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Research Article

Knowledge, Attitude and Practices of Health Insurance Schemes among Rural Women

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Abstract

The concept of Universal health Coverage (UHC) is very important in the context of health insurance and healthcare equity. UHC is based on the concept of access of population, service, and financial coverage. Therefore, nations and policymakers are taking actions to bring health insurance and quality care to the last mile, the rural areas, and women. The present study is an attempt to study knowledge, awareness, and perceptions of the rural population especially rural women, towards health insurance, it's importance and willingness to pay for it. The study uses secondary day from published literature in reputed journals and identifies interesting insights on health insurance in rural areas. The paper uses literature from the past 20 years and not more. The results highlight various factors such as illiteracy, low education levels, unemployment, lack of health insurance promotion, lack of understanding etc. that impede the growth of UHC in rural areas. People still have less knowledge and understanding of health insurance. The paper recommends for policymakers to achieve maximum access to healthcare through targeted interventions of health insurance aimed at improving understanding and building a positive attitude towards health insurance.

Keywords: rural women, CBHI, health insurance, out-of-pocket expenditure, universal health coverage, health equity

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Introduction

Health insurance has been increasingly recognised in low-income countries as a promising tool for the financing of equitable health care, by pooling risks and resources. It ensures better health care access and risk protection to poor households especially in rural areas, against catastrophic medical expenditures.

Several attempts have been made to explore the factors that increase uptake of insurance with an aim to leverage on those to increase the coverage of health insurance. Age is one such factor as it was found to increase as one advances in age. The reason for this may be due to an increase in purchasing power.[1] The number of those who are in some form of formal employment and have health insurance is more as compared to those who are unemployed.[2] Rural Women of child-bearing age (18- 45 years) are also found to be excluded from insurance. Other factors like, marital status, educational status, profession and household income all have significant impact on uptake of insurance.[3]

Qualitative assessments of insurance uptake to understand the attitudes and perceptions towards health insurance showed that many people still thought that insurance is for those in the formal sector and others thought that it was useless to pay for health insurance if they might never use the service.[4] In such low information areas people also feared the insurance companies for misappropriation of their money so they were averse to the whole idea.[5]

People residing in rural areas tend to consult private health practitioners more than government doctors due to poverty and low literacy level. In the process they incur huge medical expenditures leading millions to poverty each year in India.[6] [7]

In developing countries like India and others, providing insurance to rural population and especially women, remains a risky business owing to low levels of insurance awareness as well as poor healthcare infrastructure in rural areas.[8] [9]

The paper attempts to understand the levels of knowledge and attitudes of rural population especially women and the various factors that contribute to it as emerges from the literature review of some important studies in this context.

Literature Review

Maina, (2016)[10], studied pregnant women in a rural Kenyan district for factors affecting the uptake of health insurance. Maternal and child health in Kenya contributes for a large proportion of the expenditures made towards healthcare where one in every five Kenyans has some form of health insurance. In the cross-sectional study the information was collected through a pretested interview schedule from a sample of 139 pregnant women attending the antenatal clinic. Results showed that the median age of the women was 28 years and 62% respondents planned to pay for their deliveries through insurance. A significant relationship between insurance uptake and marital status was also seen. Those with tertiary education were more likely to take up insurance and knowledge about the benefits of insurance was associated with an increase in the uptake of insurance. Respondents' monthly income and number of children did not show any affect insurance uptake.

Bassi, et al., (2021)[11], did a descriptive, cross-sectional community-based study in Nigeria using multi-staged sampling technique to assess knowledge, attitude, and practices of the community towards National Health Insurance Scheme (NHIS). A sample of 252 eligible respondents from the community were administered a structured questionnaire from which majority of respondents were females (63.5%), aged between 20-29 years, largely married (54%) and 47.2% had achieved secondary level education. 59.5% of respondents had heard of NHIS and family and 25.5% respondents said that friends were the most common source of NHIS information. 70.7% of the respondents had good attitude towards NHIS. Registrations for NHIS were found to be only 13.3% and 88.5% of the

respondents funded their health expenditures through Out-of-pocket payment. The population has inadequate awareness and knowledge of the National Health Insurance Scheme which resulted in low registrations for the scheme. The study suggested that the government could come to the aid of communities by providing adequate awareness, knowledge, and privilege to help motivate the population to participate in the scheme.

