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Barriers to Enrollment of National Health Insurance Scheme in Uttargaya Rural Municipality, Rasuwa

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A B S T R A C T

The Social Health Security Program (SHSP) is a social protection program of the Government of Nepal that aims to enable all citizens to access quality and effective healthcare services without any financial burden. A cross-sectional household-based and quantitative in-nature study was conducted in Rasuwa district. This study's population was residents of Uttargaya rural municipality wards no 4 and 5. How different factors are related to SHI enrolment. Ethnicity (p=<0.001), religion (p=<0.001), IWI grade (p=0.010), know about health insurance (p=<0.001), the behavior of service providers (p=<0.001), neighbors enrollment (p=<0.001), discussed SHI with neighbors (p=0.001), and family members agreed to enroll (p=0.002) were significantly associated with enrollment in SHI whereas others factors did not show any significant association with enrollment in social health insurance. This study found that enrollment was significantly associated with different independent variables. Poor knowledge of SHI, unfriendly behaviors of service providers, lack of trust, and unaffordability of premium costs were identified as barriers. Furthermore, Inappropriate timing of premium collection, limited services point, feeling that enrollment was not necessary, long queue, inadequate number of enrollment assistant and mandatory refer card were also reasons for not enrolling in SHI.

INTRODUCTION

People's health must be improved if there is to be sustained economic and social growth. As stated in the WHO Constitution, achieving the highest standard of health necessitates both a renewed or ongoing push for universal health coverage in many nations and robust measures to safeguard the advancements made in other countries. In order to attain universal health coverage, nations must establish financial frameworks that allow people to access all types of medical services without having to think about cost.

People have to pay directly for health care services when they use them, which is expensive. Most healthcare funding in a number of low and middle-income countries comes from individual pocket, causing unequal access to healthcare (2). Poor people can't afford health care, so they haven't had access to it. Concerned about this, the Fifty-eighth World Health Assembly suggested that health-financing systems in many nations need to be improved to ensure access to essential services and safeguard against financial risk. For the purpose of protecting against financial risks, prepayment and pooling of resources and risks received greater attention.

The National Health Insurance will ensure that an appropriate, efficient, and quality health service has access to everyone. The governments have been provided various services through health insurance schemes, i.e. medical allowance, free health checks, consultation, and medical treatment through its own organizational structure and resources. Community health insurance in Nepal had started more than 30 years by international NGO

In 2003/04, the MoHP implemented provider-based health insurance systems in two districts Nawalparasi and Morang and in four more districts in 2005/06. In 2002, the MoHP established the Health Economics and Financing Unit (HEFU), which is in charge of analyzing the Health Public Expenditure Review and National Health Accounts. HEFU started an evaluation of CBHI later in 2012 the purpose of this assessment was to evaluate CBHI's contribution and performance.

In 2014, the Nepal government develops and implements National Health Insurance Policy in order to achieve the UHC and SDG goals and then Government of Nepal was developed Social Health Security Development Committee on February 9, 2015, and it was published in the Nepal Gazette. Firstly, In 2016, National Health Insurance Program (NHIP) was implemented from three districts Kailai, Baglung, and Ilam(6). The Social Health Security Program (SHSP) is a social protection program of the Government of Nepal that aims to enable all citizens to access quality and effective health care services without any financial burden on them.

As of 2020, only 46.9% of the world population was successfully covered by at least one social safety benefit as of 2020 (Sustainable Development Goal (SDG) indicator 1.3.1), leaving the remaining 53.1 % i.e. 4.1 billion people completely unprotected. There are major discrepancies within and within areas, with coverage rates in Europe and Central Asia (83.9%) and the Americas (64.3%) above the worldwide average, whereas Asia and the Pacific (44.1%), the Arab States (40.0%), and Africa (17.4%) have significantly worse coverage gaps.

It's been 6 years that NHI came into operation but still coverage was around 12% of total population. Only 75% of people have renewed the scheme and dropout rate is in increasing trend. There are many reasons behind it as mentioned by different study such as lack of awareness about NHI scheme, high premium rate, inappropriate timing of enrollment, difficult process of accessing services, limited service point, poor quality of health care services, unavailability of drugs, rude behavior of health service providers etc. We can state that the Nepalese health system's journey toward UHC via NHI is just getting started. Therefore, this research was serving as yet another important foundation for gathering various data that may be related to factors that facilitate or hinder enrollment in the National Health Insurance program.

