



PROGRAMMING INTERVENTIONS ON COMMUNITY HEALTH INSURANCE: A Feasibility Case Study In Uganda

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➤ Background

- Theoretical Framework on Community Health Insurance
- Empirical Context in Uganda

➤ Research Introduction

- Objectives
- Study Design

➤ Methods

- Household Survey
- Stakeholder Analysis

➤ Results

➤ Conclusions

Given global objective of **Universal Health Coverage**
major obstacles in Low and Middle Income Countries:

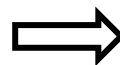
Catastrophic Health Expenditures

≥ 40% of capacity to pay

“when a household must reduce its basic expenses over a certain period of time in order to cope with the medical bills for one or more family members”

(Kawabata, 2002)

Direct payments and
inadequate financial protection



Poor access to health care and
impoverishment effects

Innovative tool to enhance coverage for rural populations by favouring community resource pooling and risk-sharing:

Community Health Insurance

“voluntary, non-profit insurance scheme, formed on the basis of an ethic of mutual aid, solidarity and the collective pooling of health risks, in which the members participate effectively in its management and functioning”

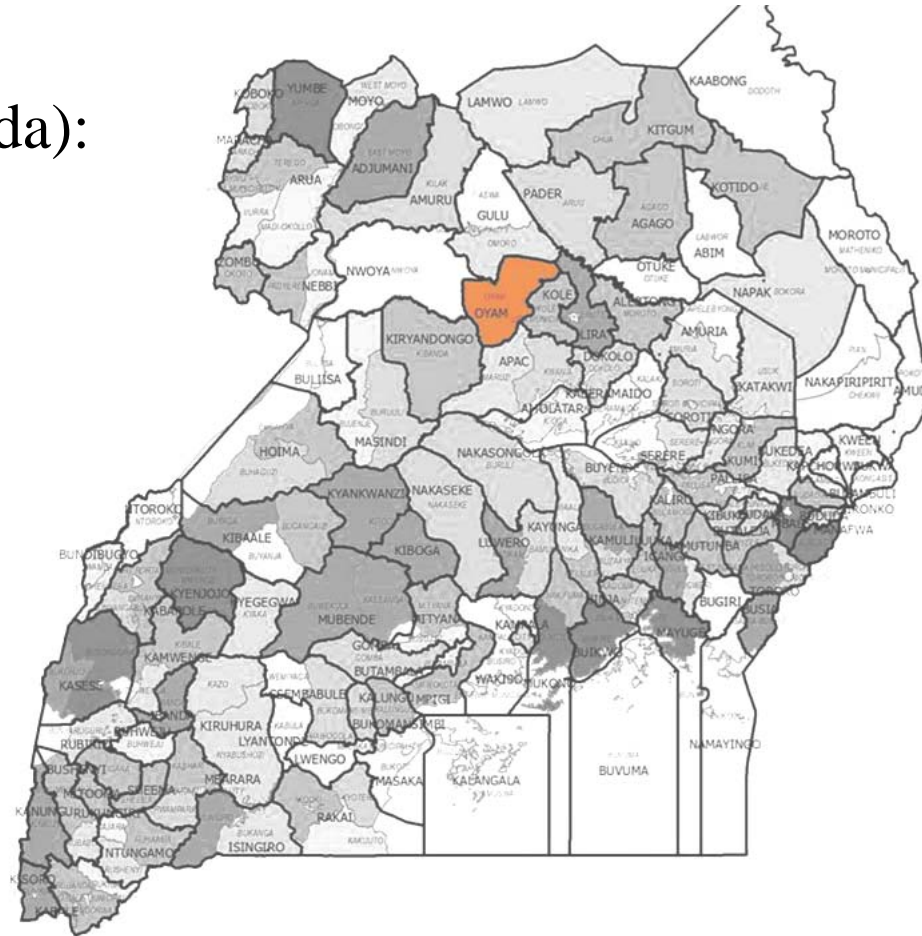
(Atim, 1998)



Concept of insurance applied at the micro-level in order to facilitate the access to care and offer financial protection.

