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Why Ugandan rural households are opting to pay community health insurance rather than use the free healthcare services

Twikirize JM, O'Brien C. Why Ugandan rural households are opting to pay community health insurance rather than use the free healthcare services

Uganda reintroduced free healthcare in 2001, but today, nine years later, less than 30 per cent of the population are using these services. This study investigated why rural households were under-utilising the government's free health services and turning to community health insurance instead. A survey carried out on 260 randomly selected households was triangulated with qualitative data gained from 3 focus groups and 12 in-depth interviews. The findings showed that 21 per cent of the households always accessed the government's free health services, while 79 per cent used private health services. The reasons given were poor quality services, including frequent drug stock-outs, unmotivated and insufficiently trained health personnel, and overcrowding. Factors influencing enrolment in community health insurance included easier access to healthcare, financial protection against the cost of care, better quality care and benefits related to mutual assistance. This has both practical and policy implications, which are discussed in this article.

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Introduction

Good health is a prerequisite to the development of any household, community or country. It translates into increased enrolment and better performance in school and high labour productivity, and it is generally an indicator of the level of socio-economic development of a country. Nevertheless, access to healthcare remains a challenge. It is estimated that 1.3 billion people worldwide lack access to healthcare (Preker et al., 2002). Most of these people are found in developing countries. In Africa, more than 50 per cent of the population lack access to modern healthcare, although the continent bears the highest burden of disease worldwide (World Health Organization, 2005). Besides the poor having limited geographical access to health services, they also lack financial access to healthcare. Most people cannot afford to pay for healthcare, and, at the same time, governments lack the necessary resources to provide adequate care. Rural households are most vulnerable as they are less able to meet the cost of healthcare and less able to recover from the loss of income associated with ill health.

In most countries, healthcare is financed through either one or a combination of the following mechanisms: tax-based financing, out-of-pocket (OOP) payments or user fees, social health insurance, private health insurance and community health insurance (CHI) (Bennett & Gilson, 2001; Criel, 1998; Donaldson & Gerard, 1993; McIntyre, 2007; Preker et al., 2002). While there is a general consensus that free healthcare (tax-based financing) is the most equitable form of health financing (McIntyre), its affordability by the governments, especially in sub-Saharan Africa, is debatable. As Carrin (2003) observed, health systems that depend on government tax revenue have generally been constrained by insufficient funding, which renders service delivery

inadequate in terms of both quantity and quality. This presents a policy challenge on how to ensure utilisation of healthcare for the poor who can least afford OOP expenses. Studies (Alderman & Lavy, 1996; Bennett, 2004; Wagstaff, 2002) have shown that people, including the poor, are willing to pay for better quality services rather than receive poor quality free healthcare. Two options thus seem to present opportunities for improving access to healthcare for the poor, namely, targeted free healthcare to selected poor segments of society and promotion of risk-pooling mechanisms that minimise OOP expenditures. The World Bank, which was the chief protagonist of user fees, has softened its position and instead is recommending prepayment mechanisms, such as insurance (McIntyre, 2007; Preker & Carrin, 2004). When such mechanisms that involve contributions and pooling of resources are in place, they might also release resources for improving the quality of healthcare in government health facilities. The present study is relevant because it has provided insights into the following policy questions: (a) Under what circumstances will people pay for healthcare?; (b) Should governments, whose resources are so constrained that they cannot provide services that are acceptable, attempt to provide 'free' care for everyone?; (c) How best should access to healthcare be improved for people who can least afford OOP expenses?; and (d) How can resources be increased to improve the quality of government-provided health services?

Uganda: the context

Uganda is situated in East Africa. It is a land-locked country covering an area of 241,551 km^2. It has a population of 27.2 million people, with an average population growth rate of 3.4 per cent. Uganda has recorded impressive economic growth rates since the early 1990s, with an average growth rate of over 6 per cent per annum (Uganda, 2007b). The percentage of the population living below the poverty line declined from 54 per cent in 1992/1993 to 31 per cent in 2006 (Sewanyana et al., 2004; Uganda Bureau of Statistics [UBOS] & Macro International, 2007). However, Uganda is still ranked among the poorest countries of the world, with a human development index of only 0.505 (United Nations Development Programme, 2007). According to the 2005/2006 National Household Survey (UBOS, 2007), nearly 8.4 million Ugandans were living in absolute poverty in 2005/2006. The majority of the poor people reside in rural areas.