LITERATURE REVIEW

In 2003/04, the MoHP implemented provider-based health insurance systems in two districts Nawalparasi and Morang and in four more districts in 2005/06. In 2002, the MoHP established the Health Economics and Financing Unit (HEFU), which is in charge of analyzing the Health Public Expenditure Review and National Health Accounts. HEFU started an evaluation of CBHI later in 2012 the purpose of this assessment was to evaluate CBHI's contribution and performance.

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METHODOLOGY

Study Design and Setting

A cross-sectional household based and quantitative in nature study was conducted in Rasuwa district. Rasuwa is one of the mountain districts of Bagmati province. District headquarter is Dhunche. Rasuwa covers an area of 1,544 km² and has a population of 45,554 according to the census 2021. It is administratively divided into 5 rural municipalities. Uttargaya rural municipality was taken as a study site. The national health insurance scheme was initiated on 2077-11-01in Rasuwa.

Study Population

The study population for this study was residents of Uttargaya rural municipality ward no 4 and 5. Respondents for this study were senior members in absence of the head of the household during the time of data collection.

Sample Size

Sample size was calculated with the help of following standard formula.
I.e. n= $(Z\alpha/\mathrm{d})\ 2 * PQ$

n= required sample size
α =5% (desired level of significance)
$Z\alpha$= $Z0.05$ = 1.96 (from the normal table)
Prevalence= 35% (10).
Q=1-P=0.65
e= 0.05 (desired error)
n= (1.96/0.05)2 × 0.35 × 0.65=349.58~ 350
Again, for finite population
$n_{\circ}$ = n/(1+n/N)
$n_{\circ}$ = 350/(1+350/1191) = 271.31~ 271

Taking 10%, non-response rate then required sample size n= 271+27= 298.

Sampling Techniques

Rasuwa district and Uttargaya Rural Municipality was selected purposively then there are five wards in Uttargaya Rural Municipality. Out of which two wards were selected randomly (lottery method). Selection of enrolled households in each ward was done using stratified sampling technique. The list of enrolled household was taken from health insurance board, Rasuwa. For identification of enrolled household, help was taken from enrollment assistants, FCHVs and local leaders. After finding the enroll household through stratified sampling technique, Non-enrolled household were neighboring household present at any direction of enrolled households was selected for data collection.

Table 1. Sampling Techniques

S. N	Ward Number	Total Households	Enrolled Households	Total sample size for ward	Ward wise proportionate for Enrolled Households	Ward wise proportionate for Non-enrolled Households
1.	4	583	123	0.489*298=146	0.61*149=91	146-91=55
2.	5	608	78	0.51*298=152	0.388*149=58	152-58=94

Data Collection Technique / Methods

Data was collected through face to face interview with eligible respondents. Any respondents deny to participate in study was ignored and only 298 respondents were interviewed. For data collection, Kobo Toolbox (an android application) was used. Study tools were developed by reviewing the literature and consulting with a supervisor. The questionnaire was first developed in English language and then translated into the Nepal language to check consistency and easy for data collection.

Validity and Reliability of the Study Tools

Literature review was done for several times and consultation with expert and supervisor was done during the development of questionnaire. Developed questionnaire was pretested among the 10% of total sample size households of study area. Any mistakes found from pretesting were corrected before conducting actual study. Findings from pretesting were not including in preparation of study report. Also, a beta test (β-test) was done before data collection for identify any problems, issues, or bugs with the software as well as device. Beta test also determining the effectiveness of the software or hardware.

Data Management and Analysis Plan

Collected data was checked for completeness on daily basis after returning from the field visits. To prevent the risk of data loss, collected data from the application was sent to the respective Kobo toolbox profile on daily basis. Data was transferred to IBM SPSS Statistics for window version 16 and analyzed.

Study Variable

Dependent Variable

The dependent variable for this study was Enrollment of National Health Insurance Scheme.

Independent Variable

1. Socio-demographic variables include: Age, Gender, Religion, Occupation, Education of HH, Ethnicity, Household size, Wealth quintile, etc.
2. Health Problem Include: Susceptible to health problem, Suffering from any health problem, health status of family, presence of chronic illness etc.
3. Barriers to use SHI Scheme include: Knowledge about SHI, Availability of service provider, Behavior of service provider, Confidence in scheme, Timing of premium, Affordability, Distance to first contact point, Process of accessing services, Service point etc.
4. Other factors include: Peer influence, Discussed Health Insurance with neighbors, Family members agreed to enroll, Ability to make decision etc.