Oyam District (Northern Uganda):

- 400,000 population
- Post-conflict region
- Poor health indicators
 - Life expectancy at birth: 48
 - Infant Mortality Rate: 114
 - Maternal Mortality Rate: 500
 - Under 5 Mortality Rate: 191
 - Total Fertility rate: 7.7
 - Expected HIV positive: 8.2%



- *Doctors with Africa Cuamm* implementing the program “Mothers and Children First”



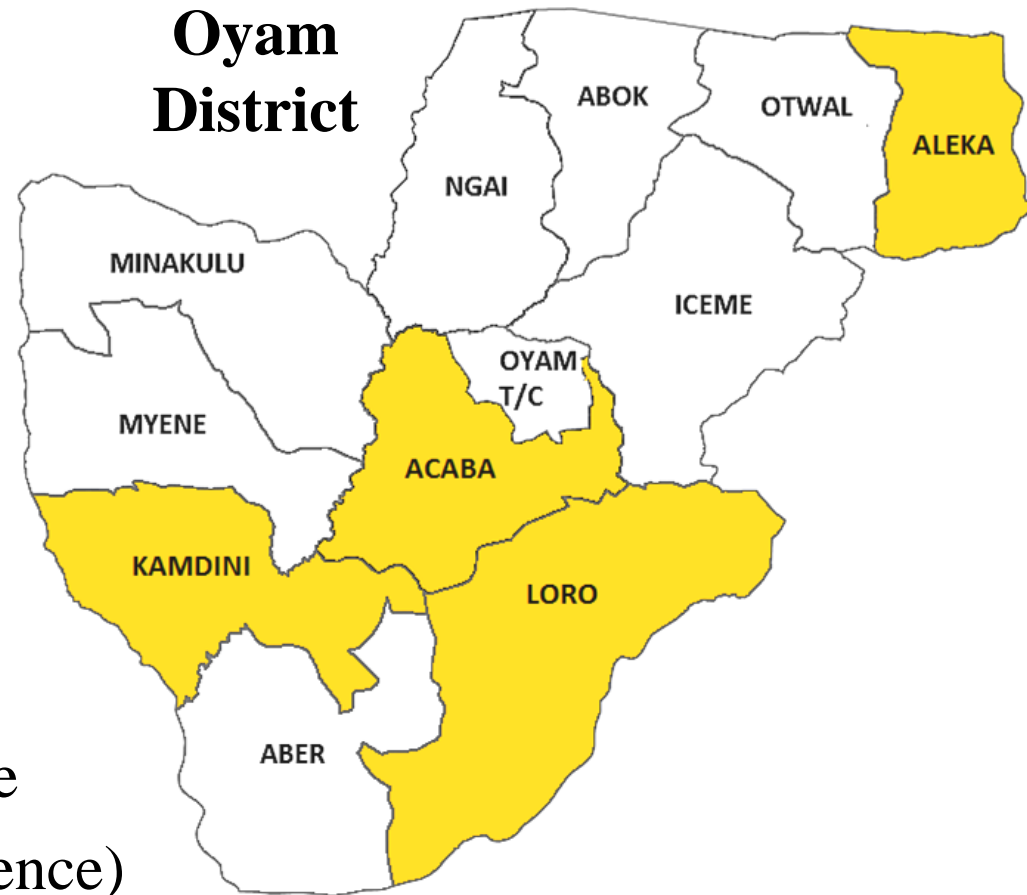
RESEARCH OBJECTIVE



- **Priority Need** Does a priority need for protection against the financial risk associated with sickness exist?
- **Quality Health Services** Is quality health care available within an acceptable distance?
- **Confidence** Does the target population have confidence in the promoters of the scheme?
- **Mutual Aid** Do traditions of mutual aid exist?
- **Affordability** Does a trend of socio-economic development exist as to enable households to pay for the scheme?
- **High Coverage** Is the potential number of covered persons sufficiently high?
- **Favourable norms** Does a favourable legal and regulatory environment exist at the national level?
- **Local Governance** Is the level of leadership and political commitment sufficiently high at the district level?

