SOCIOLOGY | RESEARCH ARTICLE

Paradoxical consequences of CBHI scheme in rural Ethiopia: Enrollees’ perceived preferential treatment to paying clients and concomitant problems

Kasahun Desyalew Mekonen¹ and Wondale Temesgen Tedla¹

Abstract: Though financial protection and improvement in health seeking behavior of rural societies is the intended role of health insurance schemes, empirical evidence indicated that the scheme faced multitude of implementation challenges. This paper examined insurance enrollees’ perceived preferential treatment for paying clients and other concomitant problems in Eastern Gojjam district of north western Ethiopia. Researchers conducted in-depth interviews with 53 enrollees, six FGDs (with a total of 48 discussants) and 7 key informants with professionals from public healthcare facilities and other health insurance administrators. The data encoding, transcription, and thematic analysis process was all conducted manually. Findings indicated that, despite the economic relief households gained, the thrust on the service delivery process seems to be far behind. Comparing them with paying patients combined with the presumed “free medical treatment” that they associated with the insurance, the perceived preferential treatment for paying patients by practitioners seems common. Due to this, most participants hold a belief that visiting private health facilities during critical illness appears preferable to get

ABOUT THE AUTHORS

Kasahun Desyalew Mekonen is an Assistant professor of Sociology in the Department of Sociology, Debre Markos University, Ethiopia. He has more than ten years of teaching experience in universities and has been active in research, community service and professional activities. He has won a number of university funder research grants since 2015. He has research experience on the areas of social determinants of health & wellbeing, migration and human trafficking, street children & vulnerable groups, urban youth, and other sociological issues. Wondale Temesgen Tedla is a senior Lecturer in the Department of Sociology, Debre Markos University, Ethiopia. He has more than eleven years of teaching experience in universities and has been actively engaged in various research and community service activities. Some of the areas of his research experience include; rural livelihood and youth, property inheritance disputes and implications, culture, social determinants of societal health issues, and others.

PUBLIC INTEREST STATEMENT

Access to quality health in developing countries including Ethiopia has been hampered by a number of intricate factors leading to poor health outcomes. To make sure that the poor have access of quality health service, community based health insurance scheme was introduced by various countries. Despite the apparent role of the scheme is financial protection and thereby improvement in health seeking behavior of disadvantaged social segments, empirical evidence indicated that the scheme has been facing multitude of implementation challenges. Hence, by observing paradoxical consequences, this sociological research was meant to examine insurance enrollees’ perceived preferential treatment for paying clients and other concomitant problems in north western parts of Ethiopia. Shortage of drugs induced frequent stock out and thereby prolonged reimbursement, High patient flow/over load in public health facilities, unnecessary price increment by private pharmacies on insurance beneficiaries and others are all concomitant problems with the perceived preferential treatment.
quality health service. The perceived preferential treatment is alleged to be happening during consultation with physicians, medicine prescription, referral service, patient flow management, and others. Shortage of drugs induced frequent stock out and thereby prolonged reimbursement process, high patient flow induced over load in public health facilities, unnecessary price increment by private pharmacies on insurance beneficiaries and confusion on annual renewal payment without using service are all concomitant problems. Necessary awareness creation interventions and also improvements of public health facilities are recommended.

**Subjects:** Indigenous Peoples; Sociology of Culture; Medical Sociology

**Keywords:** CBHI; perceived preferential treatment; public health facilities; Eastern Gojjam; Ethiopia

1. **Introduction**

Though countries have been spending an ever increasing share of their national income on health care (Brandle & Colombier, 2016), the notion of financing universal health coverage remains a global concern in general (Adam Wagstaff & Neelsen, 2019; Moses W. Mark et al., 2018) and in low and middle-income countries in particular thereby continues to be the subject of intense arguments (Aaron Yannis Gourtso et al., 2015; Margaret et al., 2018). It has been widely accepted that heavy out of pocket (OOP) payment for health care service would certainly lead households to pay considerable amount of their income for healthcare and expose them to in to poverty situation (Y. Andinet Woldemichael, Daniel Zerfu Gurara and Abebe Shimeles, 2016; Anja et al., 2015; Liu et al., 2003; Sujin & Kwon, 2015; Van Doorslaer et al., 2007, 2007; World Health Organization. (WHO), 2005). Annually, there have been nearly 150 million cases of catastrophic expenditure (which takes more than 40% of nonfood household expenditure (Xu et al., 2007) or 10% of overall household expenditure (A Wagstaff & van Doorslaer, 2003) for healthcare cost (Adebayo et al., 2015; Amare Minyihun, Measho Gebreslassie Gebregziabher and Yalemzewd Assefa Gelaw, 2019; Atnafu et al., 2017; Shire G. Mark et al., 2015).

Specifically, the level of direct healthcare spending accounted for 42% in Kenya (Dekker, 2004); around 27% in Ghana (Dekker & Wilms, 2010; Dong et al., 2004); 37% in Ethiopia (Central Statistical Agency (CSA) [Ethiopia] and ICF, 2016; Ekman, 2004; Atnafu et al., 2017); 41% in Brazilian (Barros & Bertoldi, 2008); 75% in India (Garg & Karan, 2009); 70% in Bangladesh (Van Doorslaer et al., 2005); more than 80% in Burkina Faso (Mugisha et al., 2002); and around 88% in Vietnam (Veronika et al., 2012). In fact, the actual financial burden as a result of OOP healthcare payment would be much heavier on low income households than the affluent one since they are forced to pay higher proportion of their income for medical treatment (Anagaw D Mebratie et al., 2015; Anja et al., 2015; Sujin & Kwon, 2015). Specifically, those households who spent significant amount of their overall expenses on food would suffer serious financial devastation with even a rather smaller out-of-pocket spending (Parmar et al., 2012; Shire G. Mark et al., 2015). Hence, the protection of low income households from such a catastrophic health care payment has been considered as a primary agenda in any health system of low- and middle-income countries which is ultimately meant to realize access to health care for everyone (Mukangendo et al., 2018; Nshakira-Rukundo et al., 2020; Roberts et al., 2008; Sujin & Kwon, 2015; Wang & Pielemeier, 2012; World health Organization (WHO), 2000).

In this regard, Since the 1990s, health insurance policy has been attracting tremendous attention in developing countries as a major mechanism for transforming the health service utilization by saving the society against the impoverishing effect of out-of-pocket expenditures, (Anagaw D Mebratie et al., 2015; Anja et al., 2015; Atnafu & Kwon, 2018; Carrin et al., 2005; Hsiao & Shaw, 2007; Ndiaye et al., 2007; Parmar et al., 2012; Spaan et al., 2012), (such as, use of savings, sell assets, borrow money from friends and family, etc; Andinet Woldemichael, Daniel Zerfu Gurara and Abebe Shimeles, 2016; Atnafu & Kwon, 2018; Dekker & Wilms, 2010; Dong et al., 2004). Similarly, the WHO also considers the idea of health
insurance as a promising means to attain universal health-care coverage as well (Anja et al., 2015; Jung & Jialu, 2015; Parmar et al., 2012; Spaan et al., 2012).