Inclusion Criteria or Exclusion Criteria

Inclusion Criteria

All people who are lived in Uttargaya Rural Municipality ward no 4 and 5, Rasuwa.

Exclusion Criteria

Participants with cognitive impairments or disabilities, those less than 18 yrs. people, and who refused to participate will be immediately excluded from the study.

RESULTS

Socio-demographic Characteristics

The median age and standard deviation of the household head was 45.12 and 11.125 respectively ranges from youngest 22 to oldest 69 years. Almost two third (202, 67.8%) of the households were headed by males, while (96, 32.2%) are female. The majority of households (189, 63.4%) are Brahmins/chhetri, followed by Janajati (92, 30.9%), and Dalits (17, 5.7%). the majority of households (212, 71.1%) follow Hinduism, followed by Buddhism (79, 26.5%), Christianity (4, 1.34%), Muslim (1, 0.3%)and other religions (2, 0.67%). the most common source of income for households is agriculture (168, 56.4%), followed by government job (44, 14.8%), business (32, 10.7%), and daily wages (19, 6.4%). The remaining households have other sources of income, such as foreign employment, private office, or other sources. Half of the household heads have up to secondary level education (150, 50.3%), followed by no formal education (73, 24.4%), and higher secondary education (75, 25.1%). Finally, the "IWI grade" column shows the distribution of households based on their Integrated Wealth Index grade. The highest percentage of households are classified as upper middle class (124, 41.6%), followed by middle class (120, 40.3%), rich (32, 10.7%), poor (19, 6.4%), and extremely poor (3, 1.0%).

Health Problem

According to the table, 79 out of 298 individuals (26.5%) are susceptible to some form of disease or health problem. Among those who are susceptible, (86.07%) have non-communicable diseases; while 8.8% have communicable diseases and (5.06%) have suffered from accidents or injuries. Large majorities (73.8%) of the respondents perceive their family's health status as average, while 25.5% perceive it as good and only 0.67% perceives it as poor. Around half (47.7%) of the respondents have experienced some form of health problems in the last 6 months, while the rest (26.5%) have not. About one-third (30.5%) of the respondents have under 5 years children in their families, while (27.5%) have elderly individuals above 60 years old. More than one-third (31.5%) of the respondents have chronic illnesses in their families, and among those, the most common chronic illnesses are gastritis (38.29%), asthma or respiratory problems (20%), and joint or arthritis (12%).

Barriers to use SHI Scheme

This table presents data on various aspects related to the health insurance scheme. Out of 298 respondents, (170, 57%) reported that they knew about the health insurance scheme, while (128, 43%) did not. Most respondents (271, 90.6%) reported that service providers were frequently available when visiting health facilities. The majority of those who knew about the health insurance scheme (143, 84.1%) reported that it helped to reduce the financial burden, while (27, 15.8%) reported that it did not. Among those who reported that the health insurance scheme did not reduce the financial burden, limited service points (21, 58.33%) were the most commonly reported reason.

Most respondents agreed that health insurance helps in emergency medical treatment (154, 90.5%) and to seek early treatment (148, 87.05%). Most

of research participants (148, 87.05%) said Health insurance help to seek early treatment also (164, 96.4%) research participants said they could afford their health insurance premiums. However, (122, 71.8%) of the respondents reported that the introduction of insurance only in limited health facilities led to a decline in service utility. Of those who reported that the quality of health care services was not satisfactory (7, 10.93%), lack of health services and medicine (25, 39.06%), waiting time (21, 32.81%) and distance of health institutes (11, 17.18%) was the commonly reported reason. Furthermore, almost half of the respondents (84, 49.1%) reported that using health services included in the insurance scheme was difficult, while (86, 50.5%) reported that it was easy.

Other Factors

Out of the total sample, 52.3% reported having neighbors who were enrolled in the social health insurance scheme, while 46.9% did not. Among the participants, 52.3% had discussed the social health insurance scheme with their neighbors, while 47.6% had not. Regarding the enrollment of family members, 56.3% of the participants reported that their family members agreed to enroll in the social health insurance scheme, while 43.6% reported that their family members did not agree to enroll.

