to wait at least six month. I didn't get another option than going to the private one. After I borrow money from my relative I ask the doctor were I had to go and he suggested me. It was an internal specialty clinic. He told me apparently that the owner of the clinic was his friend and he was working part time there. Then I did my surgery, it was very expensive. It is too difficult to explain the present health

professional's behaviors even if I can't generalize. How I can explain it to you? Better to silent what they are doing at this time is not good." (Female 41 year's old, technician)

Another female public servant said:

"As you see I am a 7 month pregnant. Previously, I have changed my treatment area from the public health center to the private one. because the health professionals do not give special attention and simply get in and get out approach even if I am not generalized all health professionals." (Female 36 years old, cashier)

Shortage of man power

Inadequate man power was also identified as a constraint to effective delivery to healthcare service. Medical director of the health center who participated in in- depth interview reported that our clinics are inadequate staffed and available over worked.

A medical director of the health center during in in-depth interview reported:

"We can see our clinic as example, the number of health professionals and patients flow is not proportional. Even this reduces the quality of the service provision. Let's see in one Out Patient Department (OPD) one health professional will see 30 up to 70 patient medical cards within a day. When the Patients come irregularly, the number will increase. The flow of patients to the hospital and the number of health workers (professionals) are incomparable .Therefore, there is a burden of work in this health center. This makes poor quality health care." (Female 38 years old, Medical director of the health center)

Another public servants was also support this idea, he was stated that:

"Every time when I went to the governmental health centers, it is very challenging to get the health service in the health center there will be many peoples who want a health service but also there is a few health professionals who gave services to the patients. It indicates that the health service is too poor quality services. Thus, I always choose the private health sector." (Male, 44 year old, psychologist)

Lack of training for the professional's

Some health care providers explained that lack of training on duty was also identified as poor adherence to health service quality. A male health professional in the in-depth interview who was participated reported that:

"The main reason I think for the cause of poor adherence is the lack of training for health professionals. The cases of professionals who directly joint this section from campus without getting additional training mean fresh health workers may not talk about the details of the examination, diagnosis and treatment to the patients." (Male 35 year old, pharmacist)

Another public servant participant stated that:

"Most of the time when we go to the public health sectors we don't seek what we have to properly get health service. In the public health center there is not all-embracing health service, I think it's because of the shortage of working area the other is some professional's didn't fit for their working place or they didn't update their knowledge/ didn't get training. Because of that the medical error's is increase day to day. That didn't appreciate me to go the public health center."(Male, 39 years old, environmental science)

Long wait time (medical card room) in the public health sectors

The few of public servants who participated during the interview reported that the services given in each health centers were good special waiting times to access medical services. But majority public servants reported that still there is a long waiting time to get medical service. A male public servant complained during interview:

"It's difficult to describe the health facility environment condition of health sectors. I am a diabetic and hypertensive patient; thereby I follow my treatment monthly. I always have been arrived early in the morning at local hours at the health center to get service. To your surprise, medical Clark was came to the health center at the local time for 3 hours. I stay solid three hours without any treatment, for whom you asked for such kind of problem? Because they are working together, I was complete my treatment after I stayed solid 8 hrs. I turn back to my home. At that

time I decide to stop my follow up and medication in public health sector because they annoyed me. When I go to the health sector I always feel hunger and tiresome for the minor medical checkup. The majority of the patients were stop to take or miss their appointment for such kinds of problems in the public health sectors so they will try to get their medical treatment in the private one."(Male 47 year's old, human resource)

Loss of documentation (patient medical card)

The majority of public servants were reported that there is a problem of medical card loss or not found in the governmental health center. Due to this case, some of the patients did not confirm their clinical results. In addition to this, Poor health services among health institutions bring poor adherence to quality of health service.

A female public servant who was participated in IDI reported:

"When I was going to the health center before 3 years, my card was lost and they asked me, to avoid accusation, to wait for 3-4 days until my card found. But without my fault, I suffered for 9 months to search for my card. And couldn't take my treatment for they didn't get my card. This is one of the things that annoyed me. Till this time, I haven't card; they have asked me to forget the last 7 years medical history and to start the new one. I don't know about my progress of my hypertensive and other health problem status because of this reason. If my file gets found, I may take my medical card from the health center, and start my follow-up around my workplace." (Female 42 year's old, sociologist)

Another male public servant support the pervious idea said:

"I'm not satisfied with the services given by the governmental health sectors. They don't keep our medical cards properly. They misplaced my card several times and appointed me several times and they made me bored. There was also a time that I didn't take my medical service because of this reason."(Male 45 years old, mechanical engineer)

The health professionals, as well as medical directors, argued that there is a problem of patients medical cards lost in health institution due to various reasons, for instance, lack of training for

card Clarks, manually utilization of patient's medical card instead of electronic systems and not enough room for documentation reservation in some health institutions as national level in the country. Overall, these problems are the main predictors of poor adherence to health service.

Medical director of the Akaki Kaliti Sub City woreda health center said:

"As our level patients, the medical card has the chance to lose in health center. This is also great challenge for our country. In this time our patient's medical cards are used manually. The problem behind is manpower who reworking in this section did not get training and some of them did their task through a traditional approach. Such kinds of problems are the main contributors to poor adherence to the health center." (Male 48 year's old, Medical director of the woreda health center)

4.3. Readiness to implement SHI scheme

A total of thirty four participant interviews, the key informant in-depth interviews were conducted and three major themes were emerged from the thematic analysis in the Readiness to implement SHI: readiness to be a member in SHI scheme, Readiness to Premium contribution and Readiness of stake holders to implement SHI.

