



Effects of Financial Incentives on Saving Outcomes and Material Well-Being

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Abstract

Background: Access to healthcare is made possible with the protection of financial risk. Enrollment in community-based health insurance, which prevents catastrophic health-care costs, has been proven to be influenced by knowledge and attitude. Health insurance knowledge and attitudes, however, have not been thoroughly investigated. This study's goal was to assess the informal workers' knowledge and attitudes towards community-based health insurance.

Methods: A community-based cross-sectional study was conducted with 100 randomly selected informal workers. We conducted structured face-to-face interviews using a newly developed and validated questionnaire. After being coded, the data was imported into Epi Data and exported to SPSS for analysis. Using logistic regression analysis, potential correlations between the research variables were looked for.

Results: Overall, 100 of them returned their completed questionnaires. 70% of the respondents were male. 49 (49%) of the participants completed college and above education. 40 (40%) and 60 (60%) of the participants were daily laborers and housewives, respectively. About 33 (33%) of the study participants were feeling sick a month ahead of the data collection period. Also, 65 (65%) of the study participants were worried about paying when they feel sick.

Conclusion: The unofficial workers had unfavourable attitudes and little understanding about community-based health insurance. To ensure that everyone has access to medical care, it is crucial to promote the usage of community-based health insurance.

Keywords: community-based health insurance, knowledge, attitude, informal worker,

Introduction

Microsavings products—defined as small-deposit accounts tailored for low-income individuals and families—have shown great promise in increasing household-level investments, expenditures, and long-term asset accumulation, particularly among marginalized communities and individuals (including racial minorities and immigrants) in Western industrialized countries¹⁻³ and increasingly in lower- and middle-income countries (LMICs).⁴⁻⁸ As a branch of microfinance, microsavings programs range in design, size, and structure. Examples of microsavings programs include Rotating Savings and Credit Associations, Savings and Credit Cooperatives, and more formalized mobile money or banking institutions. Options within formalized savings programs can include standard deposit accounts or savings products that offer incentives, such as matching contributions, in

return for conditional withdrawals that direct the use of savings toward education, health care, housing, or small-business development. Prior studies have shown that incentivized or conditional savings products are more effective in promoting saving habits than simply offering the opportunity to open a savings account.^{9,10}

Material and methods

The adult population lists in each of the nine sub-cities were proportionally distributed from the kebele registration books of each sub-city to achieve the requisite sample size (100). This was done using a systematic random sampling technique. Households were chosen from each kebele. Then each adult from each selected household was asked a question. When more than one eligible adult was present in the selected household, the basic random sample method was applied. We conducted structured face-to-face interviews using a newly developed and validated questionnaire. After reviewing numerous different kinds of literature, the questionnaire was developed. The survey asked about sociodemographic, health, educational, and attitude factors. The questionnaire contained multiple-choice and dichotomous questions. The content validity of the questionnaire received expert approval. It was initially written in English, translated into the native tongue, and then retranslated back into English in order to maintain consistency. The data was then gathered using the questionnaire's Amharic translation. Enumerators and supervisors completed a two-day intensive training programme to ensure the accuracy of the data. Similar to this, 5% of the overall sample population participated in field pre-test activities and role-playing exercises before the actual data collection.

The supervisor and the data collectors were both university graduates with advanced degrees, a Bsc and an MPH, respectively. Before giving the data collectors any necessary input, the supervisors and the main investigator reviewed each questionnaire each day during the data collection to ensure consistency and completeness. The internal consistency level of the pretest for the knowledge and attitude assessment characteristics ranged from 0.74 to 0.83, respectively.

Results

Overall, 100 of them returned their completed questionnaires. 70% of the respondents were male. 49 (49%) of the participants completed college and above education. 40 (40%) and 60 (60%) of the participants were daily laborers and housewives, respectively. About 33 (33%) of the study participants were feeling sick a month ahead of the data collection period. Also, 65 (65%) of the study participants were worried about paying when they feel sick.

Table 1: gender-wise distribution of subjects.

Gender	Number of subjects	Percentage
Males	70	70%
Females	30	30%
Total	100	100%

Out of 100 subjects, 70 were males and 30 were females.

