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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.

Keywords: Community health insurance; Low enrolment; Perception; Trust and Uganda

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

because of limited capacity in the skills and financial resources.

In this study, we concentrated on two schemes: the Ishaka scheme, a typical example of a provider-based CHI scheme and the Save for Health Uganda (SHU) scheme, a community run model. These two schemes are independent of each other and operate in different districts. The Ishaka CHI scheme consists of 15 groups, with a total membership of 950 people out of a population of 50,000 people within the catchment area. The premium for 3 months is Ushs[1] 15,000 for a family of 4 and Ushs 3700 for an additional person. Save for Health-Uganda (SHU) scheme was established in 1999 and acts as an umbrella group for CHI sub-schemes in the area (currently 13). The total number of beneficiaries in the scheme as of September 2006 was 3624 people, a rate of about 6% of the catchment population. The contribution per individual member of a family in the SHU scheme amounts to on average Ushs 3800 as an initial payment, and about Ushs 800 per annum. There is no rule on the level of the premium. Each scheme decides on the amount depending on the local context. In Ishaka scheme, the Ishaka hospital management in consultation with the communities decides on the premium. However, in the Save For Health Uganda scheme, it is the communities who decide their own premium. The decision in both schemes is based on factors like the cost of care, the benefit package and ability to pay.

3. Research questions and methodology

Prior to this research, we carried out a case study evaluation in early 2005 to explore the possible causes of this low enrolment rate in both Ishaka and SHU schemes. Out of this evaluation, we identified five mutually inclusive hypotheses based on users' perceptions of CHI that could explain the low enrolment in the two Ugandan schemes:

(a) Lack of information and poor understanding of the concept of CHI (prepayment of the CHI premium, risk pooling of contributions, redistribution of benefits among the whole group and access to care).
(b) Lack of trust after previous difficult experiences with local financial organisations.
(c) Problems in the ability to pay the premium.
(d) Poor involvement of the community in management of CHI. Involvement could cover decision on the premium and co-payment, benefit package, advertising the scheme and handling of complaints.
(e) More specifically for the Ugandan context, difficulties for existing groups to raise 60% of the membership or 100 families per village before enrolment.

The purpose of the present study was to validate or invalidate these hypotheses through a qualitative study set out to investigate people's current perceptions of CHI in both schemes. Data were collected in the fourth quarter of 2005 and the first three quarters of 2006.

Focus group discussions (FGD) were the main research methodology supplemented by in-depth interviews. Focus group discussions were used because CHI in Uganda is a relatively new topic about which little is known and little has been written on in the past. Also, this method did not discriminate people who cannot read or write. It also encouraged participation from those who are reluctant to be interviewed on their own including those people who feel they have nothing to say. In addition, the discussions were useful in obtaining explanations on how people hold certain opinions and how these opinions are constructed given the Ugandan context. In-depth interviews were carried out as a supplemental method to provide face-to-face conversation to explore the reasons for not joining CHI in detail. They also illuminated the voices of disadvantaged like women, widowers, and orphans, disabled and elderly. There was a possibility that they may feel constrained to express their views in a focus group. All the factors that underpin participants' answers, reasons, feelings, opinion and beliefs were fully explored in detail. Stratified purposive sampling of discussants and interviewees was used to capture unique characteristics of the discussants and interviewees. Each village/group provided five sub-populations (sub-pops). Three focus groups were organised for each sub-pop, for a total of 15 focus group discussions for each plan, and therefore, a total of 30 focus group discussions for this research. The discussants within each sub-population were selected at

[1] US$ 1 = Ushs 2,000.

random using the scheme or village register. The saturation principle was incorporated in the data collection. The questionnaires and probes kept on changing from focus group to another and from every interviewee to another so as to find information that continues to add until no more could be found.

