Strategies for sustainability and equity of prepayment health schemes in Uganda

Kyomugisha EL[1], Buregyeya E[1], Ekirapa E[1], Mugisha JF[2], Bazeyo W[1]

1 - Makerere University School of Public Health
2 - Regional Centre for Quality of Health Care, Kampala

Abstract

Background: Despite the long existence of community health insurance schemes (CHI) in Uganda, their numbers and coverage levels have remained small with limited accessibility by the poor.

Objectives: To examine issues of equity and sustainability in CHI schemes, which are prerequisites to health sector financing.

Methods: We carried out a descriptive cross-sectional study employing qualitative techniques. Eight focus group discussions (FGDs) with CHI scheme members and seven FGDs with non-members were held. Twelve Key informant interviews (KIs) were held with scheme managers, officials from Ministry of Health and one health financing organisation. We reviewed relevant documents and records of schemes.

Results: Respondents' perceptions of unfairness in schemes were: non-members were treated better in hospital than members; some members pay premiums continuously without falling sick and schemes refused to cover illnesses like diabetes and hypertension. Fairness was related with the very little payment for the services received, members paying less than non-members but both getting the same treatment and no patient discrimination based on gender, age or social status. Schemes are not sustainable because they operate on small budgets, have low enrolment and lack government support. Effect of abolition of user fees on scheme enrolment was minimal..

Conclusion Government should ensure that quality of health care does not deteriorate in the context of increased utilisation after user fees removal, schemes need substantial support to build their sustainability and there is need for technical and policy considerations about whether or not CHI has a role to play in Ugandan health system.

African Health Sciences 2009; 9(S2):S59-S65

Introduction

In the early 1980s, the sub-Saharan African region implemented a series of reforms in which governments encouraged the use of medical insurance, even at community level, to promote equity in the use of health services[1, 2]. In Uganda in 1995, the Ministry of Health's Planning Department initiated a community health-financing project as a way of developing alternative health financing strategies[3, 4, 5].

Community prepayment schemes (same as Community Based Health Insurance schemes) are schemes where individuals or households in a community voluntarily pay a certain predetermined amount of money and in return they receive a benefit package consisting of health services. CHI schemes may entirely be funded by the community members' contributions or may be supported by funds from both member contributions and another health provider mostly a non-governmental organisation (NGO) or a private hospital. A management committee or a team is responsible for administering the funds to support services at a chosen health facility. In this study, one of the schemes visited was NGO supported with some member contributions, one was a purely community-based with all contributions from members and two were private hospital supported with some member contributions. See Table 1 below.

Corresponding author
Eunice L. Kyomugisha
P.O. Box 4371
Kampala, Uganda
E-mail: kyomugisha80@yahoo.com
Telephone number: +256752664654

Table 1: CHI Schemes visited per district and source of funding

Schemes	District	Source of funding
1. Ishaka Hospital Adventist Health Plan	Bushenyi	Ishaka Adventist Hospital and contributions from members
2. Mother to Child Rescue Health Plan	Bushenyi	All contributions from members
3. Kitovu Hospital Pre-Payment Health Plan	Masaka	Kitovu Hospital and contributions from members
4. Save for Health Uganda - Luwero	Luwero	Save for Health NGO and contributions from members

The above schemes directly provide health care though the type of diseases covered may differ from scheme to scheme. Where treatment for diabetes, hypertension or major surgeries are not covered, members are allowed to seek care from another source but payment will entirely be met by the patient.

While community-health financing has been in Uganda for over ten years, and was initially started to serve the poor communities, there appears to be not more than ten CHI schemes in total and the poor still appear to face barriers in accessing health care services from these schemes. In this study, we assessed whether or not community health insurance (CHI) schemes were equitable and sustainable. What is meant by these two terms? Equity in health requires us to address differences in health status that are unnecessary, avoidable and unfair. Equity-motivated interventions seek to allocate resources preferentially to those with the lowest health status, which requires us to understand and influence the redistribution of social and economic resources for equity-oriented interventions, and understand and inform the power and ability that people (and social groups) have to make choices over health inputs and use these choices for their better health[6]. Sustainability may be defined as the capacity of the schemes to cover their costs of continued operation, without requiring external subsidies[7, 11].

