Will private health insurance schemes subscriptions continue after the introduction of National Health Insurance in Uganda?

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Abstract

Introduction: Uganda is currently designing a National Health Insurance (NHI) scheme, with the aim of raising additional resources for the health sector. Very little was known about the health insurance market in Uganda before this study, so one of our main objectives was to investigate the nature of the private health insurance market in Uganda and the opinions of various stakeholders on NHI, with the view to establish the impact of NHI implementation on the existing PHI. Specifically, we aimed to gather the opinions of employees and employers on the likely impact of NHI on their PHI schemes.

Methods: We conducted interviews with health insurance providers, and a sample of employers and employees in Kampala, using structured questionnaires and analysed quantitative data using STATA[8]. Qualitative data was analysed through grouping of emerging themes. Community-based health insurances were excluded from the study.

Results: Health insurance and/or prepayment schemes are offered by a handful of organisations or private health providers, mainly in Kampala and cover a relatively small percentage of Uganda's population. The premiums charged and the benefit packages offered by the different agencies vary widely. There are 2 health insurance agencies, 2 HMOs and about 5 or more private providers offering pre-payment schemes to their patients. Responses from a significant proportion of employers and employees show that PHI schemes may be abandoned once the mandatory NHI scheme is implemented. A few respondents argued that they would maintain their PHI subscriptions because of their perceptions of the quality of services likely to be provided under the NHI scheme.

Conclusion: If successfully introduced, the NHI scheme may displace existing private health insurance and/or pre-payment schemes in Uganda. The extent to which PHI schemes are displaced depends on whether NHI is successfully implemented and the quality of services being offered under the NHI scheme.

Key words: health financing, health insurance, pre-payment mechanisms

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Introduction

Escalating health care costs, inadequate tax revenues and the unsustainable donor funding have alerted governments of developing countries to the fact that their health sectors need money from sources other than conventional financing sources. Regrettably, the single largest source of financing for health services is out-of-pocket (OOP) payments, which exceed 25% of total health care expenditure in more than 75% of sub-Saharan countries[1]. OOP payments are a very inequitable mechanism for financing health placing a significant burden on households and present an obstacle to accessing health services especially for the poor. Over the last two decades there has been growing interest in the potential of social health insurance (SHI) as a health financing mechanism in low and middle-income countries. SHI consists of compulsory contributions into a health fund, made mainly by those who are formally employed, in return for a health care benefit package covering them and their dependants. Like many other African countries, Uganda is currently trying to find an efficient, equitable and sustainable health financing mechanism that will raise a substantial amount of funds for health, and is considering National Health Insurance (NHI) as one of the financing alternatives.

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The planned NHI stipulates that Private health insurance (PHI) will operate alongside the NHI offering an additional package for those who can afford. Although PHI is playing an increasing role in both high and low income countries, it is poorly understood by researchers and policy-makers[2]. The complementary potential of PHI to NHI needs exploration, this study was thus carried out with the following objectives:

- Explore the landscape of PHI in Uganda;
- Document the opinions of both employees and employers on the introduction of NHI; and
- Explore whether employers and employees will maintain their PHI/pre-payments schemes even after NHI has been introduced.

Methods

A cross sectional descriptive study was carried out in Kampala (capital city). Kampala was chosen because it has the largest population of people with formal employment thus would be more likely to be affected by introduction of SHI. In addition, most of the PHI agencies and HMOs are based in Kampala. Given financial constraints, it was not possible to include another city/town in the sample.

The research team consisted of two health economists and two research assistants. Data were collected using three semi-structured questionnaires designed by the senior health economist. The two research assistants were trained to conduct interviews with the different categories of stakeholders. Respondents included insurance or Health Maintenance Organisations (HMO), the employers and the employees. Interviews were conducted between September 2006 and February in 2007.

We used a two-stage random sampling method to select private and public sector employers and employees. In the first stage, we selected 35 private firms and 30 public or quasi-public organisations, based on the size of the firm. In the second stage we selected a random sample of four or five employees from each selected organisation based on their willingness to respond to the interview. The general manager in each of the selected firms was interviewed to obtained employers' views. We obtained a list of all insurance companies from the Uganda Insurance Commission (UIC). UIC provided guidance on which agencies provided health insurance. Considering that HMOs do not report to UIC, it was difficult to find comprehensive information about them. However, based on the experiences of the research team, we found out that there were four health service providers who provided some kind of pre-payment arrangement/ insurance to corporate clients and individuals. All four were included in the sample. This study excluded community-based health insurances (CBHI) schemes and the populations covered by these schemes, because they we outside the scope of the study. We believe that a similar study conducted for CBHI schemes would bring out additional interesting and informative results on the opinions of people are covered under these schemes.