The sub-pops are:

1. Sub-pop 1: those who subscribed during the entire life of the schemes (1999–2004). There is complete data available for the years 1999–2004 only.
2. Sub-pop 2: people who cancelled their subscription after the first 3 years (1999–2001).
3. Sub-pop 3: those who only subscribed during a later period (2002–2004).
4. Sub-pop 4: people who did not subscribe at any one time during the period 1999–2004, but who are in a group or village that has scheme members.
5. Sub-pop 5: persons who did not subscribe at any one time during the period 1999–2004, who were sensitised, and are in a group or village that has no schemes members, but is within the catchment area of hospital.

Sub-pop 1–4 were randomly drawn from a list of existing community groups within a scheme, whereas sub-pop 5 was chosen from a list of existing groups in one of the randomly drawn villages without plan members using the village register. The catchment area is defined as the geographical locations surrounding the hospital from which the patients come. The names of groups in the hospital catchment area and their membership were extracted from the computerised data bank of the Ishaka CHI schemes. In the SHU schemes, all the groups were investigated, except one, which was used for pre-testing. Further verification took place through checking membership registers, which are kept by group leaders. Interviewees were randomly selected from a household list of women, widowers, orphans, the disabled and elderly in each sub-pop.

Eight researchers, seven women and one man of various age groups, with a different mix of social science disciplines, were hired locally to lead the discussions. To minimise bias, the local researchers were residents outside the catchment areas of the hospitals. The researchers were trained for a period of 2 days. Pretesting of the topic guide for focus groups was done by carrying out five discussions covering each sub-pop in one sub-scheme and a village in the Save For Health Uganda scheme. Both the village and sub-scheme were outside those earmarked for investigations. The topics in the guide were tailored to each specific sub-pop. The researchers back translated the topic guide into Ruyankole and Luganda languages for the Ishaka and SHU schemes, respectively. The discussions were conducted using the translated topic guide. Two researchers, a moderator and a note taker/observer, conducted each focus group discussion and interview. The audio taped information was transcribed the same day.

A total of 30 initial focus group discussions and 18 in-depth interviews were held for both schemes. The discussants in each focus group and interviewees were both men and women. For the Save For Health schemes, 15 discussions and eight interviews were held, and total 97 villagers participated in the discussions. For the Ishaka scheme, 15 discussions and 10 interviews were held, and a total of 88 villagers participated in the discussions. Each discussion group in both schemes consisted of 4–11 respondents. A discussion took an average of 105 min, whereas interviews took an average of 50 min.

Eight supplementary discussions were conducted, instead of 10, to confirm the findings of the initial 15, for each scheme. These discussions served the purpose of revealing discontinuity with the initial interviews and searching for new information. They were carried out after preliminary analysis of the first 30 FGD and 18 in-depth interviews. There was difficulty in realising focus group discussions for the fifth sub-pops in both schemes during the verification exercise. The topic guide for these FGD evolved from the intermediate analysis for the findings from the initial 15 FGD and interviews. The framework method was used in the data analysis [7]. Indexing was completed along three lines: (1) cross analysis along the five hypotheses including reasons for joining or not joining; (2) ways of increasing enrolment; (3) comparison along the two scheme models. All the responses from the sub-pops have been compared across each of the three lines of analysis. A second researcher verified the interpretation and reliability of indexing. AskSam 3.0 software facilitated tabulation of frequencies of indexed transcripts. For each of the two plans, the complementary focus group discussions were only examined after analysis of the initial 15 focus group discussions. The same analytical process was carried out, but with no quantification of responses.

Table 1
Reasons for joining SHU scheme[a]

	Sub-pop 1	Sub-pop 2	Sub-pop 3	Total
To go to the hospital without any worries of the amount to pay	5	6	12	23
They taught us the importance of the scheme	3	1	6	10
You do not have to sell your property	3	2	1	6
To help us get good health care	–	2	–	2

[a] Sub-pop 4 and 5 were not asked reasons for joining SHU scheme.

Table 2
Reasons for joining Ishaka scheme[a]

	Sub-pop 1	Sub-pop 2	Sub-pop 3	Total
We pay less for health care than those who are not in the scheme	6	2	2	10
To get treatment in time	4	2	2	8
To stay healthy/insured	5	1	–	6
You get help even when we do not have money at the time of illness	4	1	–	5
Good service	1	1	1	3
To teach us to be disease free	2	–	–	2

[a] Sub-pop 4 and 5 were not asked reasons for joining Ishaka scheme.