Among a variety of health insurance (HI) schemes in the world (for instance, national or social health insurance (SHI) found in Philippines, Thailand and Vietnam; private health insurance (PHI) found in South Africa, Namibia, Chile and Brazil (Jehu-Appiah et al., 2012). On the other hand, community-based health insurance (CBHI) scheme is now available in countries like Ethiopia, Democratic Republic of the Congo, Rwanda, Senegal, and Ghana (Nshakira-Rukundo et al., 2020; Preker et al., 2002; Spaan et al., 2012). CBHI is usually taken as a health financing mechanism meant to particularly benefit the poor and marginalized segment of the society (Devadasan et al., 2006; Dow & Schmeer, 2003; Spaan et al., 2012; Tanja et al., 2016). It has been largely accepted as a possible way out to the challenge of generating adequate financial resources for the health sector in developing countries (Andinet Woldemichael, Daniel Zerfu Gurara and Abebe Shimeles, 2016; Carrin et al., 2005; Devadasan et al., 2006; Paul et al., 2012). Moreover, it is primarily considered as a viable means to significantly improve poor household’s access to health care by reducing financial barriers to health services (Bärnighausen et al., 2007; Criel & Waélkens, 2003; Gnawali et al., 2009; Paul et al., 2012; Shimeles, 2010; Dong et al., 2009; Carrin, 2003; Patience Cofie et al., 2013; Andinet Woldemichael, Daniel Zerfu Gurara and Abebe Shimeles, 2016).

While CBHI has become part and parcel of health financing scheme in developing countries and thereby dozens of scientific evidence on its impacts on health outcomes is available in different country’s context, the complex nature of the issues and divergent contextual factors always leave a room for further research works (Dow & Schmeer, 2003; Nshakira-Rukundo et al., 2020). For instance, scientific studies on major determinant factors of insurance subscription (Mebratie et al., 2015bb; Dror et al., 2016; Panda et al., 2014), drop out (Atinga et al., 2015; Dong et al., 2009; Mladovsky, 2014), access and utilization to modern health care (Jütting, 2004) reduce out of pocket payment and thereby financial protection (Habib et al., 2016; Nguyen et al., 2011) and other related socio-economic issues (Asfaw & von Braun, 2004a; Landmann & Frölich, 2015; Parmar et al., 2012), has been considerably assessed in comparative terms. Moreover, two systematic reviews conducted by Ekman (2004) and Preker et al. (2002) on impacts on CBHI indicated that membership to the scheme improved use of facilities in modern health care in nearly 14 nations. A reasonably comparable finding is also observed in very recent studies conducted in Ghana (Chankova et al., 2008); Afghanistan (Rao et al., 2009); Rwanda (Schneider & Hanson, 2006); China (Zhou et al., 2009); and Mali (Chankova et al., 2008; Franco, 2008). Exceptions were observed in those studies conducted by Smith and Sulzbach (2008) and Chankova et al. (2008) Ghana and Senegal respectively who found out no impact in seeking modern health care facilities (Paul et al., 2012).

There is also an argument that in the absence of rigorous experimental evidence, causality by no means can be established between health insurance and quality health as a result of the multifaceted and peculiar behavioral reactions from all concerned actors in the health care system including patients (Stella et al., 2010). Studies in most economically poor countries indicated that the issue of expanding access to health care for most people does not inevitably guarantee improved health outcomes which appears to be contrary to the already held belief that growing the utilization of health care services can be sufficient for mortality rate to decline in developing countries (Margaret et al., 2018). Often times, there is also a perception by people to associate higher cost with quality service and immediate removal of direct cash payment for services thereby subsidizing them will create a deep concern for receiving best care. This misperception may lead them to decide to use private healthcare rather than the public one unless their perception of quality of care in public facilities changes Tanja et al., 2016). According to Tanja et al. (2016), most informants hardly have faith on health insurance schemes due to all the negative stories and experience they have heard from family members and friends about the insurance which forced them to prefer OOP payment for health care services as needed.

Similarly, previous studies conducted in Ethiopian context are not that different compared to those in low- and middle-income countries. Regarding determinants of enrollment in CBHI include, perceived quality of care (Atafu & Kwon, 2018; Atnafu et al., 2017; Nageso et al., 2020; Tsega et al., 2019), educational status, family size, (Atnafu et al., 2017; Tsega et al., 2019), travel time to the nearest health
institutions (Atnafu et al., 2017), timing of premium collection (Nagso et al., 2020; Tsega et al., 2019), community solidarity (Tsega et al., 2019) overall awareness (Atnafu & Kwon, 2018; Haile et al., 2014n.d.), self-rated health status (Atnafu & Kwon, 2018) are found to be determinants of enrolment in CBHI. Other studies also indicated that participation in CBHI increase frequency of visits to public providers (Anagaw D Mebratie et al., 2015), accelerate poverty reduction efforts thereby reduce the probability of borrowing (Shigute et al., 2017). However, quality of care and the perceived preferential treatment for paying clients remains a major concern in the scheme (Anagaw D Mebratie et al., 2015).

Given that the idea of health insurance is underdeveloped in Ethiopia, the complexity of the issue is far from being adequately addressed by the existing scientific studies not to mention the socio-cultural diversity of the country itself (Atnafu & Kwon, 2018). Hence, previous studies primarily focused on evaluating the overall performance in light of enrollment, financial protection and other related aspects (Carrin et al., 2005; Ekman, 2004; Jakab & Krishnan, 2004; Spaan et al., 2012). Moreover, most studies exclusively focused on quantitative aspects thereby subjective and in-depth elements of the problem facing the scheme right now are relatively overlooked. In addition to this, most review works available on the rapidly changing nature of health insurance in developing countries are somewhat outdated (Spaan et al., 2012). Understanding the real picture of implications and associated factors of CBHI demands a holistic and multidisciplinary approach meant to capture the apparent complexities that are largely embedded within the socio-cultural, economic and political contexts (Tanja et al., 2016). Furthermore, both implications and related issues are highly dependent on a particular society’s socio-cultural contexts (Carrin et al., 2005; Drechsler & Jütting, 2007; Hsiao & Shaw, 2007; Ndjaye et al., 2007; Spaan et al., 2012). Consequently, this study critically explored the insurance enrollee’s perception of preferential treatment to paying patients in public health facilities and thereby concomitant problems which have a direct impact on the overall quality of service provision among rural societies of Ethiopia.