4.3.1. Unaffordability of health services

For the all of the participants, OOP was a means to cover their health expenditure. All participants agreed that healthcare was expensive and as a result, significant numbers of participants failed to seek medical care on time, due to a shortage of money. For the most participant the health care cost is expensive or unaffordable because of it, some didn't want to go health center for mild or moderate cases, the other choose the traditional way of treatment rather than go to health center for minor ones. They reported that they cannot afford their medical bills unless they borrow from relatives. They are always investing their money on the house rent, food, school fee … after that there will not have enough money. This has been illustrated by one participant:

"Healthcare costs are very expensive, unaffordable and I don't think they consider the income of most employees. As we all know that, the public servant monthly payment is very low and also the health service expenditure is also too much. Because of this reason I can't afford mine or my family health service cost. Most of the time if the pain is not severe, I try to heal myself by getting a rest at home but if it is severe I will go to health center by borrowing money from my relatives. In these situation the challenge part will the paying back the money." (Male, 52 years, finance officer)

On the other hand, some of the participants indicated that the cost of health services was fair in public health facilities compared than private ones, but the lack of some diagnostic tests, poor service quality and shortages of medications in the public system were major aggravating factors for extra expense and lack of access as compared to private hospitals. This has been illustrated by one participant:

"I always go to the public health centers, because the cost of medication is lower in public hospitals but there is a frequent shortage of vital medicines. Most of the time particular medicine is out of stock from public health facilities, when we try to get in private pharmacies the price is too high. This forced us to pay an extra high cost, which is unaffordable to many public servants." (Female, 47 years, Sociologist)

4.3.2. Readiness to be member in SHI scheme

Some of the public servants are ready to be a member in this scheme. They are also thinking that the implementation have to in hurry, because they think that we are losing a benefits as country even individually. This was illustrated by one participant:

"Personally, if SHI scheme implement in the public servant there will not any effect on our life style. Even I think it is late to implement if we see it according to the importance, our country is losing the chance of the improvement of our health system by financing and it can also still save our health expenditure. So I am ready to be a member in this scheme if it implement at any time." (Female 47 year's old, accountant)

And most of the participant illustrate that they are not ready to be a member if it implement as it is. The main reason was a trust issue in the working method of the scheme. The other issue raised by the participant is the quality of health system has to improve. This was illustrated by one participant:

"In this time the SHI didn't have to be implementing. Before implementing starting the health system have to upgrade one step. As we see the policy has to also minimize the gaps. What so ever there is not a clear operation of the scheme. Because of this and another reason I don't want to be a member even if it implement in this time." (Male 37 years, engineer)

4.3.3. Readiness to Premium contribution

Despite their support to implement of SHI, a majority of the participants were ready to contribute 3% of their gross monthly salary. But some of them were not ready as a reason they rose having low salary, very high cost of living, and burden of other deductions from their salary were mentioned as the major reasons for the view. One participant stated that:

"With my current income, contributing 3% is difficult. Nowadays, everything is expensive and I have a lot of other expenses such as house rent, food, school fee… for my family. I should not suffer to pay for SHI. I believe if you don't wear clean cloths and eat right, you would get sick. It is unquestionable on the need to have SHI but the contribution should not lead us to further crisis and illness." (Male, 58 years old, accountant)

Another participant stated that:

"If the contribution is too small, it is valueless as it can't cover even the basic health services, let alone costly medications and diagnoses. Hence, the program will finally fail to succeed in its objective which could have unprecedented repercussions to everyone involved." (Male, 40 years, profession didn't stated)

Another participant stated that:

"I am ready to contribute 3% but the problem is we don't know the benefits and most of the time the government obliges public servants to contribute in many development plans without our

consent. This is not a good approach. I think having a clear and genuine discussion is important to solve these ambiguities." (Male, 40 years, pharmacist)

A few of the health professionals claimed that they should not pay for services they provide, stressing that they are at high risk of infection or other harm and should therefore be entitled to get health services free of charge as compensation.

4.4. Finding of the Key-Informant's in Depth-Interview

One of the main challenges to implement SHI is poor health service quality. To improve the quality of health service is the supplies of the medications take the main role. In this country EPSA is the only giant national supply agency. The agency believe in their capacity to implement SHI scheme in our county according to professional's, distribution centers, transportation and also the most essential drugs are produced by local manufacturers so they believe that they have enough capacity. But also they have faced some challenges and that are inadequately of hard currency allowance, lower supply performance delay in reimbursement, higher customer expectation and Poor logistic. It was illustrated by the department of the Addis Ababa distribution team leader:

"EPSA is the only giant national supply chain firm, has established 19- networked distribution centers in all region more than 220 functional large and medium size vehicles (transportation). As essential health commodities for health insurance are exhaustive listed out and most of the item can be produced by local manufacturers so it is enough capacity. The main challenges are inadequately of hard currency allowance, lower supply performance delay in reimbursement, higher customer expectation and the Poor logistic reports which the real demand for essential medicines, quantification error, inadequate budget allocation to public health facility to allocate these issue (1) Offer capacity building trace to staff to health facility (2) Strengthen data quality monitoring and (3) Increase public budget for essential medicine."