4. Results

The results of all 19 focus groups per scheme were consolidated, except for enumeration, which was done only with the initial 15 focus groups and in-depth interviews per scheme. The responses were quantified, and the figures given in brackets indicate the number of direct quotes that were collected. The quotes in the text are followed by an index in the brackets, which indicate the discussion or interview from which they were collected[2]. Quantification of direct responses has been used to contribute to full understanding of respondent's opinions. The evidence gathered in field-testing of the hypotheses and data analysis is presented along three lines.

4.1. Cross analysis along the five hypotheses

4.1.1. Lack of information and poor understanding

In the Save For Health Scheme, there were two distinct categories of responses. First, there are no benefits in paying membership when you are not sick (7). "Some people were informed about the plan on issues like terms of payment, the treatment of admitted patients only and the fact that the scheme is for the poor (S 1.2 and S 1.3)". On the other hand, the role of CHI as instrument to increase access to health care is directly mentioned by a section of the respondents in the focus groups and interviewees (18). In terms of access to health care also, it was pointed out that one does not have to sell his/her property when sick (6). Discussants and interviewees who either dropped out of the scheme, or have not joined the scheme, also value it. Their responses were: "It helps, one may fall sick when one does not have money (S 2.1 and S 2.2)". Details are provided in Tables 1 and 2.

For the Ishaka scheme, similar concerns were raised (Table 4): ". . . paying before you fall sick is like buying a disease (S 1.2 and I 2.2)". Another concern expressed was: ". . . why join when I am healthy (I 3.1)". On the contrary, some discussants and interviewees pointed out that scheme members were paying less compared to those not in the scheme (10) and being treated in time (8).

There is mixed understanding of pooling of contributions in the SHU scheme. Most non-members who were involved in the discussions doubt the value of pooling: "I think that if one spends a year without falling sick, then one should not pay the coming year

[2] For example, the index (S 1.2) indicates that the quotation is from sub-pop one and the second focus group discussion of those who subscribed during the entire life of the schemes. The same applies to (I 1.1), which is for the in-depth interview from sub-pop 1and the first interviewee. Plain numbers in brackets, for example (10), indicate that the statement has been directly mentioned 10 times in the five different sub-pop FGDs, or 10 interviews.

Table 3
Reasons for not joining SHU scheme

	Sub-pop 1	Sub-pop 2	Sub-pop 3	Sub-pop 4	Sub-pop 5	Total
Cannot afford to raise the money	7	6	5	7	–	25
Do not know how the scheme works: not enough sensitization and information	3	1	6	8	3	21
Do not see how to benefit if we do not fall sick	7	1	4	5	1	18
Failed to raise the required number in the group/village	2	1	1	3	5	12
Many organisations took money from us in promise of help and pocketed the money	–	1	3	1	3	8
Big family	–	2	–	2	–	4
Not treating chronic diseases	–	–	–	3	–	3

(S 4.1)". To express their concern, the discussants said: it hurts when one does not fall sick and utilise his contributions; for there are no benefits (7). Many people have dropped out as a result of pooling (4). Those who have not fallen sick and not utilised the funds feel that there are no 'benefits' in paying membership when not sick or without a patient (12). However, some scheme members in SHU appreciate the value of pooling as put in one key statement: we need to help one another for we can never know when we will fall sick (16). For the Ishaka scheme, a majority of discussants and more so those who are non-members expressed concerns about pooling: "some people drop out when it gets to three times of payment without falling sick (S 1.1 and S 2.2)". They also stated: "I am not happy with it because if I do not fall sick, I should not pay for someone else (S 1.3)," and, "I may fall sick before the person who used my money pays (S 2.1)". However, a section of respondents were also asked about the pooling principle and replied that "we were sensitised about it" (S 1.1). "We know it and have no problem with it (S 1.1, S 2.2 and I 2.1)". It has no harm because at one time you may also fall sick or your relative may get treated with that money (6). In addition: "it is good because it is a spirit of mutualism (I 11)".