Table 2. Descriptive Statistics

Variables	Number (Frequency)	Percent (%)
Socio-demographic Characteristics		
Age of household head		
Median age=45.12		
standard deviation = 11.125		
Gender of households head		
Male	202	67.8
Female	96	32.2
Caste		
Brahmin/ Chhetri	189	63.4
Janajati	92	30.9
Dalit	17	5.7
Religion		
Hindu	212	71.1
Buddhism	79	26.5
Others	7	2.4
Main source of income		
Agriculture	168	56.4
Government job	44	14.6
Business	32	10.7
Daily wages	19	6.4
Foreign employment	13	4.4
Private Office	7	2.3
Others	15	5.0

Education of household head		
Up to secondary level	150	50.3
Higher secondary education	75	25.1
No formal education	73	24.4
Family type		
Nuclear	195	65.4
Joint	103	34.6
Family size		
Less or equal to 5	236	79.1
More than 5	62	20.8
IWI grade		
Extremely poor	3	1.0
Poor	19	6.4
Middle class	120	40.3
Upper middle class	124	41.6
Rich	32	10.7
Health Related Characteristics		
Susceptible to Any Disease or Health Problem		
Yes	79	26.5
No	219	73.4
If yes, what type of diseases(n=79)		
Non-communicable Diseases	68	86.07
Communicable Diseases	7	8.8
Accident/Injuries	4	5.06
perceive health status of family		
Average	220	73.8
Good	76	25.5
Poor	2	0.67
Health Problems experience In The Last 6 Months		
Yes	142	47.7
No	156	52.3
Presence of under 5 years children		
Yes	91	30.5
No	207	69.4
Presence of elderly (above 60)		
Yes	82	27.5
No	216	72.4
Presence of Chronic illness in family		
Yes	94	31.5
No	204	68.4
If yes, which disease related(n=94)		
Gastritis	67	38.29
Asthma or Respiratory problem	35	20
Joint or Arthritis	21	12
Uric Acid	20	11.43
Mental related	14	8

Thyroid diseases	8	4.57
Diabetes	4	2.28
Heart-related problem	3	1.71
Kidney related	2	1.14
Cancer	1	0.57
Barriers to used SHI Scheme		
you know about health Insurance scheme		
Yes	170	57
No	128	43
availability of service providers while visiting health facility		
Not available frequently	27	9.06
Frequently available	271	90.9
Health Insurance scheme helps to reduce the financial burden (n=170)		
Yes	143	84.1
No	27	15.8
If no, What is the reason behind this (n=27)		
expensive entry premium	8	22.2
limited service point	21	58.33
every year must be renew	2	5.5
unavailability of services and drugs	3	8.3
Others	2	5.5
health insurance helps in emergency medical treatment (n=170)		
Agree	154	90.5
Disagree	16	9.4
Perception about the quality of health care services (waiting time, availability of drugs) (n=170)		
Not satisfactory	34	20
Satisfactory	136	80
If Not satisfactory, What is the reason behind this (n=34)		
low-quality of health services	7	10.93
lack of health services and medicine	25	39.06
waiting time	21	32.81
distance of health institutes	11	17.18
Health Insurance helps to seek early treatment (n=170)		
Agree	148	87.05
Disagree	22	12.9
behavior of service providers (n=298)		
Friendly	59	19.79
Average	239	80.2
premium cost of health insurance(n=170)		

Affordable	164	96.4
Unaffordable	6	3.5
timing of premium collection (n=170)		
Appropriate	160	94.1
Inappropriate	10	5.8
time require to reach the service point(n=170)		
More than one hour	56	32.9
Within one hour	114	67.05
Easy of Using Health Services Included in Insurance Scheme (n=170)		
Difficult	84	49.1
Easy	86	50.5
Does the introduction of insurance only in limited health facilities lead to a decline in service utility(n=170)		
Yes	122	71.8
No	48	28.2
Others Factors		
Having neighbors with enrollment		
No	140	46.9
Yes	158	52.3
Discussed about SHI with neighbors		
No	142	47.6
Yes	156	52.3
Family members agreed to enroll		
No	130	43.6
Yes	168	56.3

Analytical Analysis

Association between Dependent and Independent Variable

The table shows how different factors are related to SHI enrolment. Ethnicity (p=<0.001), religion (p=<0.001), IWI grade (p=0.010), know about health insurance (p=<0.001), behavior of service providers (p=<0.001),neighbors enrollment (p=<0.001), discussed about SHI with neighbors (p=0.001), and family members agreed to enroll (p=0.002) were significantly associated with enrollment in SHI whereas others factors did not show any significant association with enrollment in social health insurance.