Despite improvements in economic development, Uganda's health outcomes have remained low, and the health of the population is generally poor. In 2007 figures, the total fertility rate is 6.7 children per woman. Life expectancy at birth is only 49.7 years. The maternal mortality ratio (MMR) is 435 deaths per 100,000 births; the infant mortality rate is 76 deaths per 1,000 live births, while the under 5 mortality rate (U5MR) is 137 deaths per 1,000 live births (UBOS & Macro International, 2007). Both the MMR and U5MR are some of the highest in the world (World Bank, 2005). There is generally a high burden of disease in the country. Over 70 per cent of life years lost to premature deaths are attributed to preventable diseases (Uganda, 1999; World Bank, 2005). Prenatal and maternal conditions, malaria, acute respiratory tract infections, human immune-deficiency virus, acquired immune-deficiency syndrome and diarrhoea together account for over 60 per cent of the total national death burden. Disease prevalence in Uganda increased from 29 per cent to 40 per cent between 2002 and 2006 (UBOS, 2006). Apart from communicable diseases, there is an increase in non-communicable diseases such as diabetes, mental illness, cancer, hypertension and chronic heart disease.

The government of Uganda, through the Ministry of Health, is responsible for overseeing the delivery of health services and is the major health service provider. The private sector is considered a key actor in the national health system. Recognised health service providers in the private sector include the private-not-for-profit providers (PNFP), the private-for-profit providers (PFP), and traditional and complementary medicine practitioners. According to a 2006 health facility inventory (Uganda, 2006), there are 104 hospitals in the country. Of these, 57 are government-owned, 44 are PNFP and 3 are PFP hospitals. The planning and delivery of health services are guided by a national health policy whose key strategy is the provision of a basic package of health services – the Uganda National Minimum Health Care Package – considered to address the common causes of illness and death in the country. The health system operates under a decentralised service structure where local governments are responsible for planning and overseeing the delivery of health services.

Financing healthcare in Uganda

Uganda has had two major health financing policy regimes since its independence in 1962: free healthcare and user fees. Free healthcare, which was adopted at independence with a goal of making services accessible to the wider population, seemed to have worked with some degree of success in the first decade of independence (Deininger & Mpuga, 2004). However, the socio-political turmoil of the 1970s and early 1980s led to the breakdown of the social infrastructure and distorted the

health service delivery system. In 1993, a policy of user fees, commonly known as 'cost sharing', was adopted under pressure from the international financial institutions as part of the structural adjustment programmes. User fees were seen as a mechanism for mobilising additional resources for health. An assessment of the policy later indicated that results were mixed, with reports of improved services, on the one hand, and inability to pay for services, on the other hand (World Bank, 2005). Various studies (Burnham et al., 2004; Deininger & Mpuga, 2004; Kipp et al., 2001; Kivumbi & Kintu, 2002; Mpuga, 2002; Nabyonga et al., 2005; World Bank, 2005), although highlighting the positive experiences with user fees, concluded that it was excluding the poor and the most vulnerable groups from health service utilisation.

In 2001, Uganda adopted a free healthcare policy where health services are provided to the population free of charge in all government health facilities. The major sources of finances for this policy implementation include general taxes and donor budget support. The adoption of government-provided free healthcare has led to increases in the utilisation of services, especially for the poor (Xu et al., 2005), but has different impacts on the poor and the non-poor. There was no clear change in either utilisation or catastrophic expenditures in the non-poor. It was also noted by the above authors that the incidence of catastrophic health expenditure did not decline, not even among the poor sections of the population; hence, they questioned the viability of the government's free healthcare services.

Besides the major financing mechanisms highlighted above, Uganda made an attempt to introduce CHI as a complementary health financing mechanism. CHI is any project that is managed and operated by an organisation other than government or PFP company, which provides risk pooling to cover the costs or part of the costs of healthcare services (Musau, 1999; Preker et al., 2002). The members are required to pay a fixed amount of money periodically in return for a defined package of health services. Examples of countries in Africa where CHI has been relatively successful include the Democratic Republic of Congo (Criel, 1998), Rwanda (Musango et al., 2006) and Senegal (Jutting, 2001).