And the other challenge to implement SHI is poor quality of health service, to improve the quality of health service the main stakeholder is health bureau. As a sector, the health bureau preferred that the implementation of SHI will have influence in the health service. The health centers try to address in each and every district's (woredas), but also they try to illustrate the

gaps. One of the gaps is shortage of manpower and also facilities. It was illustrated by the AAHB disease prevention team leader:

"The SHI implementation expects to have a saddle on the health service, but when it compare with the importance of the scheme it will have more benefit. As a sector, it try to address in all districts (woreda) of Addis Ababa by build at least one health center and also there is a functioning network from the higher to the lower level to address the community health problem. The most health centers are trying to give better services, but if the case is more than their strength there is a referral link /method to higher health centers/ hospital. there is also a gap in the health center services, one of these are shortage of professional's, the other one is the limitation of health service facilities and also there is a shortage of resources so it can solve by support financially the health system. One of the Healthcare financing methods is SHI, so implementing the SHI scheme can improve the healthcare service side by side."

The SHI scheme implementation is leading by SHI agency. The agency have the capacity to implement it means it have working area and professionals. But the agency director also suggests that its implementation have to be goes carefully. This was illustrated by Addis Ababa SHI agency director:

"The SHI implementation provides multi benefits for the health system and to the members but the implementation have to goes carefully and step by step, from creating awareness for all up to giving the service. Personally, if it implement as it is emotionally by seeking the profit the scheme may collapse. So these implementations have to see carefully stating from the policy up to the readiness of the stake holders, unless we are taking a risk." (AASHI agency director)

4.5. DISCUSSION

The study clearly demonstrates the information in the study area. In the study, the perspectives of the public servants have seen clearly reflected. This study examined about the challenges to implement in the public servants perspective to the preference of healthcare financing, the factors affecting the implementation for the nationally proposed SHI scheme.

The participants were boredom that the increasing the cost of health care services. It is increasing health expenditure day to day so it prejudice on their living ways. The private healthcare service payment is not affordable that according to their income. The public health center is adequate than the private one according to the payment, but when we see the payment with the service the public health center is not fair, because most health centers didn't have a diagnosis center so they referred to the private and also there is a shortages of medications so it also going to get from the private pharmacies. this study supported the healthcare service quality and customer satisfaction in some selected public and private hospitals which conducted in Addis Ababa (Kassa, 2019). Thus, the healthcare service is not affordable by the most public servants

Most of the respondents in this study show they accept on the importance of SHI for them and healthcare financing system. This is relatively higher compared to previous studies in Ethiopia and elsewhere. The difference might be due to increasing awareness about the importance of SHI or due to increasing health care costs than before. But still there is a variation from person to person. Some of participant didn't have enough knowledge about the importance of SHI, but when we see about the system of the scheme most of them didn't have any knowledge, and some of them didn't have clear information. A few of them have a better knowledge of the scheme. More than anything before the scheme start implement, it have to more focus in creating awareness about the implementing system of the SHI scheme. The most respondents in the present study showed agreement on the need for SHI. This is relatively higher compared to previous studies in Addis Ababa and elsewhere (Haile, 2014; Gidey, Gebretekle, Hogan, & Fenta, 2019).

Majority of them were voluntary to pay an amount similar to that proposed by the government. But the other participants raised concerns about which health services would be include in the

scheme, the quality and availability of health services, and age limits on coverage of dependents. More than anything the participant concern on the quality of the governmental healthcare service has to improve to increase the willingness. Knowing the interest or desire of public servants' the options of healthcare financing is important to decide the next steps have to implementation of SHI schemed. This myriad of volunteer on SHI has important health policy implication in that a most of public servants would accept the healthcare financing option provided that some changes in the policy packages would be made. In contrast, some of the participant didn't agree to contribute about 3%. The participant argued that the market service values are too low so the demand has to be low cost, it means when the service quality increase the contribution of payment will increase. The service quality and the willingness is consistent each other when the service quality improve the willingness will also improve. This might be also due to differences in economic status among elderly population across countries during retirement. It is, however, comparable to what was documented by a previous study conducted in Southern Ethiopia (Haile, 2014). Therefore finding ways to increase the income of public servants may positively increase the number of volunteers.

Usualness, the quality of health services in public health facilities was a series issue in the participant interview. All of the participants were not satisfied with the availability and quality of health services in public facilities. They suggested that increasing the number of health professionals, improving medications and equipment supply, and bringing health services closer to the community would increase the acceptability of SHI (Dibaba, Hadis, Ababor, & Assefa, 2014).

The policy gap also the main concern of the participants. During the interview, participants were presented with a fixed 3% premium, the true contribution planned for the national SHI. The participants suggest that the excluded services mainly the chronic dialysis have to be involved, and also if any service gave in this country public health sector it didn't have to be excluded included. The Addis Ababa SHI agency director: scheme didn't have to be business oriented/ didn't think only the profit it has to also think the members benefit. And it may one of the implementation challenges. The participant had concerns about ending benefits when a dependent turned 18 years old as per the recommendation of the current SHI policy. Most participants strongly contended that eligibility should not be based on age alone, but also on their

capacity to generate income. And also the number of the family was also the concern of the participant. They think it didn't take by our country context, and one of the participants was also having five children so the policy also has a gap. This idea was similar to the policy review in the reflection of SHI (Wondie, 2018).