Research design:

- Pilot area
(4 sub counties out of 12)
- Mixed-methods design
(quantitative and qualitative investigation tools in sequence)



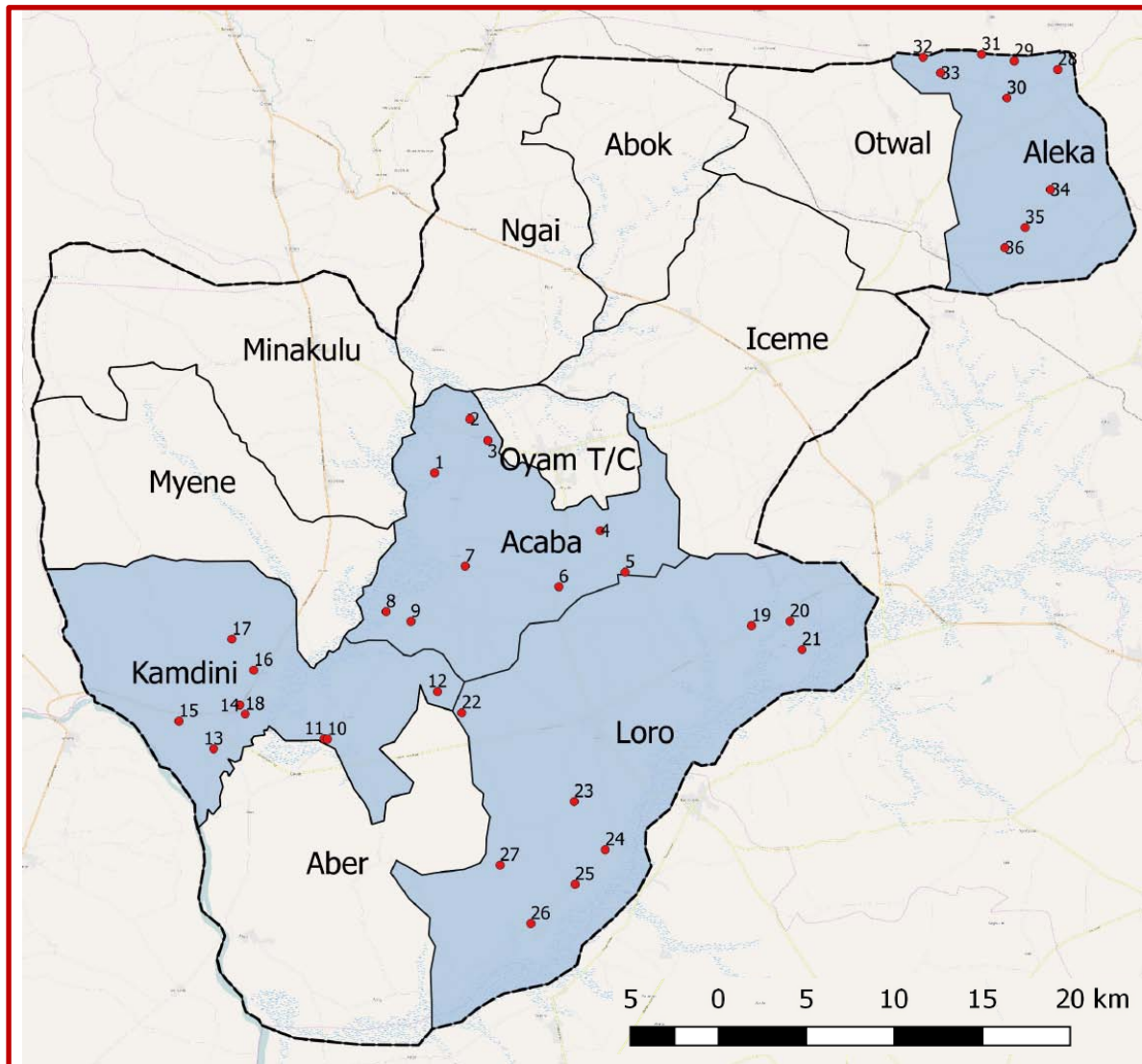


DATA COLLECTION



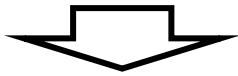
METHOD	TARGET	NUMBER
Household Survey	Community members	180 Questionnaires
	Community leaders at local level	4 Discussions
Structured Focus Group Discussion	Community groups	4 Discussions
	Authorities at sub county level	14 Interviews
Key Informant Interview	Authorities and health providers at district level	2 Interviews
	Leaders of community groups	24 interviews

HOUSEHOLD SURVEY



(Our elaboration)

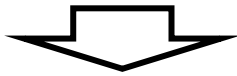
180 Household Questionnaires



- Socio-economic proxy
- Risk perceived and willingness to pay
- Health-seeking behaviors
- Health-related costs
 - Illness
 - Admission
 - Maternity
 - Chronic diseases
- Membership to local groups



Individual Key Informant Interviews (KIIs)

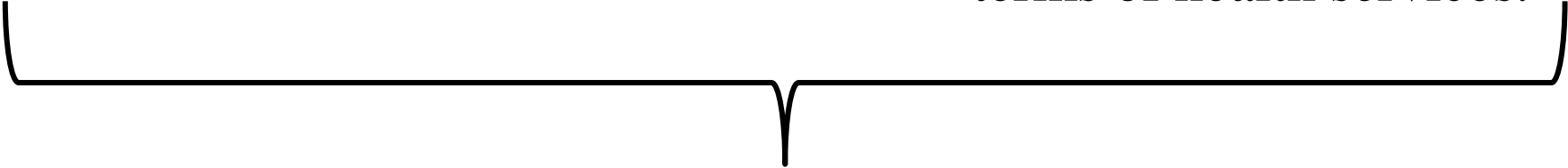


Stakeholders' interests, influence and position in relation to the scheme.

Structured Focus Group Discussions (SFGDs)



Community's capabilities, agency freedoms and opportunity dimensions in terms of health services.

- 
- Access to health care
 - Scheme design

Consulting health facilities' documents:

- Probability of using the health service
 - Expected percentage of population
 - Expected frequency rate of utilization
- Average unit cost of the health service