The study aimed to assess community perceptions of equity and sustainability in CHI schemes, distinguishing whether these perceptions reflected a desire for equal health care for all people (horizontal equity) or a desire for more health care for those with greater needs (vertical equity). We looked at people's perceptions of equity when joining and accessing health care services in schemes and their perceptions of sustainability with regard to the role of CHI schemes after the abolition of user fees, including dropout levels, coverage levels, revenue contributions and expenditures, and their role in financing health services and thereby moving towards social health insurance (SHI).

Methods

We employed a cross-sectional design and used qualitative data collection methods, which included focus group discussions and key informant interviews. The methods were an important means for validating verbal information on key issues of equity and sustainability.

Sampling was purposive and in each of the 4 schemes visited, two FGDs consisting of members were held thus making a total of 8 FGDs with scheme members. One group of members consisted of secondary school children and this was the only school group registered in a CHI scheme among the schemes visited at the time; which made it a unique case. Another category of FGDs was of non-members of the schemes and a total of seven FGDs were held in the four schemes visited. The non-members were those who dropped out of the schemes and those who had never joined the schemes. For those who dropped out of the schemes, one FGD from each scheme was held, making a total of 4 FGDs. For those who had never joined the schemes, one FGD from each scheme was held, making a total of 3 FGDs. In one scheme, however, it was not possible to bring together a group of those who had never joined the scheme. In total, 15 FGDs were conducted for the whole study. Twelve participants were expected in each FGD to make a total of 180 participants but instead 158 participants were involved.

Selection of scheme members to participate in FGDs was done randomly from the enrolment registers of the schemes that were provided by the scheme managers. The same criteria was used to select those who had dropped out of the schemes and for those who had never joined, we randomly selected them from the local council lists provided by the local council chairmen. During FGDs with scheme members, men and women were interviewed separately in order to capture any gender dynamics on equity and sustainability while, for the non-members, men and women were mixed. For each FGD, there was a moderator and a note taker.

A tape recorder was used in each FGD. All FGD participants were drawn from the catchment areas of the four CHI schemes which were located in three districts as indicated in Table 1.

Key informant interviews (KIIs) were held with scheme managers, officials from the Ministry of Health (MoH) both at the headquarters and in the districts and staff from the Uganda Protestant Medical Bureau, a faith-based NGO. Eighteen people were interviewed. We also reviewed existing literature on the equity and sustainability of CHI schemes, including financial and managerial data. Literature included Ministry of Health studies, policy documents, research reports and other relevant documents that the team accessed from the schemes.

To ensure quality control, data collection tools were pre-tested and research assistants were trained and supervised. During data collection, debriefing meetings were held at the end of each day to review data and identify any omissions and errors. Data management included audio-taping all interviews and transcribing and typing them as Microsoft Word documents. Data was coded and grouped according to the study themes. Labels were developed after a review of the data and data that belonged to the same code was listed together under the respective label. Our analysis was conducted using a master sheet along the main themes of the study. Key concepts per theme were synthesised and the numbers of FGDs and key informants who reported each concept were noted and majority responses were identified. Deductions from the synthesised data were made and verbatim key quotations from informants were incorporated to enrich the analysis, after which discussions followed.

Ethical approval was sought from the Makerere University Institute of Public Health Higher Degrees Research and Ethics Committee and from the Uganda National Council of Science and Technology. Permission to carry out the research was received from the relevant district local governments. Informed consent was sought from all study participants. A consent form bearing assurance regarding discomfort, likely benefits and rights and confidentiality of data was presented to each adult participant for signature. For the school children, the school head teacher was asked to give permission for interviews to be carried out with pupils in his school. Table 1 lists the various study sites and the respondents in the FGDs and key informant interviews.