The other concern was focused on the readiness of the SHI implementation in the public servant perspective, the most participant was supportive to the readiness idea, but some participant was strongly not accept this to implement, they also have a compliant in the policy so before start thinking implementation the policy revision have to be taken in to action (Wondie, 2018).

Hence, further review of the plan and consultation with public servants is warranted before implementing SHI. It is also important to note that implementation of SHI by itself could lead to increased patient load and further aggravate supply problems and affect the quality of health services it support the study conduct in northern part of Ethiopia (Gidey, Gebretekle, Hogan, & Fenta, 2019). This is an additional concern for policy makers to consider for the successful implementation of the SHI scheme.

CHAPTER FIVE: CONCLUSIONS AND RECOMMENDATION

5.1. CONCLUSIONS

This chapter presents the conclusion of the major findings of the study. The main themes of the study include the effects of the affordability of health services, participant's awareness of SHI, factors influencing volunteer for participate SHI scheme, service quality of governmental health centers, readiness to implement SHI scheme and policy gap of SHI in the implementation of SHI. Interviews were conducted with thirty-four informants.

The most public servants can't cover their health service expenditure this is result of the health service expensive cost and their low income. The public servants have enough knowledge about the benefit of SHI but they didn't have clear information about the functioning method so, creating awareness about the scheme has to be the first step of implementation. The most public servants have an interest to be a member and to pay for the SHI scheme but some of the participant doesn't want to pay. The main reason is the poor health service quality.

SHI implementation was influenced by the poor quality of health service. For the improving of health service quality the prior will the government decisive decision. Improving the health service will make easy to SHI implementation. There are some public servants that they don't want to be member in the SHI because they don't want to go the public health sector. The stakeholder's readiness didn't have to be considering the implementation of SHI to improve their quality of service, it has to support financially by the government or NGO's. The implementation of SHI will be adding more benefit for the healthcare system.

According to the public servant perspective the policy need to revised or correction about these issues, one of these are the benefit package it means the chronic dialysis have to involve, and the number of family also didn't consider and the age limit also have to consider. These are the challenges and the recommendation. Finally, the figure 3 will illustrate the result of the study.