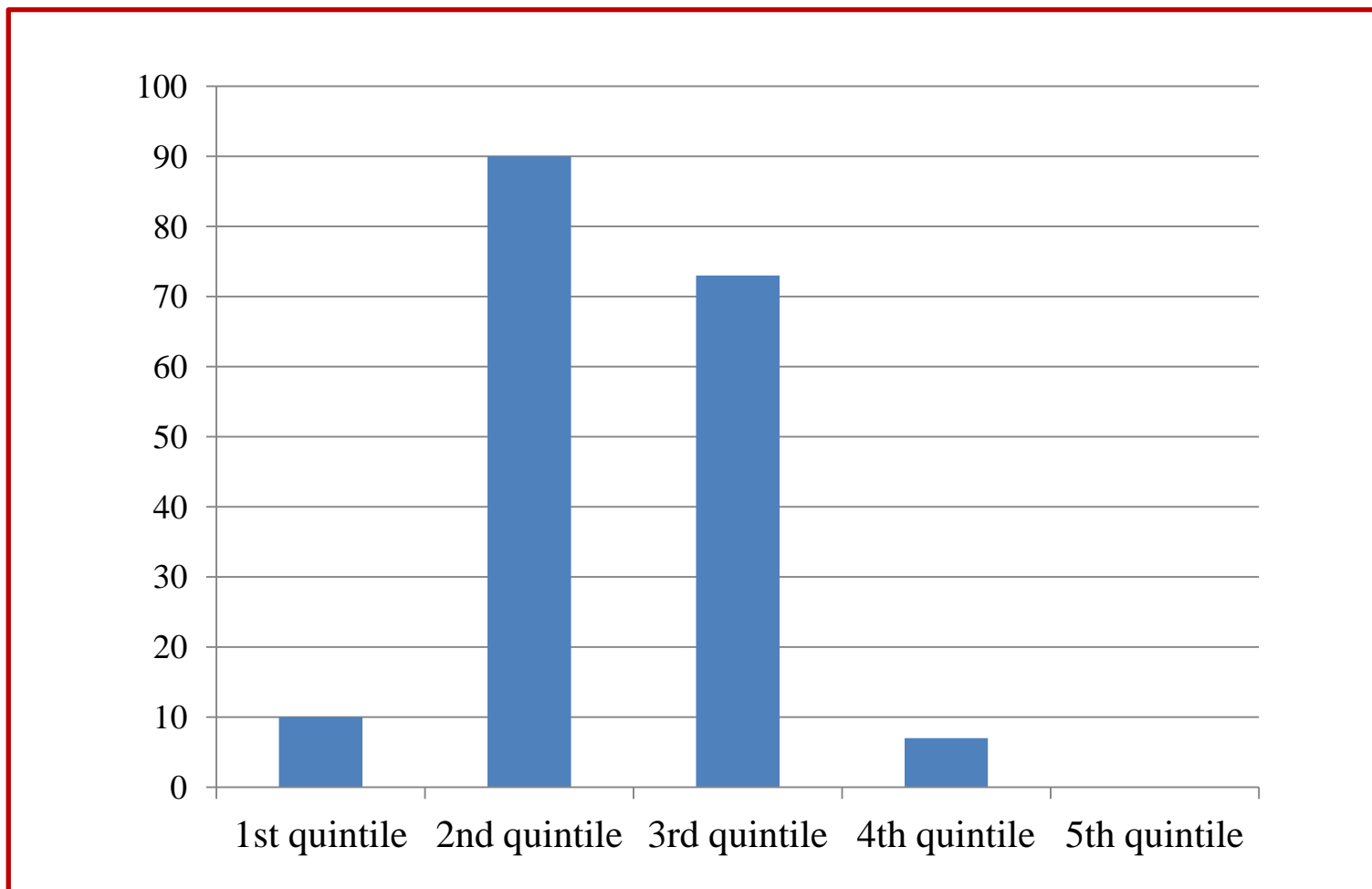
- Maternity services
- Under 5 children
- Emergency admission
- Emergency transport