In this study, we categorised health insurance organisations as those involved in collecting insurance premiums from either individuals or companies in return for a specified health benefit package for those covered by insurance. The insurers are not involved in actual health service provision. In contrast, HMOs have a dual role that involves the collection of insurance premiums from individuals and/or companies on one hand, and the actual provision of health services to those who are medically insured on the other. Further, private providers with pre-payment schemes are similar to HMOs, but they are still relatively smaller in size and offer pre-payment schemes in a manner that is largely ad-hoc, with pre-payment fees determined on a case-by-case basis (rather than in formal structure as is the case with HMOs).

All quantitative data were entered in MS Access, and later transferred an analysed using STATA[8]. Respondents' perceptions were analyzed using key themes that emerged from stakeholders.

Results

In total, information was collected from two PHI organisations, two HMOs, two private health service providers with prepayment mechanisms, 58 employers and 250 employees. Our results are presented in different sub-sections, in line with key study objectives.

Health insurance landscape in Uganda

We found that by the end of 2006, there were 19 licensed insurance companies in the country. Of the two PHI organisations (East African Underwriters and MicroCare Insurance), one insurance company offered health insurance and accident cover, while another offered health insurance as well as other life and non-life insurance services. In addition, we found that there were organisations that offered medical

pre-payment schemes and most of these organisations were HMOs. Until recently there were two main HMOs in Kampala [International Air Ambulance (IAA) and African Air Rescue (AAR)]. For these HMOs, insurance services are available to both corporate and individual or family-based clients. In addition, we found that several private providers are beginning to offer pre-payment arrangements, initially with their individual clients and later extending these arrangements to corporate clients. At the time of the study, such providers included: Case Medical Centre (CMC), Kadic Hospital, International Health Network, St Catherine's Clinic and Paragon Hospital. It is possible that there are more than these but, since there is no special registration for them (apart from the usual registration as private health providers); there is no formal way of establishing the actual number in this category. These providers are not any different from ordinary private health care providers, except for the fact that they enter into some semi-formal pre-payment arrangements with some of their clients.

In addition, we found that health insurance schemes are mainly funded by employers (on behalf of their employees), and only in very few organisation did we find that employees make a contribution to health insurance schemes. In most cases, insurance schemes cover the employee, spouse and about four dependents. The six PHI schemes studied cover about 131,600 people (across the country). This is about 0.47% of the total population. Even if all providers offering pre-payment schemes had been studied, the percentage of the population covered by health insurance or pre-payment schemes would still be less than 1% in Uganda. Lastly, the private health insurance market is not regulated, supervised or monitored in Uganda.

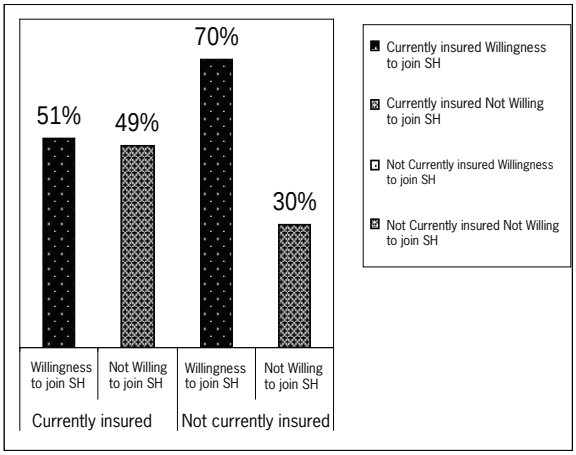
Further to establishing the landscape of PHI, we sought the opinion of both employers and employees on the proposed NHI scheme, as well as the views on the implications NHI would have for their existing PHI schemes. Our findings are summaries in three sub-sections focusing on (a) employees' (b) employers' responses, and (c) insurance agencies.

Views of employees on the impact of SHI on their health insurance schemes

We found that of the 250 employees interviewed only 96 employees were insured at the time of the interviews. We found a significant relationship between *current insurance status* and *willingness to join SHI* (P= 0.014) based on employees' responses. Employees who are not currently insured were more likely to join NHI than those currently insured and vice-verse (Figure 1). NHI is likely to displace PHI because a small percentage of the population of employees reported being insured.