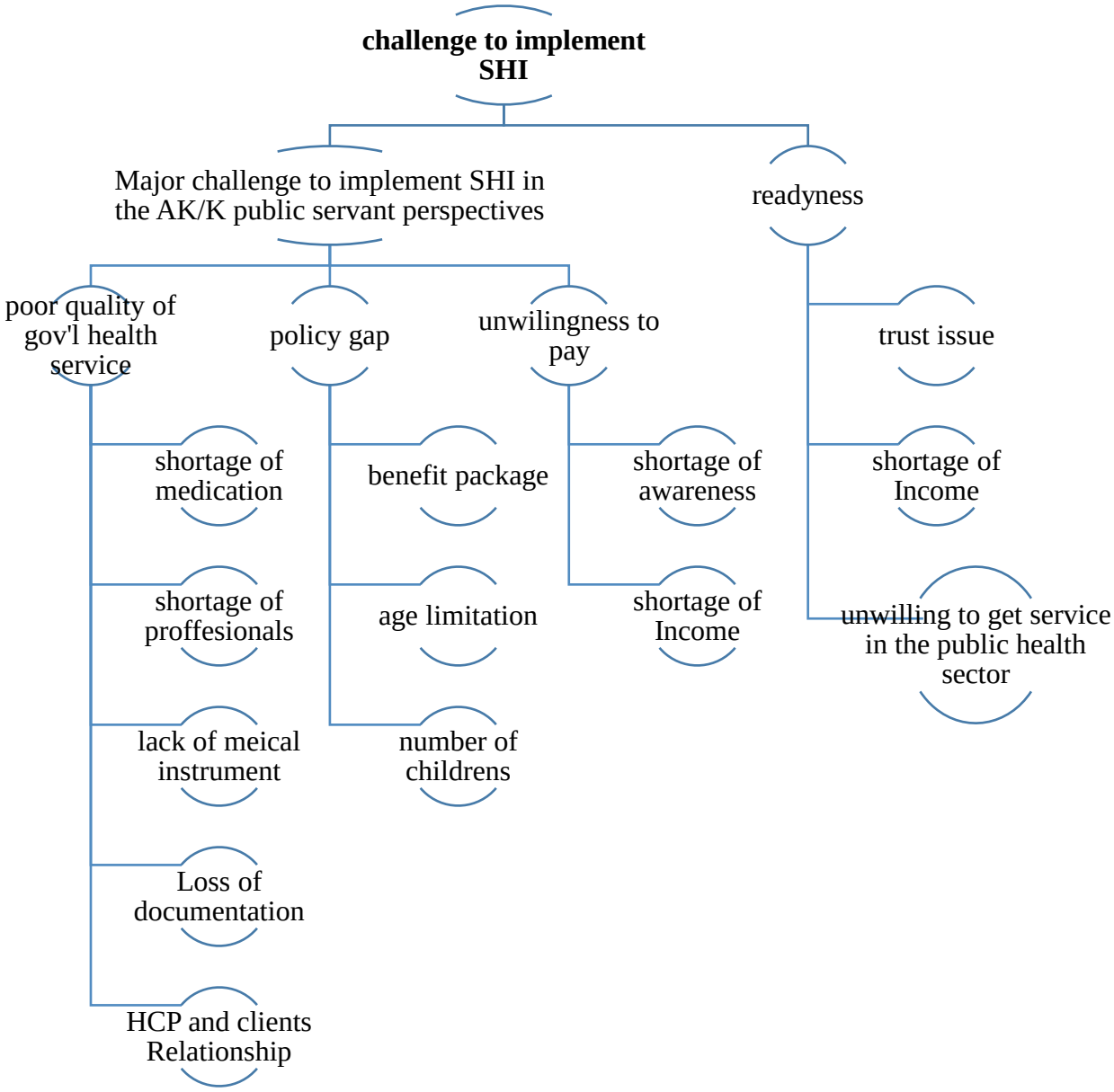

Figure 3: challenge to implement SHI in the AK/K public servant perspectives adopted from the result of these thesis

5.2. RECOMMENDATIONS

The general objective of this research study was to assess the challenges of SHI Implementation; Specific objectives were to examine the challenges of SHI as a health financing mechanism and to identify factors that challenge to implement of SHI among public servants and to assess the readiness of SHI implementation and to draw possible concussions and recommendations. Related with this questions respondents were asked what is the challenges to implement SHI, about the main factors to implement SHI scheme and to draw possible conclusions and recommendation.

Since the finding indicates some of the respondents believe that SHI has no value or advantages, but showed willingness to pay need a detailed knowledge and awareness to formal sectors. On the other hand there are significant numbers of respondents who have simple information about SHI and gave reasons that they don't have trust on the health services. The second recommendation is to improve the governmental healthcare service and the supply of medication has to more focus. The improving of healthcare service has a positive influence of SHI implementation. The third recommendation is improving the awareness and also readiness of the public servants and the policy makers should pay attention to the limitations and revise the SHI policy for its sustainable implementation that can create positive effect on its end-users.

Finally, according to my study the social worker didn't participate in SHI scheme from the policy development up to the implication. If the social worker can be participate in the implementation of SHI, the result will better than now.

5.3. IMPLICATION FOR SOCIAL WORK PRACTICES

The social worker will have significant role in implementation of SHI. Unlike many other fields of practice, social workers in the health field generally work in host organizations, such as hospitals and clinics. In addition to their professional knowledge skills and values, the practice of health social workers is influenced by the values, goals and organizational structures of those settings. In our country, the role of social workers is not acknowledgeable. In the SHI the social worker participation may make the implementation easier. The role of social worker in SHI agency, implementation and in the health care setting have to be participating in these issues, they are:

- Social work has to see as a resource discipline that informs these approaches to health, to be used by other professionals. Promoting awareness of the importance of emotional, social, family, economic and cultural influences on health, and encouraging health care professionals in general, and physicians in particular, to take these factors into account in diagnosis, treatment and prevention.
- Direct practice, psychosocial interventions: intervening in the social aspects of health insurance and health service; also using social work skills to deal with the public servants that can arise in the interest of being a member in SHI.
- Forming organizations to advocate for members of the scheme rights in general, and promoting consumerism;
- Participate in revision of SHI policy: establishing the legitimacy of social work involvement in the analysis and development of SHI policy (including health policy and health services).
- The empowerment of members: social workers being involved in setting up members of the scheme organizations aimed at empowering them and utilizing their strengths, in spite of their illnesses.
- Controlling the Quality of SHI service: development of social work quality assurance tools and mechanisms, including practice guidelines, clinical and performance indicators and computerized information systems. And Giving Training for medical personnel and supportive staffs in a variety of interpersonal skills, particularly relationship, communication and basic counseling skills with patients and families to improve the service quality of health centers.

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ANNEX

Interview Guideline for the public servants

Questionnaires prepared for the public servants working in akaki kaliti sub city administration.

Preamble

A dear respondent, my name is Muse Kidane. I am carrying out this study entitled "assessment on the challenges of social health insurance implementation in Akaki Kaliti Sub-City administration from public servants perspective". The study is part of the requirements for completion of the degree of Masters of Arts in department of social work at St. Mary University.

This study would inform the challenge to the implementation of SHI. This feedback form includes questions related to your socio-demographic background, levels of awareness in SHI, readiness to be a member and the perspective of the SHI implementation challenge. To achieve the objectives of this research, your genuine responses are highly important. I would like to assure you that the information you provide will be kept confidential. I thank you so much in advance for sacrificing your precious time to complete this questionnaire.

I. Socio-demographic background

1. Sex _____
2. Age_____
3. Religion: 1 .Orthodox, 2.Islam, 3. Protestant 4. Catholic 5. Others specify
4. Educational qualification: _____
5. Marital status: Never married, Married, Divorced and Widowed
6. Children: yes (how many) or no
7. Source of incomes: only this, I had part time job
8. Health Status: chronic, acute or well

I. Questions prepared for the public servant

1. Did you think that you can afford the health expenditure? Please explain.
2. Did you have any awareness about social health insurance; did it provide benefit for you?
3. Did you want to be a member in social health insurance scheme? Why?
4. Did you have a willingness to pay 3% monthly for social health insurance scheme? Did you have any comment on this?
5. What are the reasons that delay SHI implementation? (try to see according to Politically, Economically, Socially and also individuals willingness)
6. Where did you go to get a medical service (public or private health center)? Why?
7. What are the gaps of the governmental health centers on providing of health service and the professionals service quality?
8. Are you ready to be a member, if the social health insurance implement? What did you think the effect of this implementation on you?