- Malaria treatment



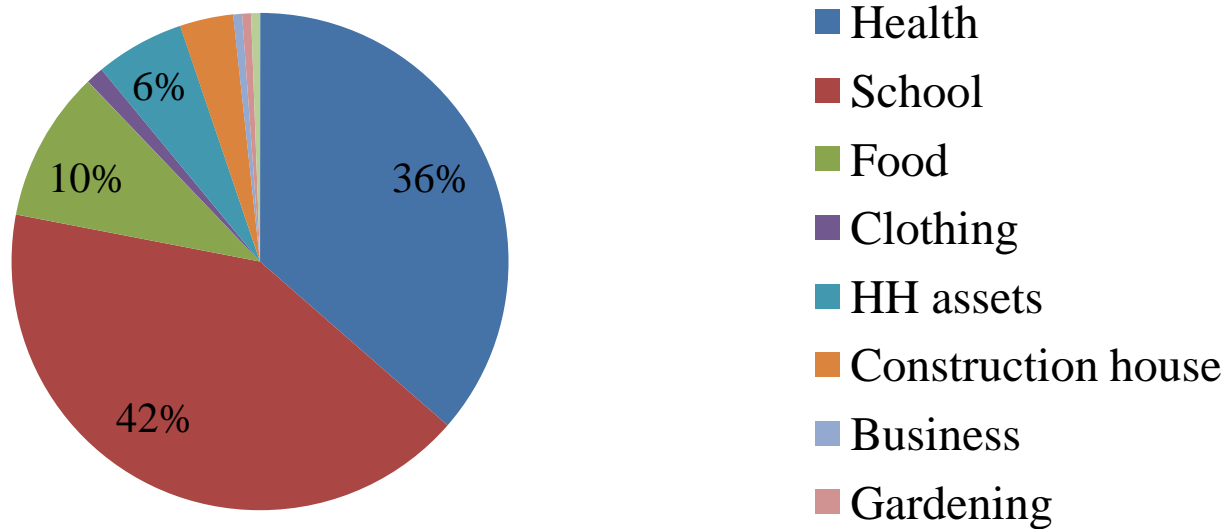
Premium calculus according to
different scenarios