The Uganda government, with support from the UK's Department for International Development, initiated the development of CHI schemes. The first scheme was launched in 1996 at Kisiizi Missionary Hospital in Rukungiri District. It was piloted as an alternative health financing strategy at a time when the official policy of the government was cost-sharing (user fees). Notwithstanding the change of policy to free healthcare in 2001 and the withdrawal of major donor funding, the CHI schemes have continued operating, and others have been established. Currently, there are about 20 schemes operating in different parts of the country.

The Kisiizi scheme is operated by an independent organisation, Microcare, on a non-profit basis. The scheme enrols households organised in groups of 20. Members pay annual premiums to Microcare, and they are in turn entitled to receive health services outlined in the benefits package from the hospital. The hospital bills are then paid by Microcare from the pooled funds. The amount of premium paid varies with household size but is progressively reduced with larger household size. For example, a 4-member household pays US$14, while a 12-member household pays US$24 per annum. At the time of the study, 20,624 individuals were enrolled in the scheme, representing about 30 per cent of the scheme's target population residing in the two sub-counties of Nyarushanje and Nyakishenyi. This article attempts to provide an understanding of *why poor rural households are opting to pay through community health insurance in an environment where healthcare is provided free in all government health facilities*.

Research design and methodology

This article is based on a case study (Yin, 2003) of one rural sub-district (Rubabo County) in south-western Uganda and one CHI scheme. It analyses the results of a household questionnaire, focus group discussions (FGD) and key informant (KI) interviews, and it provides insights into how the community views their healthcare needs and the means of meeting them. Two hundred and sixty household heads were interviewed using a questionnaire (quantitative). Twelve face-to-face in-depth interviews (qualitative) were conducted with KIs, while three FGDs with scheme members, non-scheme members and scheme dropouts were held.

Rubabo is in Rukungiri District in south-western Uganda, where the longest operating CHI scheme was in operation. Rukungiri District has a total population of 308,696 persons, with approximately 40,000 households (Uganda, 2007c). The area is predominantly rural, with subsistence farming as the major economic activity. The district has the highest levels of malaria in Uganda at 74.5 per cent (UBOS, 2006) and lies within the south-western region which records the highest levels of child malnutrition (UBOS & Macro International, 2007). There is, hence, a significant need for effective healthcare. The district has only two hospitals, both of which are PNFP. Within Rubabo County, there are four sub-counties, namely, Buyanja, Kebisoni, Nyakishenyi and Nyarushanje. The latter two sub-counties were chosen purposively for the study because they constitute the immediate catchment area for the

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CHI scheme. The aggregate population for the two sub-counties is 71,100 people (UBOS, 2007). From each sub-county, three parishes were selected randomly, and households were in turn selected from each of these parishes. The number of households randomly sampled was 260, comprising 130 CHI scheme members and 130 non-members. Sixty-five members and 65 non-members of the CHI scheme were selected from each sub-county, thus adding up to 260 households. This non-proportionate stratified sampling was preferred because of the need to conduct an in-depth analysis of the characteristics of both categories of respondents (Corbetta, 2003). The sampling frame for members of the CHI was obtained from the Kisiizi health insurance scheme office. The non-scheme member households from each parish were chosen with the assistance of the local council officers and the local stretcher (*engozi*) group chairpersons in the selected parishes (*engozi* is a local 'ambulance' used to carry sick or dead people to and from hospital because there is a lack of formal means of transport).

KIs were selected purposely to include 12 respondents from the key stakeholders in the various subsectors of the health system in Uganda, namely, the public sector, the private sector and the traditional medicine sector. In addition, three focus groups were conducted with three categories of community members, namely, members of CHI, non-members of CHI and those who had dropped out of the scheme. The purpose of these focus groups as well as the in-depth interviews was to gain a deeper understanding of the meanings that respondents attributed to questions raised in this study. Furthermore, these qualitative data augmented the data generated from the quantitative survey (Bailey, 1994).

A standardised questionnaire with pre-coded questions relating to the research objectives was administered to 260 respondents, each representing a household. Four trained research assistants assisted the principal researcher in carrying out the survey. The technique adopted was face-to-face interviews so as to better engage respondents, because literacy levels are low in Uganda's rural areas. Qualitative data were collected through FGDs and face-to-face KI interviews. Secondary sources were also used.