Interview guide questions for Key Informants

Direction: - For each of the following questions that I read accordingly, you are kindly requested to provide precise and true responses. You have the right to continue or decline from participating in this interview. Finally, I would like to promise you that all your responses will be kept confidential and used only for the purpose of this study. I hope you will give me the real information.

I. Back ground Information

1) Sex _____

2) Age _____

3) Educational background _____

4) Profession & Position in the place _____

II. Questions prepared for the EPSA (Ethiopian pharmaceutical supply agency)

1. Does the EPSA have enough capacity (supply, controlling financial system, infrastructure and so on) to implement health insurance? Write your general suggestion how it can improve for the implementation of the SHI scheme.
2. What are the benefits in the implementation of social health insurance according to improving health facilities and pharmaceutical supply?
3. What are the challenges likely to happen, if full implementation of SHI in the health facilities and supplied of pharmaceuticals?
4. What are the challenges of pharmaceutical supply chain management? Please suggest the possible solutions to the challenges you listed above? How did you think that can affect the social health insurance implementation?
5. Is there strong Information exchange among distribution officers, store managers and customers? Did the agency use the real consumption analysis in the ordering of pharmaceutical product and health facilities? Is there an established procedure for placing emergency orders? Can you explain it one by one?

III. Questions prepared for the SHI social health insurance

1. What are the benefits in the implementation of SHI according to health, economic and socially?
2. What are the reasons that delay SHI implementation? (try to see according to Politically, Economically, Socially and also individuals willingness)
3. What are the challenges likely to happen, if full implementation of SHI?
4. Do you think the health insurance agency had enough capacity (skilled man power, infrastructures, fund etc.) to implement SHI? Explain it?
5. How to improve the public servant willingness to pay? Write your suggestion?
6. Does the poor Quality of health service affect the social health insurance implementation? How it can improve?

IV. Questions prepared for the Health Bureau

1) What are the reasons that delay SHI implementation? (try to see according to Politically, Economically, Socially and also individuals willingness)
2) What are the challenges likely to happen, if it full implementation of SHI scheme in your health sector?
3) Do you think your health center had enough capacity (man power, infrastructures, fund etc.) to implement SHI? Explain it?
4) What did you think the reasons that the civil servant not willing to be a member in SHI scheme? How can minimize the challenges, please write your suggestion?
5) What is the impact of SHI implementation on the health staff in term of: Increased workload?
6) Are there any efforts being made to motivate the health staff with any sort of incentives to get quality service? If yes, please discuss

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ሶሻል ወርክ ትምህርት ክፍል

መግቢያ

በቅድስተማርያም ዩኒቨርስቲ የመሃበራዊ አገልግሎት ትምህርት ክፍል ለ2ኛ ዲግሪ ትምህርት ለማሟላት የሚሰራ ሲሆን ጥናቱም የሚያጠነጥነው በአዲስ አበባ ከተማ አስተዳደር የመንግስት ሰራተኞች ማህበራዊ የጤና መድህን ዋስትና ትግበራ ተግዳሮቶች በተመለከተ ያላቸውን እና ማህበራዊ የጤና መድህን ዋስትና አባል መሆን ያላቸዉን ዘርፈ ብዙ ጥቅሞች ለመረዳት በተመረጡ ባለ ድርሻ አካላት የሚሞላ መጠይቅ፡፡

ውድ የዚህ ውይይት ተሳታፊዎች እኔ ሙሴ ኪዳኔ እባላለሁ፡፡ በቅድስተማርያም ዩኒቨርስቲ የሶሻል ወርክ ትምህርት ክፍል የድህረ ምረቃ ፕሮግራም ተማሪ ስሆን ለሁለተኛ ዲግሪ መመረቂያ የሚሆን የሚሚያ ጥናት በማድረግ ላይ እገኛለሁ፡፡ የዚህጥናት አላማ በአቃቂ ቃሊቲ ክፍለ ከተማ አስተዳደር የመንግስት ሰራተኞች ማህበራዊ የጤና መድህን ዋስትና ትግበራ ተግዳሮቶች በተመለከተ ያላቸውን እይታ የሚያቀርቡበት ነው፡፡

በዚህ ጥናት እርስዎ እንዲሳተፉ የተመረጡበት ዋነኛ ምክንያት ከሚደረገው ጥናት ጋር ቀጥተኛ ግንኙነት ስላለዎት ነው፡፡ በዚህ ጥናት ላይ መሳተፍ ሙሉ በሙሉ በፍቃደኝነት ላይ የተመሰረተ ነው፡፡ በዚህ ጥናት ላይ የጥናቱ አላማ እንዲሳካ የርስዎ ተሳትፎ በጣም ወሳኝ ነው፡፡ ይህ መጠይቅ ለትምህርታዊ ጽሁፍ አላማ ብቻ የሚውል ይሆናል፡፡ ለጥናቱ መሳካትም የእርስዎ እውነተኛ ስሜትዎን የሚገልጸውን ምላሽ ከፍተኛ ሚናን ይጫወታል፡፡ ስለዚህም በአክብሮትና በሙሉትህትና ይህን መጠይቅ ለመመለስ እንድትተባበሩኝ እጠይቃለሁ፡፡ ጊዜዎን ሰውተው ይህን መጠይቅ ለመመለስ ፍቃደኛ በመሆንዎ ከልብ አመሰግናለሁ፡፡

➢ አጠቃላይ ሶሾዲሞግራፊግ መረጃ

1) *ፆታ*.....