- *Benefits package*
- *Copayment*

Socio-economic profile



First income use



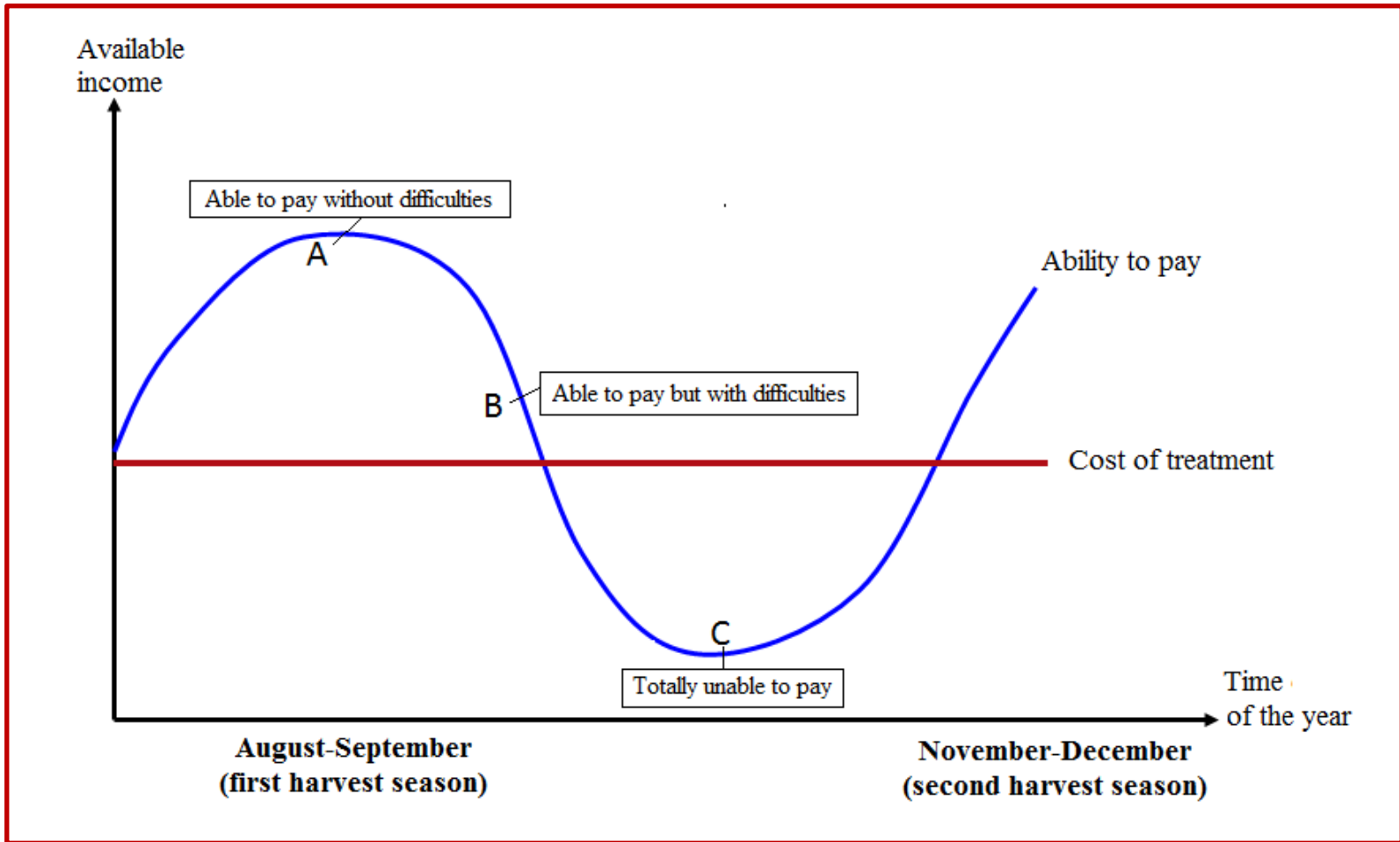
Health as priority

	Frequency	Percentage
Health as first priority	94	52%
Health among first 2 priorities	126	70%
Health among first 3 priorities	145	81%

Sources to finance health expenditures

	Frequency	Percentage
Cash ready at home	83	25%
Casual labour	10	3%
Gifts from family, friends, neighbours	6	2%
Selling crops	127	38%
Selling household assets	61	18%
Selling land	4	1%
Loan from traditional social protection groups	19	6%
Loans from family, friends, neighbours	17	5%
Loan from money lender	3	1%
Tot	330	100%

Seasonal ability to pay



(Our elaboration)

Political and technical authorities \Rightarrow Supporters, not drivers of the intervention

Existing solidarity groups \Rightarrow Most appropriate actor to manage the system at the community level (involving 75% of sample population)

- High levels of interest in the scheme
- Confidence in the promoters of the intervention
- Initial community ownership of the initiative

- **High prevalence:**

<i>SUB COUNTY</i>	<i>N GROUPS</i>
<i>Acaba</i>	<i>105</i>
<i>Aleka</i>	<i>156</i>
<i>Kamdini</i>	<i>112</i>
<i>Loro</i>	<i>111</i>
	<i>Tot: 484</i>

- **Variety of risk-sharing institutions:**

- Village Saving and Loan Association
(*credit saving funds*)
- Burial Group
(*solidarity funds*)