2. Methods and materials

2.1. Study area

This study was conducted in Amhara regional state administration which is one of the entirely eleven regional states found in the federal republic of Ethiopia. The regional state is located in North Western part of the country and further divided in to various administrative units. It consists of eleven provincial administration (locally called Zone), around 167 districts and 3429 clusters (Kebeles). The study area, Eastern Gojjam Zone is one of the aforementioned eleven provinces found in the region which consists a number of districts/woradas currently implementing CBHI scheme. The landform of Eastern Gojjam is fundamentally identified by its tremendous diversity characterized by and ecological complexity as well. It is naturally rich district which has a flat-topped plateaus, mountain ranges of the Choaqe mountain (around 4000 meters and major tributary of Nile river) to a number of gorges (the lowest of all is the Abay gorge with lower than 1000 meters) (Temesgen, 2016). This study was conducted in four rural districts or Woradas (these are Sinan, Hulet Eju Enese, Dejan and Enemay Woradas) which were randomly selected to conduct the field research. Insured household heads both in their living villages and in the hospital setting were sampled in order to maintain representativeness of the study participants in terms of recent service in medical facilities. This consideration was equally applied in the process of recruiting all study participants both for the FGD and also in-depth interviews.

2.2. Research approach and design

A cross-sectional study design with a qualitative research approach was utilized from December to February, 2019 to assess the perceived preferential treatment for paying clients among CBHI subscribers in the study area. The primary rationale behind the selected form of study design is that the basic research questions of the study do not demand examining the patterns of change and trends over time. Rather, the current state of affairs related to the implementation of CBHI scheme and the societal orientation and behavior associated with using the scheme can be addressed qualitatively by collecting the necessary data at one point in time. Besides this, the issues related to the perception of beneficiaries towards the scheme, concomitant problems and other implementation challenges reasonably have qualitative dimensions.
According to Mason (2002) qualitative approach is preferable to explore issues with wide range of dimensions of social life including other daily routines, subjective aspects and experiences of the study groups. Moreover, it is also vital approach to closely look in to the macro social processes, organizational arrangements, institutional establishments and patterns of relationships in the work environment. Creswell (2007) also further argued that qualitative approach is essential if we seek to understand the existing context of study participants through face to face collection of vital information by the researcher personally. Patton (2002) on the other hand stated that society is a multi-layered entity then qualitative enquiry sensitizes researchers to the fact of uniqueness of layers of a society and their changeability with time and context. Hence to dig out cultural aspects of indigenous knowledge, value system of the society and its gradual process of change, the force behind change and its contemporary challenges in detail qualitative research approaches is advisable.

**Secondary data:** Researchers have tried to extensively review previous research works related to the issue under investigation including empirical literature and analytical perspectives to contextualize the issues into Ethiopian context. Besides this, both published and unpublished documents accessed from the CBHI agency were extensively used. Hence, any documents relevant to this study was rigorously reviewed and systematically used to enrich the study findings.

### 2.3. Participant recruitment procedure

All participants of the study were selected purposely on the basis of various criterions for each data collection methods. For the key informant, workers in the insurance agency and their implementers (contracted public healthcare facilities in this case) were the major informants. At first, researchers tried to communicate the executive manager of the health insurance agency Debre Markos Branch office after taking ethical clearance and support latter from research and community service coordination office of the college of social science and humanities, Debre Markos University. After getting the consent of the manager, other staff members and officers working in the agency were included by her recommendation on the basis of their proximity to respond to the major research questions. Finally, necessary appointment was arranged both with the manager and other staffs in different time taking their workload in peak season of membership renewal process into consideration. All the interviews were conducted in their offices and audio recording was made in all of the face to face interviews. On the other hand, informants for the in-depth interview and FGD discussants were selected considering various socio-demographic criterion and also geographical setting to get access of appropriate informants. The informants from their own local village were selected with the support of local level administrators after having necessary discussion with the researchers regarding who will be included in the study. Hence, the recruitment procedure was carefully conducted to make sure that a wide range of view will be addressed by taking gender, age, family status and other personal exposures in to account. Unlike the FGD discussants that were all recruited by going directly to their local villages, informants for the in-depth interview were recruited from the health care facilities as well. This was particularly vital to get the fresh views of those who used public health facilities under the insurance very recently. All the previously taken necessary considerations were also maintained during the participant selection process in the hospital setting as well. So, participants were from all range of illness, gender, sex, frequency of visit and other variables. Three types of semi structured interview guides were developed and utilized to conduct the data collection activity in all data-collection methods. The entire data-collection process with all participants was conducted using Amharic (the local language) after prepared in English and then translated back into English so as to maintain the consistency. Hence, the researchers were convinced that significant level of consistency was maintained throughout the translation process.

### 3. Data collection methods

#### 3.1. Focus group discussion /FGD/

The major participants during the FGD were insured sample household heads. Given that the study society is particularly patriarchal in nature, sex-based stratification was arranged in conducting FGDs so as to create a conducive environment meant to encourage free exchange of ideas for any of the apparently sensitive questions in connection with sex. The numbers of FGDs were decided by researchers
by applying data saturation principle which helped researchers recruiting discussants for further FGD until no new insight is going to come from anymore discussion. Hence, a total of six focus group discussions (with a total of 48 discussants) were successfully conducted to generate rich data pertaining to the study objectives. The FGD guide prepared to guide the discussions which were all conducted in their local village. The fact that group interviews bring together several participants for an open conversation around a specific topic means that the researcher will have a less prominent role than in one-to-one individual interviewing situation (Maykut & Morehouse, 1994). Focus group discussion is important sources of information as many aspects of an issue can be dealt with at a time if the moderator succeeds in enabling each and every discussant engage in the topic under discussion. The method has advantage of generating rich, detailed, and valid process data that usually leave the study participants’ perspective intact (Steckler et al., 1992).

3.2. Key informant interview
In this study, seven key informant interviews were conducted with executive manager of CBHI agency at Debre Markos branch, officers from the CBHI agency, practitioners from Debre Markos referral hospital and other public health facilities. Key informant interview guide was developed for each category of informants in line with their role in the service provision process of the health insurance scheme. Informants were purposely selected based on their interest and familiarity with the concern of the study so as to maintain the validity of the findings. The date generated through this method was used to obtain a balanced view on the service delivery process under the scheme and also to identify factual challenges admittedly reported by service providers themselves.

3.3. In-depth interview
Extensive in-depth interviews were also conducted with selected beneficiary household heads both from the community rural villages/ and also from those who were found at the hospital setting seeking health-care service to make sure that both the views of service users and other insured members are considered. Accordingly, researchers conducted open-ended interviews with 53 insured household heads meant to explore their perception and associated behavioral peculiarities in relation to CBHI subscription, service utilization under the scheme and other related health seeking behaviors. Hence, researchers were able to explore the subjective meanings, attitudes, experiences, held beliefs, and other issues related to the CBHI scheme which was meant to get valid findings that can reasonably portray the true picture of the situation.