2) እድሜ.....

3) ሀይማኖት፡ - ኦርቶዶክስ..... ሙስሊም..... ፕሮቴስታንት..... ካቶሊክ..... ሌላ

4) የትምህርትደረጃ .....

1. በጤናዎ ላይ እክል ቢገጥም የሚያውጡት ወጪ ከእርስዎ አቅም አኳያ እንዴት ያዩታል?
2. ስለ ማህበራዊ የጤና መድህን ምን ያውቁሉ? ጠቀሜታው ምንድን ነው ብለው ያስባሉ?
3. እርሶስ የመህበራዊ ጤና መድህን አባል መሆን ይፈልጋሉ? ለምን?
4. የማህበራዊ የጤና መድህን አዋጅ እንደሚያሳየው የደምወዝዎን በወር 3 % እንዲከፍሉ ያስገድዳል፡፡ በዚህ ላይ የእርሶ አስተያየተ ምንድን ነው?
5. የጤና መድህን እስከ አሁን ተግባራዊ ያልሆነበት ምክንያት ምንድን ነው ብለው ያስባሉ? በዝርዝር ቢያሰረዱ፡፡
6. በእርሶ አልያም በቤተሰቦ ላይ የጤና እክል ቢገጥሞ ህክምና ለማግኘት ወዴት ይሄዳሉ (የመንግስት ወይስ የግል የጤና ተቋም) ለምን እንደሆነ በምክንያት ቢያስረዱ?
7. የመንግስት የጤና ተቋማት አገልግሎት ላይ እና ተቋማት ላይ የሚሰሩ የጤና ባለሙያዎች ማህበረሰቡን ከማስተናገድ የተመለከቱት ክፍተቶች ምንድን ናቸው?
8. በቀጣይ የበጀት ዓመት የጤና መድህን ተግባራዊ ቢደረግ በ መንግስት ሰራተኛ ላይ ምን ተፅእኖ ያደርግብኛል ብለው ያስባሉ?

B. ቁልፍ ባለ ድርሻ አካላት የሚደረግ መጠይቅ

ማብራሪያ

ለዚህ መጠይቅ ግልጽና እውነተኛ መረጃ እንደሚሰጡን እየተማመንኩኝ ሃሳብዎን በነጻነት መግለጽ ያልተገደ በመብት መሆኑን ለማረጋገጥ እወዳለሁ፡፡ ይህ መጠይቅ የሚሰበሰብበት ዋና ዓላማ ለትምህርታዊ ስራ ብቻ ይውላል፡፡ ከእርስዎ ውጭ ይህንን መረጃ እንዳያውቀው መለያ ኮድ ተሰጥቶት ስለሚቀመጥ ምንም አይነት ስጋትና ፍራቻ ሊኖርዎት አይገባም፡፡

i. ጥቅልመጠይቆች

1. ፃታ----------
2. ዕድሜ-------
3. የትምህርትደረጃ-----
4. ሙያ---------
5. የስራሃላፊነት------

❖ ይህ መጠይቅ ለ ጤና ቢሮ እና በስሩ ላሉ ብቻ ይውላል

1. ማህበራዊ የጤና መድህን አገልግሎት ተግባራዊ ማድረግ ለ ሃገራችን የጤና ስርዓት እድገት አኳያ ምን ጥቅም ሊያስገኝ ይችላል ብለው ያምናሉ?
2. ማህበራዊ የጤና መድህን አገልግሎት አፈፃፀም አዋጅ በ2010 በተወካዮች ምክር ቤት መፅደቁ ይታወቃል፤ ነገር ግን እስካሁን ተግባር ላይ መዋል አልቻለም፡፡ ምክንያቱን ምን ሊሆን ይችላል ብለው ያስባሉ? ከጤና ስርዓት አቅም፤ ምጣኔ ሀብታዊ፤ ከአመራር ቁርጠኝነት እናም ከተገልጋይ ፍላጎት አንፃር አድርገው ያስረዱ፡፡
3. የአዲስ አበባ ጤና ቢሮ የማህበራዊ የጤና መድህን አገልግሎትን ተግባር ላይ ቢውል በስሩ የሚገኙ የጤና ተቋማት ላይ ምን ተፅዕኖ አለው ብለው ያስባሉ? (ከሰው ሃይል፤ የገንዘብ ምንጭ፤ የመስሪያ ህንፃ፤ ከስራ ጫና ...) በምክንያት ያስረዱ፡፡
4. የጤና ስርዓቱ አለማደግ(መዳከም) በ ማህበራዊ የጤና መድህን ወደ ተግባር አለመውረድ ምክንያት ነው ብለው ያስባሉ? በዝርዝር ቢያስረዱ።
5. የማህበራዊ የጤና መድህን ስርዓት አባል የመሆን ፍላጎት በ መንግስት ሰራተኞች ላይ እንዲጨምር ምን ቢደረግ ብለው ይመክራሉ?
6. ማህበራዊ የጤና መድህን አገልግሎት ማስፈፀሚያ አዋጅን በድጋሚ ክፍተቱን አይቶ በድጋሚ ማወጅ በቀላሉ ወደ ተግባር ለመግባት ያግዛሉ ብለው ያምናሉ? በዝርዝር ያስረዱ።