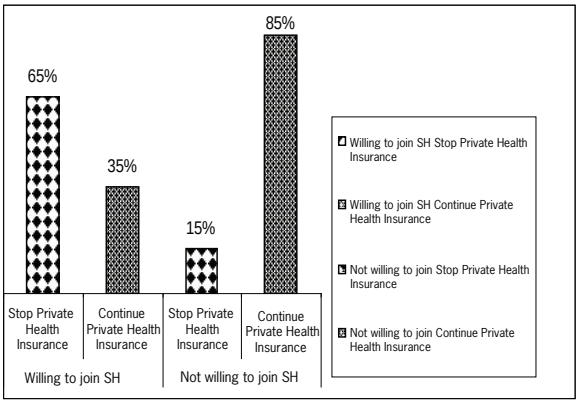
When employees were asked whether they would continue subscribing to their PHI schemes after they became members of the mandatory NHI scheme, 47% of the 96 employees (who had PHI at the time of the study) said they would still subscribe to their PHI schemes, 31% (30) said they would not and 22% (21) did not know. The 30 respondents who said they would stop subscribing to PHI when NHI is implemented argued that it would be a double cost if they subscribed to both schemes and they said that, since NHI was mandatory, they would have no choice but drop their PHI schemes. The respondents who were not certain continuing with PHI reported that this would depend on their employers' decisions, although most said that the employers would most likely drop the PHI in preference to the SHI, since it would be mandatory.

Figure 1: Relationship between employees' current insurance status and willingness to join NHI



In addition, results show that there is a significant relationship between *employees' willingness to join NHI* and *whether they will still want to subscribe to their PHI schemes* even when they are members of NHI (p=0.028). Majority (65%) of the employees willing to join SHI would stop subscribing to their private health insurance as opposed to 35% who are willing to join and who would continue subscribing to their private health insurance (Figure 2).

Figure 2: Relationship between employees' willingness to join NHI and stopping the PHI contributions



Views of employers on the impact of NHI on their health insurance schemes

Of the 58 organisations (employers) interviewed 38% said that health insurance was good for those who are not covered by any insurance scheme. They argued that NHI should be optional. When asked whether employers would continue with PHI schemes for their employees after NHI is implemented, 18 of 50 organisations (36%) said they would continue subscribing to PHI schemes, 22 (44%) said they would stop subscribing and 8 (16%) employers were not sure of what they would do.

When asked whether employers would continue with PHI even when the NHI policy is implemented, 18 of 50 organisations (36%) said they would continue, 22 (44%) said they would stop subscribing to the PHI and 8(16%) did not know. There was no significant relationship from the employer's perspective and this could have mainly been due to the small numbers of employers interviewed. Further, results indicated no significant relationship between impact of NHI on PHI for employers already with insurance and willingness to pay ($p=0.598$). It was clear however that among the employers that were willing to pay for NHI, 46% said they would continue with PHI while 54% said they would stop. Conversely, among the employers who were not willing to pay for SHI, 57% were willing to continue with PHI while 43 % were not.

According to the responses provided by the employers, it was clear that the implementation of NHI would have some impact PHI schemes that are largely supported by employers on behalf of employees.

Views of Health Insurance Organisations

All the six organizations (100%) interviewed expressed their concerns on the introduction of NHI, citing the following major reasons:

- The PHI would be pushed out of the industry due to the mandatory nature of the NHI. This would kill competition and hence poor services would be offered.
- The public was not aware of the policy and imposing such a policy on them would be resisted.
- The cost of the service under NHI would be met by the employees themselves unlike the case of PHI where the employers met the costs.

All the three stakeholders (employees, insurance organizations and employers) stated that NHI might impact negatively on their PHI schemes. Concerning this subject, the only official opinion of Government and policy makers is that PHIs could co-exist with NHI and offer additional top-up insurance for those interested in getting it. Once NHI is introduced, individuals or families under PHI schemes are likely drop PHI. Similarly, the majority of the employers mentioned that they would drop PHI if mandatory NHI was introduced.