3.4. Data analysis
Thematic data analysis technique was employed by organizing the data into similar themes and tallying the number of similar responses. After conducting the FGDs and in-depth interviews, the audio recorded data in the local language (Amharic) were translated in to English keeping the exact meaning constant. Right from the very beginning, maximum effort was made to maintain the originality and clarity of information during transcription and translation. In addition to this, the textual data was analyzed manually through careful interpretation of meanings and cross examination of association across themes. Hence, the entire data collected through all tools was thematically analyzed in line with the major objective of the study and also to enhance the clarity of the paper for all range of readers.

3.5. Ethics considerations
As the case is similar with all types of scientific studies conducted on human subjects, every single one of the necessary and apparently known ethical issues was cautiously considered. Firstly, ethical clearance letter was received from the office of research, community service and graduate program coordinator of college of social science and humanities, Debre Markos University. After that, winning the consent of participants and informing them about the purpose of the study was critically undertaken. Only oral consent of participants was considered as written consent might be impractical given that the significant majority of informants were from the rural areas with very little or no education. What the researchers did was reading the consent form for study participants (particularly for those who are unable to read and write) and made sure they confirmed their participation in the study orally. Confidentiality of any information provided by participants was guaranteed and quoted information was anonymised during
the analysis and reporting. Selection of interview setting and time was made as per the convenience of all participants as well. During the initial recruitment process, most had a suspicion of being labeled and targeted based on what they were going to talk thinking that the scheme is government affiliated in its entire system. Due to this, all the safety measures were taken care of during the data collection process that are conducted in the natural setting/rural villages/of the participants in such a way that they feel relaxed to speak their mind whatever issues they need to raise regarding the scheme and its implementation process. The researchers employed all the important techniques both to maintain the validity of the data on one hand and keep all ethical issues uncompromised.

4. Findings and discussion

4.1. Socio demographic profile of participants

Regarding the socio demographic profile of study participants, 29 were male and 24 were females. A significant majority of them were orthodox Christians (47) and the remaining 6 were Muslims in their religious affiliation. All participants were aged between 19 and 78 years. Except few, majority of them are unable to read and write because they did not attend any formal education so far. There are also few informants who can read and write without formal education only through the adult education programs that they have attended decades ago. The average family size is 6 and almost all of them employ mixed farming (farming and animal husbandry). As clearly indicated in the 2015 report of the Ethiopian Health Insurance Agency (EHIA) pilot scheme, well educated member of the society were found to have consistently higher chance to join the scheme and the case is more so particularly when one or more members of the household attend secondary level or higher educational degrees. Similarly, other socio demographic variables are found to be important determinant factor of subscription to the CBHI scheme. Moreover, the report also disclosed that educational status, sex of the household head, age and size of the land holding (cultivated land in particular) are found to be the major determinants of enrollment in the insurance scheme. To be more specific, the larger the size of the family and also the availability of elders in the household increased the chance of enrolment than the contrary. Enrolment rate is also positively correlated educational status in a consistent fashion which ranges from no education, primary education to higher education. Being female header is also found to be positively associated with enrolment compared to its counter parts as well (Ethiopian Health Insurance Agency (EHIA, 2015).

4.2. Perceived preferential treatment: When does it happen?

Though various studies confirmed that CBHI scheme create access to health care services and also increased in the frequency of visits to public health providers, poor perceptions of the quality of care provided at contracted facilities and perceived preferential treatment provided to paying patients remain major concern as well as one of the factors mentioned associated with not enrolling to the scheme. Similarly, Atafu and Kwon (2018) also confirmed that the majority of the CBHI members had a positive perception of the quality of health services provided by the surrounding health care facilities prior to the implementation of the health insurance. Having these complicated perception of beneficiaries in mind, study participants were asked to indicate the context when they feel they encounter the presumed preferential treatment for paying clients.

Most insurance subscribers have apparent misunderstanding that the insurance service in the scheme is something as if given “for free.” This perception instinctively leads them to believe that public health practitioners would give better treatment for those who are nonmembers since they pay direct cash during the service. This perception urged a reasonable size of beneficiaries to make a decision not to disclose their membership status until they get visited by the health practitioner. In addition to the perception held on the preferential treatment between insurance members and paying clients, there are studies which indicated rather a real concern on the issue. Accordingly, researchers clearly identified from various interviews and discussion that there are situations when the presumed preferential treatment happened during the service delivery process such as; during consultation with physicians, medicine prescription, referral service, patient flow management in the facilities, and others which are discussed one by one as follows.
4.2.1 Consultation with physicians

Informants argued that one of the circumstances in the service delivery process of public health facilities when they encountered the presumed preferential treatment for paying clients is during consultation with physicians. Given that most of the insurance subscribers hold a belief that the insurance is equivalent to free service, they come to believe that health practitioners give better treatment for those who are nonmembers for paying direct cash during the service. This perception led some beneficiaries to decide not to disclose their membership status until they get visited by the practitioner though not practical to do that at all. Furthermore, informants also confirmed that they prefer to hide their membership status until a final point when they are requested by service providers to show their membership card hoping that they could avoid presumed mistreatment associated with the insurance membership.

A 66 years old man interviewed around the public hospital setting who came to seek treatment expressed his belief in relation to the existence of preferential treatment during diagnosis in public facilities as follows:

“… They thought (referring to medical practitioners/doctors and nurses) we just frequently come to the health center because it is free and we are not going to pay right away. They tried to show us different signals as an expression of being boarded of the health insurance users in the hospital. … I just come back again and again for lack of better option /referring to financial capacity/ to visit private health facilities, I wish they could understand that and view us as equal with other patients as well…”

Apparently, it is the rational decision of individual households to join the scheme and membership to CBHI scheme holds some presumed reason pushing them towards it. Perhaps, the prior expectations of all beneficiary households are vital both to understand their behavior as beneficiaries and also to determine their level of satisfaction and maintaining their membership status by extension. The higher their expectations prior to their membership, the more they will get dissatisfied by the existing service delivery system. Moreover, the households overall health related consciousness, health history and other societal characteristics are also powerful in contributing to the type of decision households may pass in the process of getting membership to the CBHI scheme.

A 52 year woman who has a serious kidney problem also clearly put her concern of mistreatment she feels compared to cash users. She argued that:

“… I don’t know what they (the health practitioners) think about us but I see no good treatment for me. I have been visited a numbers of times both for myself and my younger daughter so far, and what I can see is boredom on their face and reluctance to ask us what is our illness in a reasonable detail. Even, sometimes, they interrupt us while trying to explain our symptoms for them. I didn’t see such kind of things in private hospitals though I didn’t visit them frequently due to financial constraints. So, I come to believe that this is because of the health insurance and because we don’t pay for the service when we come…”

Often times, there is also a perception by people to associate higher cost with quality service and immediate removal of direct cash payment for services thereby subsidizing them will create a deep concern for receiving best care. This misperception may lead them to decide to use private healthcare facilities rather than the public one unless their perception of quality of care in public facilities changes (Bhatia and Cleland, 2001 as cited in Tanja et al., 2016).