All interviews were audio-taped, transcribed and typed as Microsoft Word documents. Data was coded and grouped according to the study themes. Labels were developed after a review of the data and data that belonged to the same code was listed together under the respective label. Our analysis was conducted using a master sheet along the main themes of the study. Key concepts per theme were synthesized and majority responses were identified. Deductions from the synthesised data were made and verbatim key quotations were incorporated to enrich the analysis.

Results

Geographical coverage of prepayment schemes and dropout rates

The geographical coverage of CHI schemes was found to be limited and the schemes we visited were all operating within a radius of 20 to 25 kilometres. Membership in the schemes varied and so did dropout rates, and these affected revenue contributions and expenditures of the schemes. *Table 2* presents details. The figures marked with an asterisk in the table show the years when the schemes (apart from Save for Health) were operating on a deficit.

Table 2 shows membership increases for schemes 1, 2 and 3 and fluctuations for scheme 4. There were high dropout rates in 2005 under scheme 1. Scheme 3 has steadily reduced its dropout rates, while they have increased with scheme 4. However, scheme 4 did not have any dropouts in 2006. Dropout rates for scheme 2 were high in 2005, when schools were no longer allowed to enrol as members.

Table 2: Membership, dropout rates, revenues and expenditure for four CHI schemes

Year	Levels of membership	Dropouts No. (%)	Revenue Contributions (Ugandan shillings)	Expenditure (Ugandan shillings)
Scheme 1: Mother-to-child Rescue Health Plan				
2004	372	64 (17%)	5,580,000	6,500,000*
2005	284	152 (52.5%)*	4,260,000	5,400,000*
2006	484	20 (4.1%)	7,260,000	7,750,000*
2007	556	0	8,340,000	8,840,000*
Scheme 2: Kitovu Prepayment Plan				
2004	1,593	46 (2.9%)	3,467,875	4,933,953*
2005	1,236	242 (19.6%)*	2,947,775	4,788,189*
2006	884	78 (8.8%)	2,308,900	3,230,772*
Scheme 3: Save for Health Uganda Scheme				
2004	2,156	258 (12%)	5,965,700	2,290,950
2005	3,806	268 (7%)	10,255,700	4,860,650
2006	4,077	281 (6.9%)	11,040,900	6,782,500
2007	5,118	N/A	14,185,600	6,393,700
Scheme 4: Ishaka Adventist Health Plan				
2004	1,345	145 (10.8%)	16,948,895	26,331,291**
2005	1,145	200 (17.5%)	14,308,542	25,772,061**
2006	1,246	0**	14,571,362	16,115,760**
2007	1,030	216 (21%)	12,459,650	12,359,650

Source[8]

Equity and sustainability of CHI schemes: Community perceptions

Participant in FGDs and respondents in key informant interviews perceived fairness in terms of non-discriminatory and voluntary joining of the schemes, allowing people to join irrespective of family background. Fairness was also related to the very little payment for the services received, members paying less than non-members but both getting the same treatment and no discrimination towards patients based on gender, age or social status.

We pay less than non members of the scheme at the health facilities but we all get the same treatment. This is very fair.

FGD participants, Luweero, Masaka and Bushenyi districts

Participants explained that unfairness was about not allowing individuals without families to join and expecting members to continue paying premiums even when they were not sick. Further, for members to enrol, they had to be members of an already existing community-based organization and at least 60% of the organisation's members had to join before they could start accessing health services. In some schemes, another inequity was perceived in the limit imposed on families, who may register no more than four members in their insurance contracts, which is clearly prejudicial to big families.

Both FGD participants and Key Informants concurred that the most vulnerable and needy in society such as orphans, the elderly and the disabled, are not exempt from payment, even though they usually have greater health needs than the rest of the population.