Adweole, et al., (2016)[12], conducted a study in selected rural households in Nigeria to assess methods of payment for healthcare and awareness about the National Health Insurance Scheme NHIS. The study used a sample of 345 households using multistage sampling technique and data was collected using a pretested, semi-structured interviewer administered questionnaire. In the study it was found that majority of people still paid for their healthcare expenditures through out-of-pocket method as awareness of NHIS in Nigeria was poor. Results also showed that attitude towards NHIS was encouraging and willingness to enrol in the scheme if opportunity offered was also seen. Major impediments in the implementation and expansion of NHIS were lack of trust in government social policies, religious belief, and poverty. The study suggested that stakeholders should promote NHIS and its benefits through appropriate awareness programs which have socio-cultural understanding of the community.

Appiah, et al., (2012)[13], did a study on insured and uninsured households in Ghana to identify perceptions of health insurance scheme and community attributes like peer pressure and prevalent health beliefs. The study also explored the association of these perceptions held by the respondents with their household decisions to voluntarily enrol and remain in insurance schemes. A household survey comprising of 3301 households and 13 865 individuals was analysed using principal component analysis to evaluate respondents' perceptions and multinomial logistic regression was used to determine the association of identified perceptions and enrolment. 38.8% and 21.8% communities were semi-urban and rural respectively. The results demonstrated that scheme factors such as benefits, convenience, and price of NHIS. At the same time, while households held positive perceptions towards quality of care, benefits of NHIS. Though they had appropriate community health beliefs and attitudes, the respondents were negative about the price of NHIS, peer pressure and provider issues. The uninsured were more negative about the NHIS than the insured. The perceptions of providers, schemes and community attributes play a varying but important role for people to voluntarily enrol and remain in insurance schemes and thus scheme factors are of key importance which policy makers should invest in.

Shigute, et al., (2016)[14], explored the government CBHI which was launched in 2011 in 13 rural districts of Ethiopia where credit markets and well-developed insurance is lacking in Ethiopia which results in rural family's exposure to varied health risks. The aim of the study was to understand how uptake and retention of the scheme by rural households was affected by another government intervention called Productive Safety Net Program (PSNP). The CBHI scheme covered various inpatient and out-patient health care services at public facilities and monthly premium was 0.4 – 0.6 percent of household monthly income. The empirical analysis is based on household panel data survey of 2011 (sample of 1224 households), 2012 (1203 households) and 2013 (1186 households) apart from a health facility survey conducted in 2011 through Key Informant Interviews (KII) and Focus Group Discussions (FGD). Results showed that scheme enrolment reached 41 percent in 2012 but 18 percent of them dropped out of the scheme in 2013.

Ibrahim (2012)[15], conducted a study of Knowledge, attitude, and perception of people under National Health Insurance System (NHIS) in a hospital in Nigeria. The data collection was done on a sample of 144 respondents through a structured questionnaire. Results of the study showed that while all respondents were aware of the scheme, only 40.9% had knowledge of various aspects of the scheme and majority of respondents were women (53.2%). Electronic media and workplace were main source of information and all respondents had positive attitude towards the scheme but only 48% were satisfied with the services provided.

Allcock, et al., (2019)[16], studied data of 14,443 individuals aged 15 to 64 years from 2013 Namibia Demographic and Health Survey to explore the relation between health insurance awareness and utilisation and key sociodemographic factors. The study found that 8.9% of rural dwellers were insured compared to 25.7% urban dwellers. 17.5 % of population was insured, and out of which 16.2% were women which was lower than men. The socio-demographic factors namely education and wealth were positively associated with health insurance and the more a woman was educated, the more her likelihood of having health insurance (which was not found in the case of men) even with less wealth. Significant improvement in knowledge and attitudes towards health seeking and health insurance could come through education. Education has been identified as an important determinant of willingness to join and pay for health insurance[17] and elsewhere it is also associated with increased awareness about insurance schemes.[18] The study finding strongly support the theory that health insurance plays a role in healthcare accessibility and health service utilisation in context of Namibia.

Haw (2018)[19], determined the association between perceptions of patients for quality care and utilisation of Ghana National Health Insurance Scheme using a multiple linear regression model. In the study sample of 4332 respondents Three categories of patients based upon their utilisation were taken: those paying fully OOP, those paying fully with their insurance card and those paying with their card and out-of-pocket (OOP). 42% of females showed fully NHIS utilisation and higher knowledge and perception of the health insurance in the findings. The study findings also suggested that utilisation of NHIS in general was negatively associated with overall perception, and the difference across utilization categories was found to be on a higher side among patients using private facility than public facility users.