In this regard, one of a 67 years old woman who comes to diagnose her eye explained her personal beliefs in this way:

“… I am suffering a serious illness in my right eye since the last three years and I have been visiting health facility for the last couple of times. Now, I come to public hospital to use the health insurance benefit because I don’t have money right now to visit private clinics. Once I harvest my crops and get enough cash, I may try to visit private facilities where I can get
better treatment and cure relative to the public facilities under the insurance scheme. I prefer to use my health insurance when I have no cash and also during minor illnesses. This works for all my family members as well … ”

As clearly explained in the above quotation, associating quality service with private medical facilities is astonishingly prevalent and the insurance scheme is viewed as a temporary opportunity to get some relief from pain and only a transition till having enough cash to visit private facilities where the presumed better treatment is expected.

In order to triangulate the data gathered from insurance subscribers, key informant interviews were also conducted with officers working in the CBHI agency at Debre Markos branch and one of them described the situation as follows:

“ … Because of the repeated visit and high patient flow of insurance members in the public health facilities, I think, health care professionals might developed misconceptions about the patients as they presumably think that the visit is because of the free medication without serious illness. Sometimes there is a situation that parents bring their sick children to the public facilities and at same time they request medical treatment for themselves simply because they found themselves at the facilities without illness. This situation created unnecessary overload on practitioners on the already high patient flow hospitals. Due to this, beneficiaries usually complain about the mistreatment by physicians believing that this is due to simple being CBH insurance members … ”

The officer working the insurance agency further asserted that the centre also received informal reports indicating that most beneficiary households prefer to hide their membership status to get better treatment. A large amount of insurance beneficiaries developed a commonly held belief that paying that small amount of annual premium is not adequate money to enable them get maximum good treatment to attain cure from their illness. They found the annual premium rather insignificant compared to the severity of their illness that forced them to regard the insurance service as free. So, they refuse to disclose their membership status to the physicians during diagnosis to get better treatment.

On the other hand, the executive manager of CBHI agency at Debre Markos branch office also described the situation as follows:

“ … during diagnosis, beneficiaries tend to hide their membership card due to fear of mistreatment if they disclosed their membership status. Finally they took out their card when they are requested to pay the medical cost. In most cases, front line service providers such as guards and registration workers are sources of complain for the beneficiaries more than the physicians as frequently mentioned by the beneficiaries … ”

Confirming that the perceived preferential treatment might have reasonable ground on the side of most insurance subscribers, the executive manager tend to associate the problem with the front line service providers such as guards and registration workers rather that doctors and nurses. From all these, one can clearly observe the ongoing intricate interaction among actors in the medical setting and complexity of the issues contrary to what most literatures portrayed regarding the impact of the insurance scheme on health outcomes.

4.2.2 Referral service

The issue of referral service seems another concern in the service delivery process where the presumed preferential treatment took place under the CBHI scheme. According to Anagaw D Mebratie et al. (2015), the majority of households think that the quality of care in the insurance is not recommendable and also insured households members have also a complain on the wrong assumption held by health professionals who think that insured individuals came to health care facilities for simple check up as it does not involve direct out of pocket payment. Similarly, a number of previous research works also confirmed that referral service is the source of satisfaction or dissatisfaction in relation to insurance users.
43-years-old man complained about the preferential treatment that he believed happened particularly during a demand for referral service. He argued in such a way:

“… We have been facing a difficulty to get referral service though we are critically ill compared to the out of pocket users. I have been asking my relatives who are out of pocket users so many times and they confirmed me that they can get referral service anytime they want as long as they have cash. However, we, insured patients are considered as free users who simply demand costly treatments without any justifiable reason. Due to this it is very rare that we get referral service as we wish though the illness is so severe …”

Contrary to what has been indicated in the quotation, public health practitioners accuse insurance subscribers for demanding referral service without following the necessary procedure. Hence, they considered the accusation as simply a manifestation of misperceptions and other behavioral problems observed on most beneficiaries of the scheme. Practitioners in the public health facilities sometimes confronted with patients who strongly demand for referral service against the recommendation of the physician as per the severity of the disease.

One of the staff members working in the CBHI agency at Debre Markos branch described the situation as follows:

“… Beneficiaries do not want to follow the procedure and they simply want to use referral service as they come. There is also misconception on the side of the beneficiaries about the referral service as they perceive that being insured may have adverse impact on the willingness of the doctors to send them to the higher level of treatment. They simply demand referral service to hospitals no matter how severe their illness is …”

Despite the dismissal by the health practitioners and CBHI agency workers regarding the accusation in connection to referral service under the scheme, most informants have a firm assertion that they have witnessed discrimination between paying clients and insurance enrollees particularly when there is high patient flow period. They asserted that the noticeable discrimination between paying clients and insurance enrollees by service providers may give priority for that of paying clients.

4.2.3 Prescription of medicine
According to Anagaw D Mebrate et al. (2015), most insured members usually accuse practitioners in the public facilities for giving good quality medicine only for paying clients and let insurance subscribers purchase it from private pharmacies that urged them for out of pocket payments for drugs.

An insurance subscriber aged 39 expressed his concern regarding prescription of medicine as follows:

“… since we don’t pay, they don’t want to prescribe expensive medicine that can cure us with in short period of time. Hence, the medicine we get from the health insurance might be lower in quality as per the amount of our payment /referring to the annual membership premium/. There is nothing more trustworthy that getting treatment using ones cash. I usually ask myself that how could they prescribe good and expensive medicine for that small amount of money we contribute for membership? …”

As indicated above, regarding prescription of medicine, most informants developed doubts on the quality of medicines they get from the public health facilities. As a result, they tend to interrupt taking the medicine if they do not see any betterment in the consecutive few days as soon as they start taking those drugs. Their mental setup that underestimates medicines received from the insurance has an impact in dealing with their perceived wellness and also their decision to obide by the medical advice including taking medicines appropriately as prescribed.

A 47-year-old man who came with his 72-years-old father suffering from pain in the leg explains the situation this way:
“… I and my wife bring my father to get diagnosis in his leg by yesterday. We asked them to give us bed in the hospital but they refused. This is primarily due to the health insurance fee medication scheme that we don’t pay for treatment right now. Because of this, we are forced to stay outside in the cold weather to night and still we are waiting for them if they change their mind. Not only giving bed, they also don’t give us good medicine that can cure him sooner than later. We are too poor to seek treatment in private clinics which forced us insist here …”

A nurse who works in one of the public hospitals spoke about their efforts to explain everything for health insurance users so as to reduce the apparent misconception regarding the service delivery within the CBHI scheme. Despite this, she argued that the intended behavioral change regarding the misconception is not coming as such.