Prepayment is expressed in a different way than pooling. In the SHU scheme, it is good that one prepares for the future and his or her health (8). It is good for you do not have to sell your property when sick (16). This is different in Ishaka scheme; two distinct positions were presented on pre-payment. A good proportion of discussants were happy with it. It is okay if I pay and I do not fall sick for it is like buying your life (6). When you fall sick you quickly get treatment (8). The other view was: "We do not like paying without falling sick and continue paying (I 3.1)". In addition. . . "if I do not fall sick; what about my money? I see it as a loss (V 2)". Details related to lack of information and poor understanding in both SHU and Ishaka scheme are provided in Tables 3 and 4 respectively.

4.1.2. Lack of trust

The level of trust in financial organisations stands out clearly as a key factor affecting enrolment in the plans (Tables 3 and 4). In the area served by SHU scheme, the communities experienced withdraw of local financial organisations like COWE, RUFAPA, BARO and PESA, which cheated them. They collected financial contributions from members in exchange for a promise of services, like paying school fees for the children, providing loans and building houses for the people and these organizations vanished before they could fulfil their promises (39). Even families that lost people because of AIDS were affected: "We were asked to pay Ushs 20,000 in a promise to get not less than Ushs 200,000 (S 1.2 and I 2.1)"!

The Ishaka scheme, like SHU, also had similar experience of an influx of organisations that took money, with the promise of helping the community, but did nothing. These are: NKUSIBO, UNIFA, COWE, and Nyabubare Co-operative (17). COWE operated in both scheme catchment areas. Two of these organisations were involved in health care delivery: . . ."a health organisation collected money from us and promised to help but they never returned (S 3.1)". In another related concern, "some organisations collected money and promised to look after the sick but we never saw them again (I 1.2)".

The trust of some previous community financing organisations affected the initial confidence of the com-

munities in CHI schemes: ". . . gained confidence in the SHU scheme after it operated for 2 years (I 1.1)". Also it was revealed that "the money is safe for there is an account and a cashier to explain how money has been used (5)".

4.1.3. Problems in ability to pay the premium

Inability to pay for membership was pointed out as the foremost reason for not joining the two schemes (Tables 3 and 4). In regard to SHU, the reason most mentioned for not joining the schemes is lack of money (25) and being unable to pay contributions for their large families (12). In the same scheme, it was expressed that: "I want to join but paying for my 10 children is a problem (S 2.1)". In addition, limited incomes were raised as an issue: "there are competing basic needs like buying food and paying school fees (S 1.2 and I 2.2)". The other reason given is that "we can afford treatment from time to time without involvement of the scheme (S 2.2)". Indeed, in the Ishaka scheme as well, issues of low income were the most outstanding cause of not joining the scheme (Table 4). Some families have no income and are unable to pay for membership (27).

4.1.4. Involvement of the community in the management of the schemes

In the Ishaka scheme, there was a mixed reaction on members' involvement in running the scheme. A majority of the respondents had a feeling, that they are not involved (8). The key complaint was "not making decisions on everything such as the premium (S 1.2 and I 1.1)". This is different in the SHU scheme: "We spread the gospel about the scheme (6)"; "We vote (S 1.1)", "we set our own rules as members (S 2.2)" and "there are no complaints (9)". Despite members' involvement, there were issues of concern: "We prefer a credit scheme to an insurance scheme for with a credit scheme you are given a grace period (I 1.2)".

4.1.5. Difficulties to raise 60% of a group or 100 families per village before enrolment

In both schemes, the existing rules and regulations were mentioned as one of the key issues affecting enrolment (Tables 3 and 4). Indeed, "failure to achieve the required number of people in a village has made it difficult for people to enrol (S 2.2)". Nevertheless, there are controversies and concerns with the current regulations. "Rules should change so that those who don't fall sick get something from the scheme (S 1.1)". In the Ishaka scheme, "the 60% rule of a group membership should be reduced to at least 50% (S 1.1 and I 1.1)".

