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

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OVERVIEW

➢ 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**

\[ \geq 40\% \text{ of capacity to pay} \]

“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** \[\rightarrow\] **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

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

| Background | Introduction | Methods | Results | Conclusions |
Research design:

• Pilot area
  (4 sub counties out of 12)

• Mixed-methods design
  (quantitative and qualitative investigation tools in sequence)
## DATA COLLECTION

<table>
<thead>
<tr>
<th>METHOD</th>
<th>TARGET</th>
<th>NUMBER</th>
</tr>
</thead>
<tbody>
<tr>
<td>Household Survey</td>
<td>Community members</td>
<td>180 Questionnaires</td>
</tr>
<tr>
<td>Structured Focus Group Discussion</td>
<td>Community leaders at local level</td>
<td>4 Discussions</td>
</tr>
<tr>
<td></td>
<td>Community groups</td>
<td>4 Discussions</td>
</tr>
<tr>
<td>Key Informant Interview</td>
<td>Authorities at sub county level</td>
<td>14 Interviews</td>
</tr>
<tr>
<td></td>
<td>Authorities and health providers at district level</td>
<td>2 Interviews</td>
</tr>
<tr>
<td></td>
<td>Leaders of community groups</td>
<td>24 interviews</td>
</tr>
</tbody>
</table>
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
STAKEHOLDER ANALYSIS

Individual Key Informant Interviews (KII)

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

Background  Introduction  Methods  Results  Conclusions
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

Premium calculus according to different scenarios

- Benefits package
- Copayment
Socio-economic profile

1st quintile | 2nd quintile | 3rd quintile | 4th quintile | 5th quintile

- 1st quintile: 10
- 2nd quintile: 90
- 3rd quintile: 70
- 4th quintile: 10
- 5th quintile: 10
First income use

- Health: 36%
- School: 42%
- Food: 10%
- Clothing: 6%
- HH assets: 42%
- Construction house: 6%
- Business: 10%
- Gardening: 10%

Health as priority

<table>
<thead>
<tr>
<th>Priority</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health as first priority</td>
<td>94</td>
<td>52%</td>
</tr>
<tr>
<td>Health among first 2 priorities</td>
<td>126</td>
<td>70%</td>
</tr>
<tr>
<td>Health among first 3 priorities</td>
<td>145</td>
<td>81%</td>
</tr>
</tbody>
</table>
## Sources to finance health expenditures

<table>
<thead>
<tr>
<th>Source</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cash ready at home</td>
<td>83</td>
<td>25%</td>
</tr>
<tr>
<td>Casual labour</td>
<td>10</td>
<td>3%</td>
</tr>
<tr>
<td>Gifts from family, friends, neighbours</td>
<td>6</td>
<td>2%</td>
</tr>
<tr>
<td>Selling crops</td>
<td>127</td>
<td>38%</td>
</tr>
<tr>
<td>Selling household assets</td>
<td>61</td>
<td>18%</td>
</tr>
<tr>
<td>Selling land</td>
<td>4</td>
<td>1%</td>
</tr>
<tr>
<td>Loan from traditional social protection groups</td>
<td>19</td>
<td>6%</td>
</tr>
<tr>
<td>Loans from family, friends, neighbours</td>
<td>17</td>
<td>5%</td>
</tr>
<tr>
<td>Loan from money lender</td>
<td>3</td>
<td>1%</td>
</tr>
<tr>
<td><strong>Tot</strong></td>
<td><strong>330</strong></td>
<td><strong>100%</strong></td>
</tr>
</tbody>
</table>
Seasonal ability to pay

Available income

Able to pay without difficulties
A

Able to pay but with difficulties
B

Totally unable to pay
C

Ability to pay

Cost of treatment

August-September (first harvest season)

November-December (second harvest season)

Time of the year

(Our elaboration)
STAKEHOLDER ANALYSIS

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

Existing solidarity groups $\iff$ 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
INVESTIGATION ON GROUPS

<table>
<thead>
<tr>
<th>SUB COUNTY</th>
<th>N GROUPS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acaba</td>
<td>105</td>
</tr>
<tr>
<td>Aleka</td>
<td>156</td>
</tr>
<tr>
<td>Kamdini</td>
<td>112</td>
</tr>
<tr>
<td>Loro</td>
<td>111</td>
</tr>
</tbody>
</table>

Tot: 484

- High prevalence:

- 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
INVESTIGATION ON GROUPS

• Membership characteristics:
  ▪ Majority of women
  ▪ Heterogeneous age profile
  ▪ Village level

• Internal organization:
  ▪ Leadership structure
  ▪ Formal constitution
  ▪ Regular meeting
### Scenario 1
- Comprehensive package, no co-payment
  - per person: 9,440 UGX
  - per household: 62,211 UGX

### Scenario 2
- Comprehensive package, 20% co-payment
  - per person: 7,552 UGX
  - per household: 49,769 UGX

### Scenario 3
- Selective package, no co-payment
  - per person: 2,640 UGX
  - per household: 17,400 UGX

### Scenario 4
- 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