She argued as follows:

“… I used to encounter patients who use the CBHI scheme but have serious misperception for the scheme. Some of them think that because the service is free, we practitioners give preferential treatment for cash users; some others also think that we prescribe Inexpensive medicine for them … all forms of misunderstandings are common … I think the root of all this misperceptions among the insurance subscribers (given that it is observed in rural people) is related to the low awareness and their educational background which might be improved through to time, I hope … ”

Though health practitioners associate it with low awareness of insurance subscribers, the finding of the study undoubtedly revealed that there is a situation when patients throw away the medicine they get from the insurance after taking it for few days if they see no progress as they expect. This has further implications by aggravating shortage of medicines in public facilities, low membership renewal rate/drop out/and out of pocket cost for medicine among subscribers as well. All those negative consequences are happening for real whether the claim by insurance subscribers is fair or not.

4.2.4 Patient flow management

It seems that the patient flow management associated with the length of waiting time to get the service is the primary source of dissatisfaction for most beneficiaries. Various studies revealed that substantial size of insured people are particularly dissatisfied by the long waiting time they face while seeking medical treatment in public facilities. According to Atafu and Kwon (2018), using services at the hospital now is not good especially in relation to the long waiting time.

Informants of the study also strongly argued that patient flow management associated with preferential treatment for paying patients is really distressing. An old man aged 57 who has been member of the scheme for the last couple of years complained about the quality of service though he views the premium affordable.

“… Though the annual membership payment to CBHI scheme increases over time, I believe that it is not that much difficult to pay which is meant to cover medical cost of the entire household members. The point relies on the quality of the service and other tedious process we are expected to go through right beginning from the record room to the treatment. They should improve it!! … ”

Similarly, Anagaw D Mebratie et al. (2015) also indicated that insured household members also have a feeling that preferential treatment is given for paying patients during order of service provision. They believe that quick service is given for paying patients assuming that insured patients always come to the health facility for every minor case for the reason that they are not going to pay direct cash. He also further argued that doctors/facilities may also prefer to treat the uninsured due to the paper work required to receive payments for insured patients and the payment lag.
4.3. Concomitant problems that aggravate the perceived preferential treatment

Study participants were also inquired to identify those elements related to the CBHI scheme and the entire service delivery system in public facilities that would aggravate their perceived preferential treatment causing further dissatisfactions on the scheme. The following are some of the critical issues that most informants and discussants mentioned frequently as underlining problems aggravating the apparent dissatisfaction. The following four main subtopics will independently deal with those problems as follows.

4.3.1 Frequent stock out and thereby prolonged reimbursement process

FGD discussants unanimously argued that the frequent stock out and thereby prolonged reimbursement process is their primary headache related to using the insurance service. They argued that they are usually forced to borrow money to buy medicines during stock out in addition to the extended period it takes to get their money back. In addition to the apparent complain on the insurance service and perceived preferential treatment that subscribers hold, shortage of drugs further aggravates the already dissatisfying insurance package. According to the executive manager of CBHI agency at Debre Markos branch, shortage of drugs in the entire Amhara regional state/the study area/is so critical and it is ranked the lowest compared to other regional states at national level. The in-depth interview conducted with the executive manager revealed that there is inadequate drug supply for Amhara region which is one of the serious challenges they are facing in the implementation process of the insurance scheme.

The informant further argued that, compared to Oromia and Tigray regions where there is no exaggerated problem in relation to drug supply, the level of drug supply in Amhara region only covers around 40% of the actual demand by the region. This puts the region at the lowest rank in its share of drug supply at national level. She further argued that drug supply problem of the region is the worst problem which has an adverse implication on the overall regional health sector in general and the implementation of community-based health insurance in particular. Due to this fact, there might be frequent stock out which cause intense dissatisfaction among insurance subscribers as well. Moreover, the problem of reimbursement and lack of awareness about the procedure in services utilization through CBHI channel expose large number of enrollees to additional healthcare payment and also dissatisfaction on the entire service delivery system. Yismaw Jembere (2018) also firmly indicated that frequent stock out and a combination of other factors is found to be the primary reason for dropout from the scheme. Fetched from shortage of drugs in the region, the health insurance scheme is facing serious challenges in providing quality service in most public health facilities.

As clearly indicated by the staff members working in CBHI agency at Debre Markos district, there is a serious problem faced by the beneficiaries in relation to the reimbursement process of the cost of drugs purchased outside of the public facilities/ resulted from the stock-out/. He argued about the situation in the following way:

“…There is a problem in the refunding process of the drug costs purchased outside of the public facilities. The frequency of time to refund is in three months basis and there are some woredas/districts/ who are able to refund it in a monthly basis. Hence, beneficiaries face a difficulty to incur transportation cost to the nearby center to get it reimbursed as they are expected to pay more that the anticipated amount of repayment in the process. This is a real challenge that we are facing today in relation to implementing the insurance scheme …”

In relation to the reimbursement process, one can easily understand that the apparent disappointment on the side of insurance subscribers is not only at their perception level; rather the existing reality is by far imaginable which is causing them dissatisfied about the service delivery process.

4.3.2 High patient flow induced over load

The implementation of CBHI scheme in rural societies of Ethiopia brought a number of implications. The first apparent implication would be a significant change in the health seeking behavior of the society in terms of increased visit to modern health facilities. Participation in the scheme enhanced the use of
formal medical treatment when ever illness occur in one of the household members compared to the previous practice of over reliance only on traditional medicine. The major benefit, once can mention, would be enhancing the health seeking behavior of the society by encouraging them seek formal health care service than other alternative treatments and avoidance of delay visits to health centers. Due to this fact, it apparently created patient overflow on the already under developed/under staffed/public medical facilities of the country.

The overload on health facilities following the implementation of health insurance is one major challenge usually mentioned by a number of actors. According to Yismaw Jembere (2018), high utilization and patient flow is compromising the quality of services in some indicators such as, long waiting time, drug shortage, and mistreatment by health care providers which are considered as challenges by most beneficiaries. The health care to patient ratio and doctor to patient ratio is so high that can adversely affects the entire service delivery process. On the other hand, medical practitioners argued that there is also a tendency among the beneficiary households to bring all of the family members to the medical facility to check if the health insurance works for them which partly emanates from the disbelieve on the program itself. Consequently, this in return created unnecessary load on the health facilities and health care practitioners by drastically increasing the patients flow beyond what is supposed to be treated per day. Being conscious of this fact, unknowingly, the health practitioners developed apathy for the insured/beneficiary households/ during service delivery process.

