

# Community health insurance in Uganda: Why does enrolment remain low? A view from beneath

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## Abstract

Community Health Insurance (CHI) in Uganda faces low enrolment despite interest by the Ugandan health sector to have CHI as an elaborate health sector financing mechanism. User fees have been abolished in all government facilities and CHI in Uganda is limited to the private not for profit sub-sector, mainly church-related rural hospitals. In this study, the reasons for the low enrolment are investigated in two different models of CHI. Focus group discussions and in-depth interviews were carried out with members and non-members of CHI schemes in order to acquire more insight and understanding in people's perception of CHI, in their reasons for joining and not joining and in the possibilities they see to increase enrolment. This study, which is unprecedented in East Africa, clearly points to a mixed understanding on the basic principles of CHI and on the routine functioning of the schemes. The lack of good information is mentioned by many. Problems in ability to pay the premium, poor quality of health care, the rigid design in terms of enrolment requirements and problems of trust are other important reasons for people not to join. Our findings are grossly in line with the results of similar studies conducted in West Africa even if a number of context-specific issues have been identified. The study provides relevant elements for the design of a national policy on CHI in Uganda and other sub-Saharan countries.

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## 1. Introduction

Community Health Insurance (CHI) is seen as a promising mechanism to increase access to health care and to generate additional financial resources for health

services [1]. It has an important comparative advantage over user-fees through the pooling of risks and resources it implies [2]. The World Health Organisation has pointed out that in those countries with a small formal sector, the only viable way of promoting pooling of financial reserves is at community level [3].

The current coverage of CHI remains low. There is need to have more insight on why this is so. We hypothesize that people may have rational and understandable reasons for not joining CHI. Studies carried

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out in West Africa have tried to investigate the causes of this low enrolment. In a study in Burkina Faso, for instance, the low demand for CHI was attributed to institutional rigidities in the timing of the collection of the premium rather than to poverty per se [4]. Another study conducted in Guinea Conakry pointed to the poor quality of care in the health services as one of the main causes of the low and even declining enrolment in CHI despite initial enthusiasm at the set up of the scheme [5]. There are, however, no similar elaborate studies that have been conducted in Uganda or in any other East African country for that matter.

In this paper, the findings of a qualitative study investigating the reasons for the low enrolment are presented. The study explored people's perception of CHI. It also provides useful policy lessons concerning the place and role of CHI in Uganda. This study presents useful insights in the design of interventions aimed at increasing enrolment in CHI.

The paper is structured as follows; the first part of the paper situates Ugandan CHI schemes in a wider international perspective. In the second part, the Ugandan health system is briefly presented and the main features of Ugandan CHI schemes are highlighted. In the third part, we present our research questions in more detail and describe the methodology used in the study. The results and their discussion are then presented in the fourth and fifth part respectively. In our conclusion, we present some of the areas that still remain to be explored in more detail.

## 2. Context

The Uganda health care system is pluralistic in nature; it has a public owned sub-system providing 60% of the health units, the Private Not for Profit (PNFP) providing 30% and the remainder (10%) is by the private for profit sub-sector. The PNFP health units are often in remote underserved areas and often the only provider. The total health expenditure in Uganda is estimated to be US\$ 20 per capita per annum. Of this, 58% is private out of pocket expenditure, 22% from the government and the remainder 20% is from donors. CHI is one of the mechanisms envisaged in the Ugandan health sector strategic plan 2005/6-2009/10 to finance health services. The Ugandan government abolished

user-fees in 2001 in the general wings of public hospitals. User-fees in private not for profit health units provide over 50% of the hospitals running expenses. Patients are unable to meet the treatment costs [6]. The provider-based model of CHI was introduced by these hospitals so as to offer a mechanism for paying for health care that does not directly relate to the time of need of care. Also, CHI was to provide a stable source of income for the hospitals. The public perceive PNFP health units as offering better care than public units. Despite abolition of user-fees, the out of pocket expenses have kept high thus financial accessibility has remained a challenge and unsustainable. The Ugandan government has now put up a program to promote CHI schemes since 2005. A 2006 country inventory of CHI schemes showed low enrolment despite promotion of CHI schemes in Uganda since the mid 1990s. There are 40,000 people enrolled in the schemes out of a target population of over half a million in the districts with schemes. Moreover, the total number of schemes has not exceeded 14. Most of the schemes provide in-patient and out-patient care including deliveries at the facility where the scheme is based or the facility contracted by the scheme to provide services. The type of services in PNFP hospitals (faith-based) are believed to be of a good and relatively higher quality than public-owned hospitals. The majority of CHI schemes in Uganda are provider-based plans that target community groups as clients and do not cater for care at health centres and other lower level units. Provider-based schemes are owned by the facility itself and are usually managed by facility staff, thus resembling health maintenance organizations. However, an alternative model of CHI has been implemented in Uganda in recent years: the community-owned model where a member organisation is actually the insurer. A group is defined as people involved in an activity, having a register and minute record of their regular meetings. A group could also be a village (smallest administrative area with a population of 1000 people). There has not been a situation where two schemes operate in the same area. There are also no specific regulations in Uganda limiting the number of schemes. The Ministry of Health is in the process of formulating of a draft bill to regulate CHI schemes. The umbrella organisation of CHI Schemes in Uganda, Uganda Community Based Health Financing Association has not been able to steer the process of increasing the enrolment into schemes

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