4.2. Ways of increasing membership

All the sub-pops in both schemes were asked to propose ways of increasing enrolment. The results are presented in Tables 5 and 6 for SHU and Ishaka scheme, respectively. In both schemes, the main proposals made by the respondents were: decrease contributions, increase information and sensitization, make the rules for joining more flexible, and include health centre care in the benefits provided by the schemes. In Ishaka, two specific issues were raised: one relates to the desire to have members more closely involved in the decision-making process on the scheme; the other is their wish to include chronic diseases in the package of benefits.

Table 4
Reasons for not joining Ishaka scheme

	Sub-pop 1	Sub-pop 2	Sub-pop 3	Sub-pop 4	Sub-pop 5	Total
Not enough money to pay for membership	3	7	2	1	8	21
Do not know how the scheme works	4	1	2	6	1	14
Not falling sick after paying membership is regarded as money wasted	4	2	1	4	2	13
Previous financial organisations which cheated people/collapsed	3	–	1	–	–	4
Not allowing individual families to join without a group/failed to get a group/not reaching 60% enrolment	2	1	1	–	–	4
Joining is associated with inviting disease.	2	1	–	–	–	3
Some people simply do not want to join	–	1	1	1	–	3
Not doing some diagnostic tests and drugs being out of stock	–	–	2	–	–	2

Table 5
Ways of increasing enrolment in SHU

	Sub-pop 1	Sub-pop 2	Sub-pop 3	Sub-pop 4	Sub-pop 5	Total
Decrease the contributions	3	2	5	1	4	15
Sensitization of villagers including politicians and non-members	7	1	2	4	–	14
Change the regulations: enrolment to be on family basis rather than groups or minimum numbers	3	1		5	3	12
Involve nearby health centres/and other hospitals	1	–	7	2	–	10
Provide projects where members can get money	4	1	–	–	–	6
Provide transport and allowances to leaders/mobilizers	4	–	1	–	–	5
SHU to identify organisations which can pay for us/members to look for organisations to pay for us	3	–	–	1	1	5
Provide advertising materials (e.g, T shirts and calendars).	1		2	1	–	4
Have credit schemes (contributory medical credit schemes rather than pooling)	3	–	–	1	–	4
Provide special facilities for members (no lining up at the hospital)	2	–	1	–	–	3
Provide transport to patients	1	–	1	–	–	2

4.3. Comparisons along the two models

In this section, we present a comparison of the two schemes along the lines of two important issues.

4.3.1. Taking care of those who are unable to pay

In the SHU scheme, there were opposing views on how those who are unable to pay a premium should be handled. A majority felt that something should be done: "We should raise money for them (4)". In addition, "the rich should pay more money and the difference should be used to pay for those who can not afford (S 1.1)". In the Ishaka scheme, the following proposals were put forward: "the scheme should cater for them (S 2.2)", "they can be enrolled as individuals (S 1.1 and S 2.2)" and "they can sell part of their land or go for treatment in government units (I 2.2)". Other members of the scheme had no opinion: "there is no way of helping them (S 1.1 and I 3.1)".

4.3.2. Bargaining power and the quality of care

In regard to the bargaining power of members and effect on quality of health care delivery, members of SHU scheme felt that the scheme has helped. The plan members receive a reduction on cost of treatment: "when you are a scheme member and you fall sick, there is a 12% reduction on the money the scheme pays (S 1.1)". It was also pointed out that "when you are a scheme member, they quickly give you care at Kiwoko hospital (S 1.1, I 1.1 and I 2.2)". In regard to staff; "we