According to the executive manager of CBHI at Debre Markos branch, the problem of over load can be put as follows:

‘... there is high patient flow following the CBHI and thereby created fatigue among the health care practitioners who are working beyond the standard number of patients to be treated per day. They are now forced to see more than 70 and 80 patients per day beyond the standard number 40 patients. This is a challenge to conduct the health treatment system of taking time in assessing the medical history of the patients (80 %) of the disease identification mechanism plus 20 % of investigation. This in turn created a misperception by the beneficiaries that we are mistreated for being insured households ...’

Correspondingly, Fink et al. (2013) also indicated that the absence of financial incentives for health service providers who provide medical treatment for enrolled households adversely affect the quality of health received by them, and may have rather discourage the behavior of seeking modern health care (Paul et al., 2012). Hence, one can understand that the high patient flow significantly increased the work load in the absence of necessary incentives which is considered as the major factor behind the perceived mistreatment by most beneficiaries. Besides this the work load increases without any increment on incentives is believed to have an impact on the moral hazards and mistreatment of members as most frequently mentioned it.

4.3.3 Unnecessary price increment by private pharmacies on CBHI beneficiaries

According to the executive manager of the CBHI Debre Markos branch office, there is a tendency by the private pharmacies to make unnecessary price increment on drugs during out of stock prescription being aware of the health insurance. Most of the private pharmacies viewed such sales as a big opportunity for them to seek high profit which they could not get otherwise in the normal market mechanism. This is the combined effect of reckless purchase by beneficiaries thinking of the refund and also the pharmacies misuse the opportunity being aware of the insurance case. Private pharmacies view insurance subscriptions as a good source of profit. Beneficiaries who go to the private pharmacies to purchase drugs which are not found in the public sector forced to pay many folds beyond the normal price. Even though the agency is expected to refund the cost, the immediate demand of large amount of out of pocket expenditure is also another headache for the beneficiaries themselves as well.

The executive manager further argued about the proposed solution planned to be implemented so as to alleviate the situation/problem/as follows:
“... to reduce the out of pocket purchase during stock out and its related unnecessary price increment by private pharmacies, we are planning to establish contract with private pharmacies in a negotiated maximum of 30 % profit per a drug item. Even though this solves the problem of sudden drug purchase by beneficiaries, it has a room for unnecessary deals between the physicians and the contracted pharmacy to send any drug prescription out of the public facility to the private pharmacies so s t maximize profit following sole increment. This would certainly have an impact in the financial sustainability of the CBHI scheme as it costs more than the normal pricing of drugs ...”

As clearly stated earlier, the over pricing of private sector on insurance subscribers is bringing loss on the agency in general as it is responsible pay any annual cost demanded by the beneficiaries. This is stressful on the issues of financial sustainability of the insurance agency as well. This leads to, the manager further asserted, financial deficiencies by some woradas/districts and thereby interruption of the medical service for beneficiaries from those areas. Frequently, some woradas totally consumed their collected finance from membership too early and fail to pay the money requested by health care providers. In the mean time the health care providers decided to deny such services for those beneficiaries who came from these specific woradas/districts/. Under such circumstances, insured households who encountered such kind of challenges tend to develop a negative perception toward the scheme and begin to refuse annual membership renewal some other time when requested to do so.

4.3.4 Confusion related to annual renewal payment without using service

Most beneficiaries misunderstood the fundamental philosophy of CBHI scheme and claimed transfer of premium for the next year if they did not visit medical facility during the year that they paid for. Informants argued that they thought that it is not fair to pay annual fee for the following year without receiving any medical service for the then paid year. It is clear that awareness problem is still prevalent and serious public education and discussion seems to be quite important to raise their awareness and avoid confusions. Besides this, inappropriate understanding of the scheme might have an adverse impact on their level of satisfaction as well as to eventually remain member of the scheme.

A staff member who is working at Debre Markos CBHI center puts the challenges they usually encounter with those beneficiaries who did not use any medical service throughout the year yet asked to pay membership renewal fee for the following year.

He puts it as follows:

“... They assume that it may not be fair to be asked to pay annual renewal premium without using the service in return to the payment for last year. Therefore they would like to transfer the payment to the next year thinking that they didn't make any visit to medical facilities for the paid money. This is largely due to the awareness problem from the side of the community regarding the purpose of the health insurance package in general. It is primarily meant to cover the health care cost of the community through sharing without calculating the private financial costs involving any visit that the household made per year. Yet most people don't have that kind of thought regarding the scheme which causes many undesirable dealings ...”

Though the aforementioned problem is a direct manifestation of lack of awareness regarding the fundamental philosophy of the insurance scheme and the entire service delivery process, the actual problem is still taking its share of further aggravating the distrust that insurance subscribers hold towards the scheme. Perhaps, continuous awareness raising campaign on rural societies might help in reducing the awareness problem specifically related to the annual renewal process.

5. Discussion

It appears reasonable to argue that there's a significant consensus on the notion of health insurance policy which has been attracting tremendous interest in low- and middle-income countries as a viable mechanism for transforming the health service utilization by saving the society against the impoverishing effect of out-of-pocket expenditures (Carrin et al., 2005; Hsiao & Shaw, 2007; Ndiaye et al., 2007).
Likewise, CBHI is typically taken as a health financing mechanism particularly intended to benefit the poor and marginalized segment of the society (Span et al., 2012). In terms of access to modern health care and various other health indicators, Ethiopia positioned low even when compared to other low-income countries. One among the explanations for low achievements on healthcare services is the user fee charges (FMoH, 2011). To resolve challenges related to access, quality and utilization of health services, CBHI scheme becomes a viable mechanism for developing countries including Ethiopia (UNDP, 2011; WHO, 2010; Haile et al., 2014). Subsequently, the CBHI scheme is accepted to improve the health care financing to reach and cover the massive segment of the agricultural society in the country (Agago et al., 2014; Atafu & Kwon, 2018; Ethiopian Health Insurance Agency (EHIA), 2015).

Holding the slight inconsistency constant, various investigations in Ethiopian context affirmed the accomplishment of CBHI scheme in partly attaining the financial protection and enhancement of service utilization issues. In consistent with the study findings by Stella et al. (2010) and Anagaw D Mebratie et al. (2015), this study also indicated that the implementation of the insurance scheme provided economic relief and enhanced health service utilization including for women and children. Other than the greater part of the obvious benefits of the CBHI which have been appreciated by most beneficiary households, the relatively new nature of the phenomenon in the country challenged the successful implementation of the scheme as well. One of the challenges goes to level of confidence and thrust beneficiaries have on the entire service delivery process and the apparently identifiable gaps associated with the structure of insurance scheme itself. Apparently, the perception held by beneficiaries regarding the preferential treatment given for paying clients in public facilities remained a major concern threatening quality service provision. In this regard, the findings of this study revealed that CBHI in Eastern Gojiarm district of north western Ethiopia is yet to achieve its initial philosophy of quality service provision. This is basically the result of the complex behavioral responses from both the patient and health care providers including the health insurance agency actors as well.