A computer-assisted analysis was done using the Statistical Package for Social Sciences (SPSS Inc, Chicago, Illinois, USA) evaluation version). Based on the descriptive design of the study, bivariate analysis was done. Cross tabulations were used to compare households that were enrolled in CHI with households that were not enrolled, with regard to access to healthcare. Chi-square tests were used to estimate levels of significance of relationships between selected variables and healthcare access and utilisation. Other measures of association, namely, lambda and Cramer's V, were used to estimate the strength and direction of the relationships among the key variables. These are non-parametric measures, and they were chosen because the data were mostly nominal and categorical. Thus, these tests were deemed more appropriate. Because of the use of non-parametric measures, no predictions of cause–effect relationships can be claimed. However, this limitation was minimised by triangulating the survey findings with qualitative information. Thematic analysis was employed for data gained from FGDs and KI interviews. Emerging themes and sub-themes emanating from the data were identified. Triangulation of data from all three sources (questionnaires, FGDs, KI interviews), together with secondary sources, provided a fuller understanding and helped to strengthen the conclusions reached.

Study findings

Only the main findings are presented in this article.

Profile of household respondents

One half of the respondents were members of the CHI scheme, while the other half were non-members (Table 1). The majority of respondents were younger than 45 years (62.3%), with only 37.7 per cent aged 45 years or older. The percentage of household heads aged 50 years and older was higher among scheme members (30%) than non-scheme members (20%). Though not statistically significant, the difference could imply that the scheme attracts households that are headed by older adults more than households headed by younger adults. With regard to marital status, most respondents (83.1%) were married. There were slightly more widowed respondents among scheme members (12.3%) than among non-scheme members (10.8%), although the results are not significant ($p = 0.725$). Because widowhood is often associated with vulnerability, the results could imply that the CHI has the potential to enrol people from different socio-economic groups. More scheme members (45.4%) had larger households (seven or more people) than those of non-scheme members (27%). The chi-square tests indicated a significant relationship between household size and enrolment ($p = 0.041$). It appears that households with larger families tend to enrol in the scheme. More than half of all respondents (53.1%) had attained a primary level of education, while only 11.5 per cent had attained tertiary education. No significant relationship was found between the level of education and enrolment ($p = 0.505$). The main occupation for both members and non-members of CHI (61.5%) was peasant farming. Land ownership was used as a proxy for household wealth status

Table 1. Selected characteristics of household respondents ($n = 260$).

	Community health insurance enrolment status						Significance (p-value)	Lambda	Cramer's V
	Member		Non-member		Total				
	n	Per cent	*n*	Per cent	*n*	Per cent			
Age of household head									
18–24	2	1.5	3	2.3	5	1.9	0.286	0.154 (0.096)	0.169 (0.286)
25–29	14	10.8	17	13.1	31	11.9			
30–34	15	11.5	22	16.9	37	14.2			
35–39	27	20.8	20	15.4	47	18.1			
40–44	19	14.6	23	17.7	42	16.2			
45–49	14	10.8	19	14.6	33	12.7			
50 and above	39	30.0	26	20.0	65	25.0			
Total	130	100.0	130	100.0	260	100.0			
Sex of household head									
Male	108	83.1	111	85.4	219	84.2	0.610	0.023 (0.839)	0.032 (0.610)
Female	22	16.9	19	14.6	41	15.8			
Total	130	100.0	130	100.0	260	100.0			
Marital status									
Single	5	3.8	3	2.3	8	3.1	0.725	0.031 (0.788)	0.071 (0.725)
Married	107	82.3	109	83.8	216	83.1			
Separated/divorced	2	1.5	4	3.1	6	2.3			
Widowed	16	12.3	14	10.8	30	11.5			
Total	130	100.0	130	100.0	260	100.0			
Household size									
1–2	11	8.5	12	9.2	23	8.8	0.041*	0.185 (0.061)	0.196 (0.041)*
3–4	25	19.2	36	27.7	61	23.5			
5–6	35	26.9	47	36.2	82	31.5			
7–8	37	28.5	23	17.7	60	23.1			
9 and above	22	16.9	12	9.2	34	13.1			
Total	130	100.0	130	100.0	260	100.0			
Highest level of education completed									
None	12	9.2	11	8.5	23	8.8	0.526	0.085 (0.426)	0.127 (0.526)
Primary	67	51.5	71	54.6	138	53.1			
Secondary[a]	23	17.7	29	22.3	52	20.0			
High school[b]	4	3.1	2	1.5	6	2.3			
Vocational	8	6.2	3	2.3	11	4.2			
Tertiary level	16	12.3	14	10.8	30	11.5			
Total	130	100.0	130	100.0	260	100.0			
Occupation of household head									
Peasant farmer	85	79.4	83	75.5	168	77.4	0.277	0.047 (0.702)	0.171 (0.277)
Petty trader/small-scale enterprise	11	10.3	12	10.9	23	10.6			
Salaried employment[c]	5	4.7	7	6.4	12	5.6			
Others[d]	6	5.6	8	7.3	14	6.5			
Total	107	100.0	110	100.0	217	100.0			
Land ownership									
Nil	0	0.0	7	5.4	7	2.7	0.020*	0.154 (0.071)	0.212 (0.020)*
Less than 1 acre	49	37.7	61	46.9	110	42.3			
2–4 acres	67	51.5	48	36.9	115	44.2			
More than 5 acres	11	8.5	10	7.7	21	8.1			
More than 10 acres	3	2.3	4	3.1	7	2.7			
Total	130	100.0	130	100.0	260	100.0			