Cofie, et al., (2013)[20], analysed the effect of Information, Education, and Communication (IEC) interventions and activities on the adoption of a community-based health insurance (CHI) scheme in largely rural Nouna town of Burkina Faso and the factors that improved or limited the campaign’s effectiveness. Data collection for the study was done through a survey of 250 randomly selected heads of households, 11% which were females. In-depth interviews were also conducted with purposively selected 22 community leaders and through field observations. Multivariate logistic regression models and bivariate analysis were used to assess the association between household exposure to campaign and knowledge of scheme, as well as household exposure to campaign and enrolment in the scheme. Th results showed that the IEC campaign had a positive effect on knowledge levels of households about the CHI and to a lesser degree on household enrolment in the scheme. The effectiveness of the campaign was mainly influenced by frequent and consistent IEC messages from multiple media channels like radio, mobile information van and CHI team, and participation of community heads in the CHI scheme promotion. Education was identified as a significant and influential socio-demographic determinant of knowledge and enrolment among household heads.

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Dupas & Jain, (2021)[21], found striking gender-based disparities in a government health insurance program for poor people in Rajasthan state of India. Administrative data of over 4 million hospital visits was used and it was found that females accounted for only 43% of hospital visits among adults and 33% among children. Non-child-birth spending was about two-thirds on males. The results showed that costs of care-seeking were not completely offset with the program as some households allocated more resources to male than female health and lowering costs did not benefit the females much. Another important insight from the study was that long-term exposure of the insurance scheme to the village-level female leaders helped reduce the gender gap in utilization though with moderately. The study suggested that increasing access to social services and subsidising it may increase levels of female utilization, but it might not generate significant results to address gender inequalities unless actions that specifically target females.

Murti, Widyaningsih (2016)[22]**,** studied socio-economic determinants of healthcare membership in women of reproductive age in Indonesia. The study used data from Indonesia Demographic and Health Survey (DHS) OF 2012 to study a sample of 15,112 women. Only 6,041 (40. 0%) of the women were covered by insurance which was majorly a social security program and more urban women as compared to rural women were having health insurance. Education played a part also with women having college level education more likely to have health insurances compared to women with lesser education background. Interestingly, study analysis also indicated a positive association among women and the spouses' education on women's health insurance membership. The results emphasise that it is very important to consider socioeconomic determinants in order to advance the universal health coverage program and bring considerable improvement in maternal and child health in Indonesia.

Kihaule (2014)[23]**,** analysed the outcomes of purchasing health insurance plans as determinants of scheme membership as little attention was given to this gap in research literature. Micro-health insurance scheme members in rural areas in Tanzania were analysed in association with their utilisation of health services with the help of matching estimator method. Data from Tanzania Demographic and Health Survey of 2011 was used for the study. Results of the study showed that insurance scheme helped increase utilisation of health services among poor households, but the scheme did not provide any protection against catastrophic health spending in episodes of illness of rural households. The reasons are that the households had to incur additional expenditures when visiting the health facilities in episodes of illness and that the plans provide limited range of benefits to households. The study had both men and women respondents, and women gave most information of health compared to men. The study reiterated that actions must be taken to motivate rural Thus, it is recommended that poor households should be encouraged to enrol in the micro health insurance schemes and adequate supplies should be provided at health facilities to minimize out of pocket spending.

Stafford (2018)[24]**,** studied the role of community-based promoters in the delivery and utilisation of health insurance among rural and marginalised population of Gujarat state of India. VimoSEWA community-based insurance promoters also called, 'aagewans' and the beneficiaries of VimoSEWA's insurance who are self-employed women with very less prior access to financial protection were studied through field visits and personal interviews in rural districts of Gujarat. The role of VimoSEWA aagewans in promoting and delivering health insurance to self-employed women in Gujarat is significant because insurance improves the financial stability of these women and their

families. Furthermore, health insurance is effective in decreasing high out-of-pocket healthcare expenses and improving access to quality healthcare services. However, the benefits of health insurance can only be attained by marginalized populations if insurance is made accessible to these communities through proper delivery methods. The results demonstrated that community-based health insurance promoters played a crucial role in extending health and social insurance coverage to marginalised populations especially to rural women, as they adapted their services to the needs and limitations of self-employed women in their communities in understanding of health insurance policies and its utilisation.

Dhavale & Ahuja (2019)[25], did a study to examine determinants of health insurance in Indore district. It mentioned in the literature that the driving factors for insurance uptake for 3 Community Based Health Insurance Schemes in Rural areas of Bihar and Uttar Pradesh offered by the Self Help Groups (SHG'S) found that greater financial liabilities in a household made them more attracted to health insurance but enrolment in such schemes was unaffected by that. In the National Insurance schemes (RSBY), the economically and socially backward sections and rural women were more likely to be enrolled and become beneficiaries.