But on the other hand, the schemes are not equitable because a rich man in the village pays the same amount as the poor man

Key informant interview, Ministry of Health.

The most needy people in our community especially the orphans, the disabled and the elderly still pay in the schemes. They have more health needs and should be excused.

FGD participants, Bushenyi, Masaka and Luweero

The inability to cater for chronic illnesses like diabetes and high blood pressure was considered unfair. Participants also perceived unfairness in the way non-members were often given better treatment than members in CHI health facilities because non-members pay cash for treatment and usually pay more than members, so health workers feel they should be given first priority in treatment:

*We should not be made to wait to get treatment simply because we pay less money than non- members. We all deserve equal treatment.*FGD, scheme

member participants – Ishaka Adventist Health Plan.

A unique group of CHI members consisted of students. At their school, enrolment in the scheme was mandatory to help them prevent incurring high costs when they fell sick, but the students saw it as unfair. The process was undemocratic because they were enrolled without their consent or their parents' consent. The problem is compounded because the premium is deducted from their school fees, which means they are excluded from treatment at the scheme's health facility if they have not paid their fees in full.

Some of us take long to pay school fees and we are not allowed to get treatment from the scheme until the fees debts are cleared. The school did not consult us neither our parents, about enrolling into the scheme; which was unfair. We were only informed after the decision was made.

FGD with school children, Ishaka Adventist Health Plan.

Both FGDs and Key Informants' perceptions of sustainability covered four key aspects: continuity and members' sense of ownership of their health programmes, good leadership, behaviour of health workers and participatory planning. While Key Informants wanted schemes that operated as long as possible, allowing members to take ownership of their programmes without it being forced on them, FGD participants felt that schemes can run on their own if they had good leadership that can support them start income generation activities and attract more members. If attitudes of health workers towards scheme members improved, more members would join and sustainability of the schemes would be achieved, FGD participants added.

We would sustain ourselves better if membership in the scheme was high but because some health workers are rude; some members keep dropping out of the scheme.

FGD participants, Ishaka Adventist Health Plan

Participants further noted that continuity was also dependent on high membership enrolment levels, which are still too low due to a poor understanding among communities of the concept of pooling risks – communities need to be sensitised to this concept. Key informants observed that members' involvement in planning and decision making was crucial in sustaining CHI schemes. Members are usually informed about already made decisions by the top management of the schemes, which was also revealed during FGDs.

When new premiums are set by the management, members are only informed about the steps that were taken in deciding the new premium calculation. They are therefore not involved in planning for premiums and other policy issues. They are informed.

Key Informant interview, Kitovu Pre-payment Plan.

Some Key Informants were concerned that the lack of a legal framework and policy that should govern CHI schemes could make a number of people doubt the operations of CHI and therefore decide not to join or leave if already members. It is a serious issue that needs to be looked into by Uganda by the lead umbrella organisation.

The role of CHI schemes after the abolition of user fees

FGD participants revealed that abolition of user fees in government health facilities did not negatively impact on enrolment into the schemes. Other CHI schemes lost members to government health facilities for the first few months after fees were scrapped, but they soon returned because the quality of service in government health facilities was reported to be poorer, with congestion, long queues and lack of staff. For instance, in the *Mother-to-child Rescue Health Plan*, it was reported that the number of scheme members increased from 25 to 112 in the year that user fees were abolished.

Role of prepayment schemes in financing health and moving towards SHI in Uganda

Key informants thought the role of schemes was direct and indirect: directly, members contribute to their own health care and, indirectly, to those who use government health facilities elsewhere – they reduce congestion and levels of utilisation of those services. Further, schemes provide some funds for the procurement of drugs and payment of equipment for the health facilities to which they are attached. This local subsidy enables the provision of good health care services. Public health facilities do not provide for all the health needs of the people and so organising the communities to pay for their own health care was thought to be a significant contribution to health care financing.