Source: Field data, September 2007.

Notes: [a] 'Secondary' is also known as the ordinary level of education. It is the level immediately after the primary level and takes 4 years.

[b] High school is a 2-year study period preceding tertiary (university or college) level of education.

[c] The specific categories reported under salaried employment mainly included: teaching service, health worker and political/public administration.

[d] The category 'others' mainly included pit sawing, builder, tailor, casual labourer and others.

* The chi-square statistic is significant at 0.01 level.

(World Development Report, 2002). While the percentage of scheme members and non-scheme members who reported owning 1 acre of land or less is almost the same, more scheme members (48.5%) than non-scheme members (35.4%) reported ownership of at least 2–4 acres of land. The chi-square tests indicated a significant relationship between land ownership and status of enrolment ($p = 0.020$), reflecting some socio-economic differences between the members and non-members of the CHI scheme.

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Table 2. Level and cause of illness among respondents.

	Community health insurance enrolment status						Significance (p-value)	Lambda	Cramer's V
	Member		Non-member		Total				
	n	Per cent	*n*	Per cent	*n*	Per cent			
Have you fallen sick in the last 6 months?									
Yes	62	47.7	74	57.4	136	52.3	0.136	0.092 (0.302)	0.092 (0.136)
No	68	52.3	56	42.6	124	47.7			
Total	130	100.0	130	100.0	260	100.0			
Cause of illness									
Malaria	27	43.5	50	67.6	77	56.6	0.005*	0.242 (0.023)	0.330 (0.005*)
Others[a]	23	37.1	13	17.6	36	26.5			
Respiratory tract infection	5	8.1	9	12.2	14	10.3			
Accident	5	8.1	0	0.0	5	3.7			
Diarrhoea	2	3.2	2	2.7	4	2.9			
Total	62	100.0	74	100.0	136	100.0			
Sought any form of treatment or healthcare for last illness episode									
Yes	61	98.4	69	93.2	130	95.6	0.146	–	0.125 (0.146)
No	1	1.6	5	6.8	6	4.4			
Total	62	100.0	74	100.0	136	100.0			
Source of care for last illness episode									
PNFP hospital	45	73.8	20	29.0	65	50.0	0.001*	0.410 (0.001*)	0.489 (0.000*)
Private health facility	10	16.4	14	20.3	24	18.5			
Government health centre	4	6.6	21	30.4	25	19.2			
PNFP health centre	1	1.6	6	8.7	7	5.4			
Other	0	0.0	5	7.2	5	3.8			
Government hospital	1	1.6	3	4.3	4	3.1			
Total	61	100.0	69	100.0	130	100.0			

Notes: [a] Other conditions most commonly reported include ulcers, asthma, hypertension, headache, child delivery, urinary tract infections, routine HIV/AIDS check-up and others.
* The chi-square statistic is significant at the 0.01 confidence level. Approximate significance of the value in parentheses, based on chi-square tests.
AIDS = acquired immune-deficiency syndrome; HIV = human immune-deficiency virus; PNFP = private-not-for-profit.

Level of illness and healthcare-seeking patterns

Respondents were asked if they had fallen sick during the 6 months preceding the survey. The cause of illness and the source of healthcare were also explored.