Raza, et al., (2016)[26], investigated healthcare seeking behaviour of members of CBHI schemes in rural Bihar and Uttar Pradesh (two poorest states of India). Data from household surveys conducted between March and May 2010 in Vaishali district in Bihar and Kanpur Dehat and Pratapgarh districts in Uttar Pradesh was drawn for the study and baseline surveys were conducted before the implementation of three CBHI schemes. The target group for the schemes consisted of 3686 SHG households representing 21,366 individuals and the primary respondents consisted of SHG members themselves or the head of the household. Women consisted of half of the adult respondents. Results showed the majority of SHG rural households did access some form of care. In the case of acute illnesses, only 14 percent of respondents forego care and 30% did not seek care in case of chronic illness. Usage patterns also showed overwhelming use of private care for both outpatient and inpatient services especially in case of acute illness (90%). Substantial proportion of healthcare (56 % in acute cases and 30 % in chronic illnesses) was provided by non-degree allopathic providers. The study showed that proximity being an important factor influencing healthcare-seeking behaviour, CBHI schemes should also consider reimbursement for transportation costs etc.

Michielsen, et al., (2011)[27], researched on potential of health insurance interventions for improving access to quality care in India based on experiences with community health insurance schemes. The study found that freedom of choice of poor people especially from rural areas is often limited because good quality health facilities are lacking or unknown.

Aggarwal (2011)[28], analysed equity and renewal of enrolment, and utilisation of community-based health insurance especially of Yeshasvini health care programme. A primary survey of 4109 households was conducted in rural Karnataka. The findings from the study demonstrated that compared to enrolments and renewals, more inequities existed in utilisation, even though they were found to be less pronounced. An important insight from the study emerged that community-based health insurance (CBHI) was an effective mechanism to reach the disadvantaged population, but it cannot be considered as substitute for government-created health infrastructure.

Khan, et al., (2021)[29], explored distribution of health insurance types across demographic and socioeconomic factors and found that both prevalence and type of coverage differed across subgroups. Coverage by the national schemes in female-headed households was higher than in male-headed households and it also was found to be double among rural households than urban households. The study also found that rural households were more likely to be covered by any health insurance than urban households.

Gopalan & Durairaj (2012)[30], studied purchase of and financial access to non-maternal healthcare in rural Orissa state of India. Though one-fourth of the households surveyed had done health insurance coverage for inpatient care, very few could make use of them. From the study sample of 800 women, 93.4% did not have any financial risk-protection done for the last episode of non-maternal healthcare due to lack of finances, non-comprehensive nature of insurance mechanisms to protect non-maternal healthcare and very less family support. The study results exhibited a clear household prioritization, towards maternal care despite women having considerable non-maternal healthcare needs which are not adequately programmed into the health financing mechanisms

Lofgren, et al., (2008)[31], did a study in rural Vietnam, to analyse willingness-to-pay for health insurance. Epidemiological Field Laboratory for Health Systems Research was used and, 2070 households were randomly selected for the study and 64% of the respondents were females. Variables such as health care need, income, age, and educational level emerged as significant determinants of households' willingness to pay. Also, age was negatively related to willingness to pay. This study stressed on the potential for public information schemes that could change the negative attitude towards health insurance. Results suggested for policy makers to win the trust of the population in relation to a health insurance.

Savitha, Kiran (2012)[32], conducted a descriptive study in rural Karnataka state of India, to ascertain the knowledge and awareness about features of a health insurance scheme namely Sampoorna Suraksha Programme (SSP) a micro-insurance programme. Primary data on insured members was collected using survey methodology. The respondents were mainly women (87%) and married (70.7%). One-fifth of them were illiterate and more than half of them were from low-income families. The results of the study reaffirmed that insured members of SSP had different levels of knowledge and awareness of the number of benefits and other features of SSP. The members who had been renewing the membership had higher degree of knowledge and awareness of scheme features rather than the newly insured SSP members. The positive trends on knowledge and awareness were attributable to level of education, high income, and members living in more developed districts of Karnataka.

Conclusion

Health insurance coverage is poor in rural areas and very less for rural women. Positive attitudes are gradually building towards health insurance, but a lot more needs to be done. The paper highlights the importance of strategic understanding of the needs, wants, interests, perceptions, and practices of the target population in rural areas, when it comes to propagating health insurance. Women from rural areas tend to neglect their own health compared to urban women, owing to lack of education, and financial resources. Health insurance, such as community-based health insurance can bring more health coverage to them which can result in better healthcare access. Strategic interventions at

community, government and private insurer level to better structure and communicate health insurance schemes will see better knowledge and utilisation of health insurance in rural population.

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