Key informants further noted that CHI has a role to play in moving Uganda towards SHI because members in CHI already understand the benefits of health insurance. They know the challenges, have experienced some successes and can learn how to help communities embrace health insurance.

Therefore, it was suggested that SHI should be a community health programme in partnership with government to design policies and guidelines and clearly define the roles of CHI and SHI:

> *The CHI schemes should be the ones feeding the SHI on what is being done at community level. The SHI should be facilitating the CHI.*
>
> Key informant – Masaka district.

General assessment of the schemes studied

An overall assessment of the four schemes studied shows that Save for Health, Luweero scheme was better at enrolling members and has experienced lesser deficits compared to the other 3 schemes. Whereas Kitovu Pre-payment Plan and Ishaka Adventist Health Plan seemed to top up some costs of surgery for members of their schemes, it was not the case with Mother to child Rescue Health Plan and Save for Health, Luweero. In provision of treatment, ailments such as high blood pressure and diabetes, common among the elderly, were not catered for by all the schemes and Kitovu Pre-payment Plan in particular did not also cater for dental problems. Ishaka Adventist Health Plan registered more unfair treatment of members while receiving treatment compared to other schemes. The key observation is that schemes may still need more support from both NGOs and government in order to slowly move towards sustainability and sufficiently meet the health needs of the communities.

Discussion

When the poor pay the same insurance premiums - with no regard for age, gender and social status – these schemes and their practices are inequitable and contravene the notion of vertical equity in health care financing and provision. This is because the poor have greater health needs but less money to pay for them than the rich do. Those who can pay more should do so; in other words, the rich should pay higher premiums than the poor. Sufferers of chronic ailments such as diabetics and high blood pressure all have different health needs and so should get appropriately different care. Our results confirm those of Carrin *et al*[9], who found that premiums that are levied as a flat sum pose a disadvantage to the poorest – flat contributions are, therefore, regressive, in that they do not favour low income earners and those with diseases that are expensive to treat.

It is true that the practice of giving treatment to non-members first before members is unfair, according to members, but this is more of a problem with the attitude of health care providers than an actual issue of health inequity because it involves non-members, in other words those who do not have a stake in the schemes. In contrast, it would be a serious equity issue if some scheme members received preferential treatment over other scheme members.

According to participants, the concept of sustainability is confused with longevity and yet sustainability requires the scheme to ensure that revenues from premium contributions can actually cover its benefit packages (expenditures). Over the years, the expenditures of some schemes have been higher than their contributions as a result of low enrolment and high dropout rates, leading to a small risk pool within the scheme. Often, this means the only members left are the high-risk ones who need to use the health services frequently, increasing the scheme's operational costs.

Community health insurance schemes have not died out since the introduction of free services in government health facilities, which implies they may still have a role to play in national health service provision. Private health services are perceived to be better than government ones by most Ugandans and patients tend to use private health facilities because of this perception, despite the availability of free health care services in public facilities. Our findings support earlier findings by Xu *et* al[10], which reveal that the removal of user fees from public sector facilities has not necessarily improved access. There are still problems, such as unofficial fees, drug stock-outs and overworked staff, who are too tired to provide quality service. .

Participants' suggestions that the role of CHI schemes in moving towards social health insurance in Uganda can be significant if CHI and SHI are able to co-exist, is contrary to the available literature and the results of our study, which reveal that CHI risk pools that are too small to service the claims of their members via contribution revenues. There are therefore doubts as to whether or not CHI schemes are worthwhile investing in, unless they are clearly linked to a broader strategy to ensure universal insurance coverage.

Conclusions and recommendations

Many of the CHI schemes we studied used inequitable practices. The rich and poor paid a flat

premium and no exemptions were given to the most vulnerable such as the poor, the elderly and orphans; enrolment was limited to four household members, so larger families were excluded from the scheme and coverage levels were low. Nevertheless, some schemes laudably demonstrated equity, by showing no discrimination according to age, gender and social status at their health facilities.