Logistic Regression on Independent Variable and Enrollment

The table presents correlation coefficients (COR) and their corresponding 95% confidence intervals (95% CI) for various socio-demographic characteristics and factors influencing health insurance enrollment. In terms of ethnicity, individuals belonging to the Dalit and Janajati groups exhibit positive correlations of 2.716 and 16.293, respectively, compared to the reference group Brahmin/Chhetri. The religion category shows that individuals practicing Buddhism have a notably lower correlation of 0.145, denoted as statistically

significant with three asterisks, while individuals following other religions exhibit a correlation of 0.553. Regarding Index of Wellbeing (IWI) grade, the "Poor" category shows a positive correlation of 2.267, and the "Middle class" category demonstrates a statistically significant negative correlation of 0.133. Barriers to using the health insurance (SHI) scheme, such as lack of awareness (COR=0.131), and factors related to service providers' behavior and social interactions, such as average behavior (COR=0.328) and not having neighbors enrolled (COR=0.556), also display correlations. These findings provide insights into the relationships between socio-demographic factors and health insurance enrollment, highlighting potential influencing factors that may contribute to disparities in enrollment patterns within the studied population.

Table 3. Inferential Statistics

Variables	**Enroll household N=149**	**Not-enroll household N=149**	**p-value**	**Cramer's V**	**COR**	**95% CI**
	No. (%)	**No. (%)**				
Socio-demographic characteristics						
Ethnicity			**<0.001**	**0.289**		
Brahmin/chhetri	105 (55.6%)	84 (44.4%)			Ref	
Dalit	15 (88.2%)	2 (11.8%)			2.716	1.606-4.591
Janajati	29 (31.5%)	63 (68.5%)			16.293	3.494-75.968
Religion			**<0.001**	**0.284**		
Hindu	123 (58.0%)	89 (42.0%)			Ref	
Buddhism	21 (26.6%)	58 (73.4%)			0.145***	0.026-0.804
Others	5 (71.4%)	2 (28.6%)			0.553	0.105-2.914
IWI grade			**0.010**	**0.212**		
Extremely poor	2 (66.7%)	1 (33.3%)			Ref	
Poor	2 (10.5%)	17 (89.5%)			2.267	0.186-27.582
Middle class	64 (53.3%)	56 (46.7%)			0.133***	0.026-0.675.
Upper middle class	66 (53.2%)	58 (46.8%)			1.339	0.613-2.927
Rich	15 (46.9%)	17 (53.1%)			1.249	0.573-2.720
Barriers to use SHI scheme						

you know about health Insurance scheme			**<0.001**	**0.461**		
Yes	119 (70.0%)	51 (30.0%)			Ref	
No	30 (23.4%)	98 (76.6%)			0.131	0.078-0.222
behavior of service providers			**<0.001**	**0.211**		
Friendly	17 (28.8%)	42 (71.2%)			Ref	
Average	132 (55.2%)	107 (44.8%)			0.328	0.177-0.609
Others factors						
Having neighbors with enrollment			**<0.001**	**0.202**		
Yes	94 (59.5%)	64 (40.5%)			Ref	
No	55 (39.3%)	85 (61.7%)			0.556	0.246-1.252
Discussed about SHI with neighbors			**0.001**	**0.188**		
Yes	92 (59%)	64 (41%)			Ref	
No	57 (40.1%)	85 (59.9%)			0.785	0.226-2.726
Family members agreed to enroll			**0.002**	**0.183**		
Yes	97 (57.7%)	71 (42.3%)			Ref	
No	52 (40%)	78 (60%)			0.958	0.014-1.506

DISCUSSION

An analytical cross sectional study was conducted in uttargaya rural municipality, Rasuwa. A total of 298 people were participated in the study. This study demonstrated a relationship between household head's ethnicity and SHI enrollment, with families headed by men being more likely to enroll in SHI. Similar to this, a research in northwestern Ethiopia discovered that households led by men were more likely to enroll than those headed by female (11) . With respect to the research carried out in Nepal's Rautahat District, this finding was in contrast (12). However, meta-analysis suggests that CBHI participation was positively associated with households headed by women (13). Finding that households with a male head were more likely to enroll in SHI points to the male-dominated society of Rasuwa, where men hold the majority of decision-making roles.