- Farmers Group
(*rotating work assignments*)

- **Mutual-aid component in health**

- **Membership characteristics:**

- Majority of women
- Heterogeneous age profile
- Village level

- **Internal organization:**

- Leadership structure
- Formal constitution
- Regular meeting



		Annual premium
<i>Scenario 1</i> Comprehensive package, no co-payment	per person	9,440 UGX
	per household	62,211 UGX
<i>Scenario 2</i> Comprehensive package, 20% co-payment	per person	7,552 UGX
	per household	49,769 UGX
<i>Scenario 3</i> Selective package, no co-payment	per person	2,640 UGX
	per household	17,400 UGX
<i>Scenario 4</i> Selective package, 20% co-payment	per person	2,112 UGX
	per household	13,920 UGX
Household size = 6.59		1 US\$ = 3,616

According to the research outcomes,
all the **feasibility preconditions** are **verified**:

- Priority Need
- Quality Health Services
- Confidence
- Mutual Aid
- Affordability
- High Coverage
- Favourable norms
- Local Governance

CONCLUSIONS



Viability of **CHI model** in Oyam District: this option has the potential to improve the access to health care of the local population.



Importance of mixed methods assessment providing evidence for informed decision-making about the **scheme design and implementation**.



Relevance of **research-action strategy** for the next phases of intervention.

***THANK YOU
FOR YOUR ATTENTION***