Most of the CHI schemes were not sustainable because they need external funding and are unable to raise sufficient funds due to low membership enrolment and small risk pools. The stringent membership requirements, the inability to cater for those with chronic diseases, coupled with the lack of a legal framework and policy to govern CHI schemes, have all deterred many from enrolling and have also encouraged existing members to leave. This raises serious concerns about the future sustainability of schemes.

We recommend that government increases funding for health services to ensure that quality of care does not deteriorate in the context of increased utilisation after removal of user fees, and it needs to step in to deal with problems such as 'unofficial' fees. There needs to be extensive technical and policy considerations about whether or not CHI schemes have a role to play in the Ugandan health system. CHI schemes may become the basis for providing health services to the informal sector if universal insurance coverage is envisaged (as has been done in Ghana). This will help address the problem of small risk pools and CHI schemes will need substantial support to build management capacity and will need to be larger than they currently are.

Acknowledgements

Our sincere appreciation to the scheme managers, all study participants and research assistants for their support and contributions, Professor Diane McIntyre of the University of Cape Town, South Africa, Rebecca Pointer, Pierre Norden and Rene Loewenson, of the Regional Network for Equity in Health in east and southern Africa (EQUINET) and the Training and Research Support Centre (TARSC), and Prof. James Tumwine of Makerere University College of Health Sciences, for their invaluable guidance and mentoring. We are indebted to EQUINET and the Uganda Health equity network for their capacity support towards publication of this paper, the School of Public Health, Makerere University, which acted as the host institution, and EQUINET and IDRC Canada, which funded this study.

References

1 Mwabu G, Wang'ombe J, Okello M and Munish G (eds). Improving health policy in Africa. University of Nairobi Press: Nairobi; 2004

2 Criel B. District-based health insurance in sub-Saharan Africa: Studies in health services organisation and policy. Antwerp Institute of Tropical Medicine: Netherlands; 1998.

3 Walford V, Basaza R, Magezi A, Matsiko A, Noble G, Somerwell F, Thornberry J and Yates R. Uganda Community Health Financing Project: Output to purpose review. Ministry of Health: Kampala; 2000.

4 Basaza R (2002) Community health insurance: Experiences in the context of political economic and governance concerns: Why has enrolment remained small? Health Financing Conference, Tilburg University: Netherlands; 29-31 August 2002.

6 Derriennic Y, Wolf K and Kiwanuka-Mukiibi P. An assessment of community-based health financing activities in Uganda. Partners for Health Reform Plus: Kampala; 2004.

7 EQUINET, TARSC Bibliography and Overview: Equity in Health in the Southern African Development Community (SADC) Region. Policy Series 2. EQUINET: Harare; 1998.

8 Magezi A, Matsiko A and Wheeler M A study of future financial viability of community health insurance schemes in Uganda. Uganda Community-based Health Financing Association: Kampala; 2000.

9 Ishaka Adventist Health Plan, Kitovu Pre-payment Plan, Mother-to-child Rescue Health Plan and Save for Health Uganda. Managerial and financial records for schemes in Bushenyi, Masaka and Luweero districts, Uganda. (2004–2007)

10 Carrin G, Waelkens M P and Criel B. Community-based health insurance in developing countries: A study of its contribution to the performance of health financing systems. Trop Med Int Health. 2005; 10(8): 799–811.

11 Xu K, Evans DB, Kadama P, Nabyoga J, Ogwal PO and Aguilar AM. The elimination of user fees in Uganda: Impact on utilisation and catastrophic health expenditure, Discussion Paper 4. Department of Health System Financing, Cluster Evidence and Information for Policy (EIP), World Health Organisation: Geneva; 2005.

12 Schneider, P. and F. Diop (2001). Synopsis of results on the impact of community-based health insurance (CBHI) on financial accessibility to health care in Rwanda. Washington, DC, The World Bank: 22 pages.