More than half of all respondents reported an episode of illness in the 6 months preceding the survey. Non-members of the CHI scheme (57%) were more likely to report an illness than were scheme members (48%). The most commonly reported cause of illness was malaria (56.6%). This was higher among non-scheme members by 24 per cent. The chi-square ($p = 0.005$) and other measures of association (lambda: 0.242; Cramer's V: 0.330) indicated a significant though moderate relationship between the cause of illness and CHI enrolment.

Almost all of the respondents who became sick sought formal healthcare (see Table 2). Although the figures did not show significant differences in healthcare-seeking patterns between members and non-members of the CHI scheme, data gathered through in-depth interviews suggested that members of the insurance scheme were more likely to seek treatment earlier than were non-scheme members.

> *Scheme-members tend to report early for treatment since they know that they will not have to pay. This has even improved the management of conditions on the part of the health workers.* (Administrator, Kisiizi Hospital, September 2007)

The key explanation is that membership in a CHI scheme reduces out-of-pocket payments for healthcare, which in turn encourages healthcare-seeking, especially among the poor.

Usual and preferred source of healthcare

The usual source of healthcare refers to the commonly visited health facility by an individual during an illness episode. This is contrasted with the preferred source of healthcare, which refers to the more desirable health facility reported by individuals or households. With the decentralisation of health services in Uganda, health centre three (HC III) is designated as the primary facility for provision of healthcare. These facilities are available in almost every sub-county in Uganda. However, while the majority of respondents (46.5%) indicated that the nearest health facility to their homes was a government HC III (data not

Table 3. Usual and preferred sources of healthcare for households.

	Community health insurance enrolment status						Significance (p-value)	Lambda	Cramer's V
	Member		Non-member		Total				
	n	Per cent	*n*	Per cent	*n*	Per cent			
Usual source of healthcare									
PNFP hospital	99	76.2	38	29.2	137	52.7	0.000*	0.469 (0.000*)	0.510 (0.000*)
Government health centre	9	6.9	49	37.7	58	22.3			
Private clinic	8	6.2	24	18.5	32	12.3			
PNFP health centre	14	10.8	14	10.8	28	10.8			
Government hospital	0	0.0	5	3.8	5	1.9			
Total	130	100.0	130	100.0	260	100.0			
Preferred source of healthcare									
PNFP health facility	113	86.9	96	73.8	209	80.4	0.003*	0.131 (0.016)	
Private health facility	16	12.3	21	16.2	37	14.2		0.212 (0.003*)	
Government health facility	1	0.8	12	9.2	13	5.0			
Private drug shop	0	0.0	1	0.8	1	0.4			
Total	130	100.0	130	100.0	260	100.0			

Notes: * The chi-square statistic is significant at the 0.01 confidence level.
Approximate significance of the value in parentheses, based on chi-square tests.
Source: Field data, September 2007.
PNFP = private-not-for-profit.

shown), the usual source of healthcare for most of them (63.5%) was a PNFP health facility (either hospital or health centre). The findings indicated a low preference and utilisation of government health facilities as shown in Table 3.

The majority of respondents (52.7%) sought care from the PNFP hospital, while only 22 per cent usually sought care from a government health centre. A significant majority of both scheme members (86.9%) and non-scheme members (73.8%) mentioned the PNFP health facility as their preferred source of healthcare. This was followed by the PFP health facility and the government health facility, respectively. In contrast to the usual source of healthcare, the directional and symmetric tests (lambda: 0.131; Cramer's V: 0.212) did not indicate a strong relationship between the preferred source of healthcare and enrolment. This implied that there were no significant differences in provider preferences between members and non-members of CHI.

Level of use of government health services

As indicated earlier, the government has the largest network of health centres and therefore provides much easier geographical access (shorter distance) to healthcare to the population. In addition, the services are provided free of charge, hence enhancing financial access. However, this access does not guarantee actual use of the services (utilisation). Respondents were asked how often they utilised the government health services (Figure 1).

Only about 21 per cent of all respondents said that they always utilise government health services, while a third of them said that they rarely utilise these services. It is worth noting that even among non-scheme members, a considerably low utilisation of government health facilities was found, with 27 per cent and 10.8 per cent of them reporting that they rarely or never used the services, respectively.

Obstacles in utilising government-provided free healthcare

A number of limitations in utilising government-provided free healthcare were identified. Table 4 summarises the responses from the household survey.