Ethnicity was found to be associated with Social Health Insurance enrollment. Underprivileged ethnic groups i,e janajati had a lower likelihood of

enrolling in SHI than privileged ethnic groups, which include Brahmin, Chhetri also Underprivileged ethnic groups Dalit. Similar research from Nepal provides support for this finding(12)(14). This may be because those from higher castes or ethnic groups may have more access to resources like information and services. In this study, the main source of income and Social Health Insurance enrollment not showed any significant association. Similarly, a study from Bhaktapur, Nepal found a significant association between occupation and utilization of Social Health Insurance (15). also household head education status and enrollment in social health insurance were not significantly associate. Simarly others study also not found a significant association(15)(12)(16). This suggests that low-income people might not be able to afford the essential insurance program premiums or payments. However, a research from the northwest of Ethiopia found that households with poor and middle wealth index were more likely enroll into CBHI scheme compared to the rich wealth index(17).

The decision to participate in social health insurance programs increases with perceived susceptibility to health issues or diseases. This conclusion is backed by additional researches(18) (19)which showed that individuals who felt vulnerable to health issues were more likely to enroll in HI. The likelihood of enrolling in health insurance was higher for individuals who thought their family's health was in poor condition than for those who thought it was in excellent standing. This outcome agrees with research from India(20), northwest Ethiopia(11), and western Ethiopia(17). However, there was no such association found between perceived health status and enrollment in one previous study. Illness experience in previous six months, Presence of children under the age of 5 years, was fond no significantly associated with enrollment. There was no association between SHI enrollment and presence of senior (over 60) family members. However, similar studies (12)(10) did not support this outcome. Having chronically ill members in family increase the probability of enrollment. This was consistent with findings of many researches form Nepal(21)(22)(10) and Ethiopia(11).

Having good knowledge about SHI increased the enrolling in SHI, indicating a strong relationship between knowledge and enrolment. A meta-analysis from LMICs (13), as well as studies from Ethiopia (13)(20) (20) and Nepal (23) confirmed this fact. This suggests that knowledge was one of the barriers for enrollment in SHI scheme. The perception of service providers' rude and ignorant behavior toward insured patients was discovered to be significantly related to SHI enrollment. Studies conducted in Nepal (23)(24)(19) and Ethiopia (25)(26) also supported this assertion.

Peer influence from neighbors who are enrolled in SHI and respondents who have discussed SHI with neighbors were found to be statistically significant predictors and facilitators of enrolment, followed by family members' approval. Additionally, past researches (11) (18) (19)also supported this. Inappropriate timing of premium collection, limited services point, feeling that enrollment was not necessary, long queue, inadequate number of enrollment assistant and mandatory refer card were identified as causes for

non-enrollment. These explanations were somewhat consistent with earlier research (27)(24).

Despite the serious issues raised above, this study uses a cross-sectional design. As a result, it is challenging to confidently draw strong causal relationships between SHI enrolment and its factors. Further research using both a quantitative and a qualitative study design is suggested in order to better understand the drivers of the low coverage of SHI and supply side concerns.

CONCLUSIONS AND RECOMMENDATIONS

This study found that enrollment was significantly associated with different independent variables. Socio-demographic variables such as the household head's ethnicity, Religion, and IWI (international wealth index) grade were found to be statistically significant in relation to enrolment in the SHI scheme. Further, Know about health insurance scheme, Behavior of service providers was discovered to be significantly associated with enrolling in SHI.

Poor knowledge of SHI, unfriendly behaviors of service providers, lack of trust, and unaffordability of premium costs were identified as barriers. Furthermore, Inappropriate timing of premium collection, limited services point, feeling that enrollment was not necessary, long queue, inadequate number of enrollment assistant and mandatory refer card were also reasons for not enrolling in SHI. However, the most significant indicators for increasing enrollment coverage were having neighbors who had SHI membership, discussion about SHI with neighbors, and family member's approval. However, there was no conclusive significant association between Genders, the main source of income, the household head's education, the size of the family, susceptible to health problem, Perceive health status, suffering from health problems, presence of fewer than 5 children, the presence of elderly people, and presence of chronic diseases.

FURTHER STUDY

This research still has limitations so further research on the topic still needs to be carried out “Barriers to Enrollment of National Health Insurance Scheme.”

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