PROCLAMATION No. 690/2010

A PROCLAMATION TO PROVIDE FOR SOCIAL HEALTH INSURANCE

WHEREAS, expansion of health service coverage plays a significant role to an accelerated socio-economic development of the country;

WHEREAS, cost sharing between beneficiaries and government in the health sector is critical to achieve universal health care coverage;

WHEREAS, social health insurance is one of the sustainable health care financing mechanisms which enhances equitable access to improved health services through cross-subsidization;

NOW, THEREFORE, in accordance with Article 55(1) of the Constitution of the Federal Democratic Republic of Ethiopia it is here by proclaimed as follows:

PART ONE

GENERAL

9. Short Title

This Proclamation may be cited as the "Social Health Insurance Proclamation No.690 /2010."

10. Definitions

In this Proclamation, unless the context otherwise requires:

1/ "employer" means a public office, a public enterprise or any person that employs at least ten employees;

2/ "employee" means any employee having a three month and above period of service and includes public officials, management staff, judges, prosecutors, members of the police, members of the House of Peoples' Representatives, salaried members of the House of the Federation and salaried labor union officials, and may not include members of the Defense Forces;

3/ "pensioner" means any person receiving monthly pension payments from the Social Security Agency and includes survivors of a pensioner;

4/ "health facility" means any health facility that have concluded an agreement with the Agency to provide services for beneficiaries;

5/ "member" means a person registered for the social health insurance scheme and paying contribution to the scheme;

6/ "salary" means the monthly remuneration paid to an employee for the service he renders during regular working hours;

7/ "beneficiary" means a person entitled to receive the benefit packages under the social health insurance scheme;

8/ "child" means the natural, adopted or stepchild of a member who has not attained the age of 18 years and includes any child who is under the guardianship of the member in accordance with the law;

9/ "spouse" means a person married to a member;

10/ "family" comprises the spouse and children of a member and includes mentally or physically impaired children of the member who have attained the age of 18 years but cannot sustain themselves;

11/ "health service package" means health services covered by the social health insurance scheme;

12/ "Agency" means an agency established by regulation to be issued by the Council of Ministers for the implementation of this Proclamation;

13/ "person" means any natural or juridical person;

14/ Any expression in the masculine gender includes the feminine.

PART TWO

SOCIAL HEALTH INSURANCE SCHEME

11. Establishment

A social health insurance scheme is hereby established.

12. Objective

The objective of the social health insurance scheme shall be to provide quality and sustainable universal health care coverage to the beneficiary through pooling of risks and reducing financial barriers at the point of service delivery.

13. Membership

1/ Employees and pensioners shall be members of the social health insurance scheme.

2/ Every employer shall get registered all its employees with the Agency for the social health insurance scheme.

3/ The Social Security Agency shall get registered all pensioners with the Agency.

4/ The Agency shall provide guidelines on registration of members.

14. Sources of Finance

The social health insurance scheme shall have the following sources of finance:

1/ members‟ contributions;

2/ employers‟ contributions;

3/ investment income; and

4/ Other related sources.

15. Beneficiaries

1/ Beneficiaries of the social health insurance scheme shall be members and their families.

2/ Any member shall have the obligation to provide accurate information about his family composition and use the service properly.

16. Health Service Package

1/ The health service package to be provided to beneficiaries shall include essential health services and other critical curative services.

2/ The particulars of the health service package referred to in sub-article (1) of this Article shall be determined by regulation taking into consideration the contributions to be collected pursuant to Article 9 of this Proclamation.

17. Contributions

1/ Members and employers shall contribute to the social health insurance. The Government shall also make additional contributions for pensioners.

2/ The amount and payment modality of contributions to be made pursuant to sub-article (1) Of this Article shall be determined by regulation to be issued for the implementation of this Proclamation; provided, however, that an employee and employer shall make equal percentage contributions based on the salary of the employee.

3/ Any employer shall withhold the contributions of employees from their monthly salaries and timely transfer the same to the Agency together with its own matching contributions.

4/ The Social Security Agency shall transfer to the Agency the monthly contributions of pensioners together with the matching contributions of the government.

5/ Any pensioner who is re-employed without foregoing his monthly pension allowance shall be considered as an employee for the purpose of this Article.

6/ Any employer shall furnish the Agency with particulars regarding each employee's salary and other related information as may be required by the Agency.

PART THREE

MISCELLANEOUS PROVISIONS

18. Power to Issue Regulation

The Council of Ministers may issue regulations necessary for the implementation of this Proclamation.

19. Inapplicable Laws

1/ No law, regulation, directive or practice shall, in so far as it is inconsistent with this Proclamation, be applicable in respect of matters provided for by this Proclamation.

2/ notwithstanding the provisions of sub article (1) of this Article, this Proclamation shall not affect: Additional medical benefits granted under collective agreements concluded in accordance with the Labor Proclamation No. 377/2003; and b) Additional medical benefits granted by police health institutions to members of the police

20. Effective Date

This Proclamation shall come into force a year after its publication in the Federal Negarit Gazeta,

Done at Addis Ababa, this 19th day of August, 2010,

GIRMA WOLDEGEORGIS

PRESIDENT OF THE FEDERAL DEMOCRATIC REPUBLIC OF ETHIOPIA