Discussion

This study has shown that PHI or pre-payment schemes with providers in Uganda occupy a relatively small market in the Uganda[3]. This is similar to the findings of other researchers which showed that PHI in sub-Saharan Africa plays only a marginal role[4]. At the time of the study, a reasonable proportion of employees were part of a PHI scheme and a similar proportion of employees had some health benefit arrangement at the workplace. PHI has provided primary financial protection for workers and their families in other developing countries as well[5]. Although these findings may not be replicated to the whole country, the study area was the capital city where majority of PHI or pre-payment schemes operate. The exploration of whether or not employers and employees will continue with PHI schemes requires an in-depth understanding of the proposed NHI scheme, as well as other contextual issues, which are beyond the scope of this paper. However, the authors have been involved in other related research that allows them to discuss the findings within the right context. Previous work done by the authors described the

features of the proposed NHI scheme and other related contextual issues[6,7]. Our discussion is based on our findings and the authors' prior knowledge of related contextual issues.

Initial competition between PHI and NHI

Since NHI subscriptions are compulsory, contributions will be made by all eligible organisations and individuals. However, there are possibilities for PHI agencies to retain a significant proportion of their current subscriptions initially, as stakeholders wait to see whether NHI will function properly or not. In other words, given the scepticism about the functionality and sustainability of NHI[3], there will be some element of competition between PHI and NHI at the beginning, but only at the level of benefit packages and service provision. Experiences where PHI co -existed with SHI showed that, most social security programs in the region had a low coverage, coped with high administrative costs, suffered inefficiency, corruption, escalating costs and competition was evident[8].

It is important to note, that even with the introduction of NHI it is still possible to have mechanisms that allow PHI agencies to work with the NHI scheme instead of competing with them. PHI schemes can be valuable tools to complement other health financing options in developing countries if carefully managed and adopted to local needs and preferences[9]. For instance, their expertise and experience in the insurance business could open mutually beneficial synergistic opportunities, such as subcontracting administrative or actuarial tasks to PHIs[10]. An analysis of the first private health sector insurance company in Ghana showed experiences that public sector planners could learn from in the development of a SHI scheme[11]. Furthermore, organisations offering PHI could be allowed to offer top-up insurance packages for interested clients, to cover additional health services not covered by NHI. However, research has shown that in the developing world, it is often too expensive and this restricts its reach to a relatively small group of people who are willing and able to pay for such services, as such, does not facilitate the move towards universal coverage[12].

NHI displacement effect

Our findings show that the majority of the employers (44%) and employees (65%) would stop subscribing to their PHI schemes. This finding is consistent with McIntyre's argument that NHI is more likely to displace voluntary PHI than general tax revenue[1,13]. On the contrary, this study found that some of employees might still prefer to continue with their PHI schemes even when mandatory NHI is introduced, although a relatively higher percentage of employers would not continue with PHI. For both employees and employers, their desire to continue with PHI schemes was more related to their misgivings about the quality of health services that will be offered under NHI, and not necessarily based on their desire to be covered for more specialised health services (with additional top-up PHI). Barrientos (2000) found that with the co existence of SHI and PHI, due to insufficient oversight and regulation by the government, a large part of the wealthy population opted out of the social health insurance scheme which suffered problems of insufficiency[14].

Role of PHI/pre – payment mechanisms after introduction of NHI

The nature and regulation of PHI/pre-payment mechanisms in Uganda requires discussion. The current design of NHI stipulates that PHI will play a complementary role offering an additional package. In this study, we found that HMOs' dual role of collecting premiums and providing services is currently not regulated in Uganda. Under the NHI scheme, if they are willing, it is likely that HMOs will be accredited to provide services under NHI[7]. If this is the case, we are of the opinion that there is need for NHI to explicitly establish whether HMOs would be allowed to continue to play this dual role while at the same time providing services under the NHI scheme. Private providers offering prepayment mechanism can only participate in the scheme as providers meaning that they will have to stop their pre-payment mechanisms if they want to be considered for accreditation.

The fact that PHI industry is poorly regulated and monitored is a cause for concern. Studies in low income countries noted that PHI can only contribute to health system goals when regulated appropriately [15,16]. We recommend that this area is addressed alongside other preparations for the introduction of NHI in Uganda. This is especially critical if some of the HMOs are accredited as service providers under NHI.

Conclusion

If successfully implemented, the NHI scheme is likely to displace existing PHI schemes. The role of providers of PHI in Uganda, after the introduction of NHI, has not been comprehensively and effectively tackled as part of the preparatory activities in designing the NHI scheme. Although there could be a potential for collaboration and complementary role between PHI and NHI schemes, it seems unlikely to happen. This will initially result in competition between NHI and PHI, and ultimately into closure of most of the PHI schemes if NHI is successfully introduced.

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