The vast majority that is 95 (95%) of the respondents were aware of community-based health insurance. Their source of information was family, 49 (49%); television, 19 (19%); friends, 29 (29%) and magazine, 3 (3%), respectively. Taking the knowledge assessing questions into consideration, the composite score of the respondents having a good knowledge of CBHI was

55%. Taking the ten attitude assessing questions into consideration, the composite score of the respondents having a favourable attitude towards community-based health insurance was about 58%.

Discussion

The effect of individual behavior on health outcomes is considerable with estimates that up to 40% of premature deaths in the developed world are attributable to unhealthy behaviors, such as smoking, poor diet and sedentary lifestyle.¹¹ Reducing morbidity and mortality losses in the future is likely to depend as much on motivating changes in behavior as on developing new treatments or technologies and many countries and health systems are now directing resources to this end.^{12,13}

A range of tools are at the disposal of policy makers seeking to influence behavior including legislation, price signals (taxes and subsidies) and information campaigns. Although the use of incentives in wider public policy is nothing new, their role in encouraging health behaviors is a relatively recent phenomenon.¹⁴ Incentives can take a number of forms including cash or alternatively vouchers that can then be exchanged for desirable items. The apparent enthusiasm for using incentives to influence health behaviors has come about as the full economic and social costs of unhealthy behaviors have become apparent and with the finding that health behaviors can be significantly affected by the structure of economic incentives that individuals face.^{15,16} Examples of incentive schemes recently implemented in the United Kingdom include the 'Give It Up For Baby' programme in Tayside, Scotland to encourage pregnant smokers to quit the habit and the 'Pounds for Pounds' scheme in Kent, England to influence weight control.¹⁷ In diabetes care, incentive programs directed at patients show promise as a means to influence patient behavior and intermediate outcomes such as weight loss.¹⁸

In this study, overall, 100 of them returned their completed questionnaires. 70% of the respondents were male. 49 (49%) of the participants completed college and above education. 40 (40%) and 60 (60%) of the participants were daily laborers and housewives, respectively. About 33 (33%) of the study participants were feeling sick a month ahead of the data collection period. Also, 65 (65%) of the study participants were worried about paying when they feel sick. The vast majority that is 95 (95%) of the respondents were aware of community-based health insurance. Their source of information was family, 49 (49%); television, 19 (19%); friends, 29 (29%) and magazine, 3 (3%), respectively. Taking the knowledge assessing questions into consideration, the composite score of the respondents having a good knowledge of CBHI was 55%. Taking the ten attitude assessing questions into consideration, the composite score of the respondents having a favourable attitude towards community-based health insurance was about 58%.

The study revealed that 55% of the respondents had good knowledge of community-based health insurance. This finding was lower compared to the study finding from South Africa, 80.2%.¹⁹ Whereas it was higher compared to the study from Cameron 25.6%.²⁰ The discrepancy might be due to variation in geographical location, time, social norms, lifestyles, and/or different socio-economic conditions, and health information dissemination. The other possible justification for this difference might be due to the variation in the variables used to measure the knowledge level of CBHI for the current study and the former studies. This

shows that there is a discrepancy in awareness creation for residents from country to country due to different reasons. These could be due to low access to health education about the health insurance issue. This could also be due to the place where the study was done, religious aspect, social belief, low social media coverage, and many other reasons.

Moreover, about 58% of the study participants had a favorable attitude towards community-based health insurance. This finding was lower than the study findings of Tehulederie, Ethiopia.²¹ This finding was higher than the studies conducted in south India, 40%,²² and Nigeria, 52.5%.²³ This difference might be attributed from the spectrum of the study population at which the former studies focused at the national level while the current study is confined only at the specific-segmented population (informal workers). The finding indicated that a bit more than a quarter of the respondents (27.4%) got information from their family, which was lower than the study conducted in the Cameron littoral region of Douala, 61%.²⁰ This could be varied due to the variation in their educational status, poor communication within the family, and health system of the countries.

Conclusion

The unofficial workers had unfavourable attitudes and little understanding about community-based health insurance. To ensure that everyone has access to medical care, it is crucial to promote the usage of community-based health insurance.

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