One of the key findings of this study is that insurance members view the service within the scheme as if it is given at no cost. This apparent misunderstanding leads them to hold a belief that medical practitioners would give better treatment for nonmembers since they pay direct cash during the service. Furthermore, there is a firm belief that the perceived preferential treatment happen during various points of the service utilization process; such as during consultation with physicians, medicine prescription, referral service, patient flow management, and others. This finding is also in consistent with a number of scholars who, in one or the other way, investigated some aspects of the health insurance scheme in numerous contexts. As an example, Anagaw D Mebratie et al. (2015) found out that there is a noticeable complain by insured people regarding the wrong assumption held by medical professionals who think that insured individuals came to health care facilities for easy check up since they don’t pay direct out of pocket cash. This is often partly the results of the disparity in health care to patient ratio and doctor patient ratio that came together with the start of the insurance and thereby high patient flow.

A tendency by some beneficiary households who tend to bring all of the members of the family to prove whether or not the insurance scheme really works is mentioned among the awareness problems that further aggravated the situation. Being conscious of this fact, unknowingly, the health center practitioners developed apathy on the process of service delivery for the health insurance beneficiary households. The noticeable mistreatment on the side of practitioners towards insured patients might be partly attributed to high patient flow and absence of adequate incentives. A number of previous studies including Fink et al. (2013), Paul et al. (2012), and Paul et al. (2012) might fall to this category. For the foremost part, this situation has an adverse impact on the quality of service provision which goes against the fundamental principle of the insurance scheme. Similarly, Haskard-Zolnierek and DiMatteo (2009); Steckler et al. (1992) and Morse, Sweeny & Legg (2015) held a similar assertion that it has been widely recognized that good doctor-patient communication yields a host of positive psychological and health outcomes but other elements of these experiences, such as characteristics of the situation and traits of the parties involved, may influence patients’ construal of healthcare encounters and their outcomes following the visit.
Moreover, findings of the study also disclosed that the perceived preferential treatment also happened during prescription of medicine. Beneficiary households also accuse professionals for giving good medicine only for paying clients and let the insured members to purchase from private pharmacies which again urged them for out of pocket payments for drugs. Correspondingly, study findings by Anagaw D Mebratie et al. (2015), Paul et al. (2012), and Fink et al. (2013) are found to be in harmony with the findings indicating that there is a low level of health care provider satisfaction and poor perceived quality of care by enrollees themselves. There is also an argument that cost-saving pressures faced by public facilities may lead providers to institute measures to reduce the number of contacts by insurance enrollees, such as providing poorer quality care to insured patients (Robinson, 2001). Contrary to the findings of Fink et al. (2013 and Paul et al. (2012) who indicated that poor perception of quality of care provided at contracted facilities was one of the factors mentioned associated with not enrolling, there is also a culturally held beliefs in the societal tradition that putting money aside for future health care call illness was one of the hindrances for enrollment (Fink et al., 2013).

A range of concomitant problems were identified that are aggravating the existing perceived preferential treatment for paying clients which adversely affected the service delivery process under the scheme. These include; shortage of drugs induced frequent stock out and thereby prolonged reimbursement process, high patient flow induced over load in public health facilities, unnecessary price increment by private pharmacies on insurance beneficiaries, and confusion on annual renewal payment without using service are all concomitant problems. This finding is in consistent with Atafu and Kwon (2018) who revealed that the positive perception for health facilities prior to the insurance scheme is eroded due to many factors one of which is the prolonged waiting time which is particularly become disturbing. Through CBHI primarily operates under the philosophy of mutual support, solidarity, and also collective risk pooling system for the presumed health risks in the society (Mathauer & Behrendt, 2017; Wang & Pielemeier, 2012), there is tremendous confusion among most beneficiaries regarding the annual renewal process who misunderstood the fundamental philosophy of the scheme and claimed transfer of premium for the next year if they didn’t visit medical facility in the paid year. Sociologically speaking, it can be argued that this health insurance scheme basically evolves from traditional kin-based mutual and voluntary associations such as burial groups (such as Iddir in Ethiopian context; Dercon et al., 2006) or any other forms of self-help social groups (Nshakira-Rukundo et al., 2020; Spaan et al., 2012).

The implications of all the aforementioned perception of preferential treatment for paying clients and other concomitant problems that insurance users tend to associate good quality service with private facilities or cash users. Bhatia and Cleland (2001) as as cited in (Tanja et al., 2016) argued that, often times, there is also a perception by people to associate higher cost with quality service and immediate removal of direct cash payment for services thereby subsidizing them will create a deep concern for receiving best care. Consistently, Tanja et al. (2016) also found out that most informants hardly have faith on health insurance schemes due to all the negative stories and experience they have heard from family members and friends about the insurance which forced them to prefer OOP payment for health care services as required.

6. Conclusion

In conclusion, this study was meant to examine insurance enrollees’ perceived preferential treatment for paying clients and other concomitant problems in some selected rural areas of Eastern Gojjam district of north western Ethiopia. This qualitative investigation revealed that despite the economic relief households gained, the thrust on the service delivery process seems to be far behind. Comparing them with paying patients combined with the presumed “free medical treatment” that they associated with the insurance, the perceived preferential treatment for paying patients by practitioners seems common. Due to this, most participants
hold a belief that visiting private health facilities during critical illness appears preferable to get quality medical service if their financial capacity allowed them. The perceived preferential treatment is alleged to be happening during consultation with physicians, medicine prescription, referral service, patient flow management, and others. Shortage of drugs induced frequent stock out and thereby prolonged reimbursement process, High patient flow induced over load in public health facilities, Unnecessary price increment by private pharmacies on insurance beneficiaries and confusion on annual renewal payment without using service are all concomitant problems. Due to this, most of participants hold a belief that visiting private health facilities during critical illness is by far preferable to get quality medical service if their financial capacity allowed them. Necessary behavioral intervention meant to improve awareness and also improvements of public facilities are recommended. Some of the aforementioned issues related to the scheme can be easily overcome through regular behavioral interventions by improving the understanding of insured households. Whereas, the issue of patient overloads, shortage of drugs, problems related to the reimbursement, and other things require collaborative effort of stakeholders and considerable time. The result has future implication regarding the sustainability of CBHI scheme by helping beneficiaries build thrust on the service provision process in addition to the objective challenges associated with the health system.

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Author details
Kasahun Desaylew Mekonen
E-mail: desaylewkosahun@gmail.com

Acknowledgments
This work was supported by Debre Markos University.

Author details
Kasahun Desaylew Mekonen
E-mail: desaylewkosahun@gmail.com

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