Table 6
Ways of increasing enrolment in Ishaka scheme

	Sub-pop 1	Sub-pop 2	Sub-pop 3	Sub-pop 4	Sub-pop 5	Total
To decrease the contributions	5	4	2	10	6	27
More sensitization/seminars	3	4	2	7	2	18
To join as an individual family or less than 60% of a group	7	1	1	–	2	11
Give more attention to scheme members: no lining up, private wards	–	–	6	2	1	9
Cater for all diseases incl. chronic ones like diabetes	2	2	2	–	2	8
Transport for far away members	1	1	1	1	1	4
Sell mosquito nets at reduced prices		1			2	3
Increase period in which contributions have to be made	2	–	–	–	–	2
Allow us make decisions covering our group	1	–	1	–	–	2
Expand services to nearby health centres	1	–	1	–	–	2
Involve Local Council officials	–	–	–	2	–	2
Not to pay if you have not fallen sick	–	–	–	–	2	2

told SHU about the nurses who were treating us badly and they reformed (S 1.1 and S 2.1)". However, there are outstanding concerns; members of the scheme are demanding special treatment: "we want lining up with non-members of the scheme for treatment to be abolished (S 1.1)". In the Ishaka scheme, poor quality of care was cited as one of the reasons stopping people from joining the scheme. There is no modern equipment in Ishaka Hospital compared to private clinics (5). Other quality issues raised were: "the hospital is dirty (S 1.1and S 2.1)" and "they prescribe drugs and tell us to buy them from somewhere else yet we have already paid our money (S 1.1 and S 1.3)". The idea of exclusions in the package of benefits is not well understood: "they do not treat all diseases (5)". Scheme members were asked if they have any bargaining power on prices of health care: "we do not do it (8)", "the hospital staff sits and decides the amount we are to pay and they come and tell us (S 1.1 and S 2.1)". It was revealed that "scheme members are mistreated in the hospital for example removing a member from a bed and giving it to a non-member because the latter has come with cash (S 3.1)"and "members hide their cards so that they are not identified as scheme members lest they are given poor quality of care (S 2.1)".

From our analysis, we identify other causes of low enrolment that were not previously hypothesised: first, alternative packages that could include transport and treatment of chronic diseases. The fact that the Ishaka scheme does not handle some chronic diseases was also mentioned. Some joined without the knowledge that some diseases are not treated, and so they dropped out when they realized it (8). This is different from the SHU scheme, where treatment is now provided for all diseases. Secondly, distance from the hospital to the villages is a factor in both schemes: "It was expensive for me to travel 27 km to and from Ishaka hospital (S 1.2 and S 3.1)". Nearby health centre should be involved. The same proposals were raised in the SHU scheme: "the scheme should use health centres near the people (S 1.3 and S 2.1)".

5. Discussion

There were some methodological limitations in this study. First, there were gender concerns where females could not express themselves freely in presence of father-in-laws or husbands. Nevertheless, in-depth interviews provided a one-on-one session with female interviewees, who brought out most of their concerns. There were difficulties in gathering supplementary discussion groups for sub-population 5 from both schemes. However, the tool used for supplementary focus groups was the same for all focus groups and a majority of the issues were clarified by other supplementary FGDs.

On the basis of this study, the following mutually inclusive explanations for the low enrolment in the two CHI schemes that were investigated are held. They are discussed along three health financing functions of a health system: revenue collection, pooling of resources and purchasing of services in line with World Health Report, 2000.

5.1. Revenue collection

5.1.1. Inability to pay the premium

Incapacity to pay the premium stands out as the single most contributing factor to inability to join the two schemes. Currently, there is no mechanism to enrol those who cannot afford the premium. The absolute poverty level, measured with the National Poverty Index, NPI (income including food, of less than 1US$ per day, per capita), is 32.7% in the area served by SHU (Luwero district) is 33.3% in the Ishaka scheme (Bushenyi District). The national average poverty level is 38.8% [8]. The communities in both schemes did not complain about the co-payments, which are within the affordable limits of the plan members. Perhaps introduction of Income Generating Activities (IGA), as in the case Bwamanda scheme in DR Congo, which is part of the larger integrated development project (CDI Bwamanda), could ameliorate the situation [10]. Indeed, where some communities have expressed interest to join the scheme, limited incomes are a constraint. The WHO discussion paper on CHI in developing countries points out that exemptions for poor households, donations both international and local have a crucial role to play as way of promoting increased membership and universal coverage [9]. These findings are contrary to the ones in Nouna District of Burkina Faso [2] and Maliando scheme in Guinea Conackry [5] where poverty per se was not the most outstanding obstacle. Other behavioural constraints may cause the poor to remain uninsured even when they might be better off

with insurance. They may rely on solidarity from family and friends to smooth out consumption and financial shocks related to ill health over time [14]. There is also a challenge in that the premiums are based on average health care costs. When premiums in a CHI scheme are based on average health care costs of the target population, a number of households, usually the healthy ones, may not be interested in signing up, judging that the contributions proposed are exaggerated in view of the low health care costs [12]. However, the main reason for people enrolling into CHI is to reduce anxiety of falling sick when they may not have funds. The principle of solidarity requires that more healthy members of the community contribute to the less healthy. These explanations were being provided during sensitization.

5.1.2. Long distance from the communities to provider health facilities

The distance factor was not included in our hypotheses. The communities proposed involvement of nearby health centres. It must be noted that the majority of the health centres are publicly owned, and therefore, have no user-fees. This fact poses a challenge. The high coverage of the Bwamanda scheme was associated with a network of 23 health centres, and a clear referral policy to the hospital, that patients had to first be seen at the health centres [10] .The geographical gap could also be addressed by scaled contributions based on the location of contributors distance from the hospital. The homesteads near the hospital could pay more than those at a far distance. Based on one of the authors (BC) personal working experience, the RAHA scheme in India is using a similar approach of sliding contributions with distance from the hospital with some promising results.

5.1.3. Poor quality health care

Faith based hospitals were considered as having good quality of care before this research. However, quality concerns like cleanliness, long queues, and absence of some prescribed medicines, come up as causes of low enrolment in the Ishaka scheme. Poor quality of care was the single most important contributor of low enrolment in the Maliando scheme [5]. Surprisingly, the issue of 'free' public owned health services did not come up as a direct cause of low enrolment in the plans. This could be explained by the fact that over 58% of the total health expenditure in Uganda is private, out-of-pocket expenditure, despite the abolition of user-fees. Secondly, PNFP units are the only hospitals in their localities, so the communities have always paid for their health care. However, the recognition that for African households, financial accessibility to quality health care is a strongly felt need partly explains the current wave of promotion of CHI in Africa [13].

5.1.4. Difficulties for existing groups to raise 60% of the membership or 100 families per village before enrolment

The Ishaka scheme like majority of the schemes in Uganda, fixed the requirement that at minimum, 60% of any group must join a scheme before enrolment, as a measure against adverse selection [15]. SHU also arbitrarily established a policy that at least 100 people per village must enrol in each sub-scheme before accessing benefits. There were no provisions for alternative contributory arrangements for those who wish to join as single families or groups that cannot enrol up to 60% or 100 families. This rule is a measure against adverse selection. It is rigid, not adapted to reality, not empirically arrived at and an obstacle to enrolment into the schemes. Communities in both schemes would like to have at least an alternative to these two requirements.

5.2. Pooling of resources

5.2.1. Lack of trust in local financial organizations

Both communities in Ishaka and SHU have had a negative experience with local financial organisations. The communities are still suspicious about joining financial organisations. However, the interviews show that the communities have gained confidence in the schemes. This is not being translated into an increment in enrolment. Lack of trust could be explained by the fact that only members of the scheme have gained confidence, but those not yet enrolled most likely do not have this experience. Confidence in the plan alone may not translate into higher coverage as well as is the case with the Nouna scheme [2]. This observation reinforces the call for sensitisation and more focused social marketing. The authorities could play a trust building role through information campaigns, supervision of the CHI, and monitoring provider performance. In addition, the authorities could demonstrate solidarity by joining the plans and subsidizing the enrolment of vulnerable groups [15]. The use of existing entry-points,

such as micro-credits plans, development organizations involved in agriculture which have won the population's trust, may make it easier to start up a CHI scheme [17].

5.2.2. Lack of information and poor understanding of the concepts of CHI

Our study shows that a large section of the communities poorly understand the concept of pooling contributions. Even prepayment is associated with inviting diseases. It is only those who are members that have a relatively better understanding of pooling and prepayment. Not adequate sensitisation has been done and the content of the sensitization needs to be tailored to the core principles of CHI. For example, our study has clearly pointed to misunderstanding of the benefit of CHI: people would complain not to have benefited from the scheme if they do not fall sick—as if one would wish for sickness in order to benefit from the scheme. In the study on Community Health Fund in Tanzania, the tacit findings were that overall education and promotion was needed to increase understanding of the benefits and management of the fund [18]. In this study, the poor knowledge of the insurance components is likely to be due to a communication and sensitization campaigns that do not convey information in an effective manner or to trigger curiosity beyond the disclosure of the premium level as in the case of Nouna District in Burkina Faso, West Africa [2]. However, it must be observed that a good understanding of CHI principles, per se, will not directly translate into increased enrolment. The enrolment rate in the Maliando Mutual Health Organisation was 6% in 1999, despite good understanding of the concepts and principles of CHI [5].

5.2.3. Poor involvement of the community in management of the hospital-based CHI model

There is poor involvement of the members of the Ishaka scheme (provider run model) in the decision making process, whereas from the evidence adduced, members are centrally involved in running the SHU scheme (community-driven model). Most provider run models tend to have minimal involvement of the community in management of the schemes [18,19]. However, community involvement has not translated into increased membership in the SHU scheme.

5.3. Purchasing of services

5.3.1. An unattractive benefit package

The exclusion of treatment of chronic diseases in the benefits package of the Ishaka schemes comes out as a contributing cause to low enrolment. People with chronic diseases are the people in most need and should be reached by the plan as much as possible. In addition, the management of the schemes could explore whether ambulance services could be included in the package of benefits, as in the case of the CHI schemes in Rwanda [16]. A study on CHI schemes in India indicated that rural, illiterate communities can participate actively in the design of a benefit package and make judicious choices [11]. A similar study in Burkina Faso also showed that understanding and thereafter meeting, consumers' preferences can in fact ensure that policy makers set compound health interventions in line with people's needs and expectations, thus maximizing community participation [4].

6. Conclusion

The study provides some elements for inclusion in the development of a national policy on CHI in Uganda, and possibly in other low- or middle-income countries. Such CHI policy could be part of health financing strategic plan with a clear roadmap of how it plans to transit from the current health financing state dominated by inequitable, catastrophic and impoverishing direct out-of-pocket payments to a visionary scenario of universal coverage [20].

The study has validated/invalidated the initial hypotheses in the context of the two schemes. Other findings are unique in the context of the two schemes, but were previously not considered. These are the unresearched entrance rules into the plans, the benefit package that create a barrier to enrolment and the lack of involvement of first line health units which reduces the attractiveness of the CHI schemes. The study provides a case of government which abolished user-fees and is now putting up a program to promote CHI. Shaw and Ainsworth argue that countries must introduce user-fees as prerequisite for development of health insurance [21]. This is different from the case of Tanzania which previously abolished user-fees and had to introduce them as one of the steps towards intro-

duction of health insurance [18]. The promotion of health insurance amidst abolition of user-fees in public units in an environment where private out-of-pocket expenditure is the main source of financing provides a policy dilemma that needs to be researched on so that the country develops an appropriate health financing plan.

This study demonstrates that in both schemes, there is poor understanding of the concepts of CHI principles, in particular concerning the pooling of contributions and the prepayment of the premiums. In order for the schemes to address these deficiencies, support will have to be solicited. The support will involve the government of Uganda, in particular the Ministry of Health and the concerned District Health Teams, and the plan officials, with support of development partners (donors). They could dialogue with the communities, scheme staff and the providers to improve enrolment in the plans. Subsidies to the poorest members of the community could increase enrolment and thus access to care [22,23]. More importantly, donors and governments could finance research/projects that test different approaches to extending insurance to the poorest [24].

In order to get a full picture on the reasons for low enrolment, it is recommended to also investigate how health care providers and health system managers perceive CHI. The added value of CHI, linked to other development programs, like microfinance institutions and cooperatives, also merits further investigation. Finally, a full stakeholder analysis, with a focus on the political economy of health care and under table payments in health units are areas for further research which will provide useful inputs in the entire policy development process of CHI.

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