Most respondents (76.9%) reported the unavailability of drugs in the government health facilities as a major inhibiting factor. This shortage of drugs was also emphasised as a setback in findings gathered from the FGDs and KIs:

> . . . *every time you go there* [government health facility] *you are told there are no drugs. You have to buy drugs from somewhere else. If you cannot buy, you just go back home and wait for the illness to go or to die. If you can, you end up going to seek serious care somewhere else like at Kisiizi Hospital.* (Non-scheme members' FGD, April, 2008)

> *The public healthcare is in essence not free. Patients are just given prescriptions to go and buy drugs. The patient does not consider that as free healthcare. They get disillusioned.* (KI, Ministry of Health, April, 2008)

The lack of diagnostic equipment and other basic facilities such as theatres and laboratories were also

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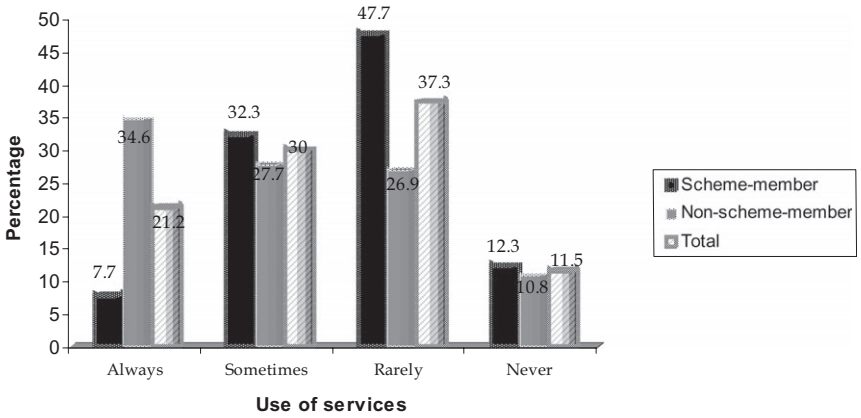

Figure 1. Level of use of government health services (n = 260).
Source: Field data, September 2007.

Table 4. Obstacles in accessing free healthcare.

Cause of difficulty in accessing government health services	Community health insurance enrolment status					
	Member		Non-member		Total	
	f	Per cent	*f*	Per cent	*f*	Per cent
Unavailability of drugs	91	70.0	109	83.8	200	76.9
Lack of equipment and other facilities	32	24.6	35	26.9	67	25.8
Low availability of health personnel	19	14.6	19	14.6	38	14.6
Distance to the health facility	16	12.3	6	4.6	22	8.5
Overcrowding	5	3.8	3	2.3	8	3.1
Cost of care	7	5.4	1	0.8	8	3.1
Long waiting hours	6	4.6	1	0.8	7	2.7
Others	11	8.5	8	6.2	19	7.3

Note: The percentages do not add up to 100 because of multiple responses.
Source: Field data, September 2007.

identified as key impediments in the utilisation of free health services. Nearly 25 per cent (24.6%) of scheme members and 26.9 per cent of non-scheme members mentioned this as an inhibiting factor in the utilisation of the services. A number of KIs also confirmed this limitation:

> *There are no storage facilities for drugs – assuming that the drugs were available. No basic equipment for diagnosing and treating patients. Not even a microscope is available. So what health service availability is that?* (Public health service provider, April, 2008)

Community members often referred to the lack of diagnostic equipment in the health centres as 'treating what they do not know', and it came out strongly as one of the constraints to utilising the government's free healthcare.

Respondents also mentioned that they found it difficult to use public health facilities because the medical personnel are either not available or only available on certain days:

> *. . . the doctor is in most cases absent. I think he works on particular days and on others he does not come . . . during weekends and holidays, they do not work, as if people do not fall sick on those days . . . also on market days the health centres are closed . . . It is difficult to get attention from a government health centre.* (Non-scheme members' FGD, April, 2008)

> *When you look at the health centre, what is available? A nursing aide or nursing assistant who is not able to deliver the services and yet . . . even if I am poor and the government has said free healthcare, they should give me quality care.* (Executive director, Traditional and Modern Health Practitioners Together Against [HIV] AIDS and Other Diseases, May, 2008)

Other human resource constraints related to low commitment among the health personnel, semi-skilled personnel running the health centres and inadequate staffing levels that led to work overload for the few personnel at the health centres.

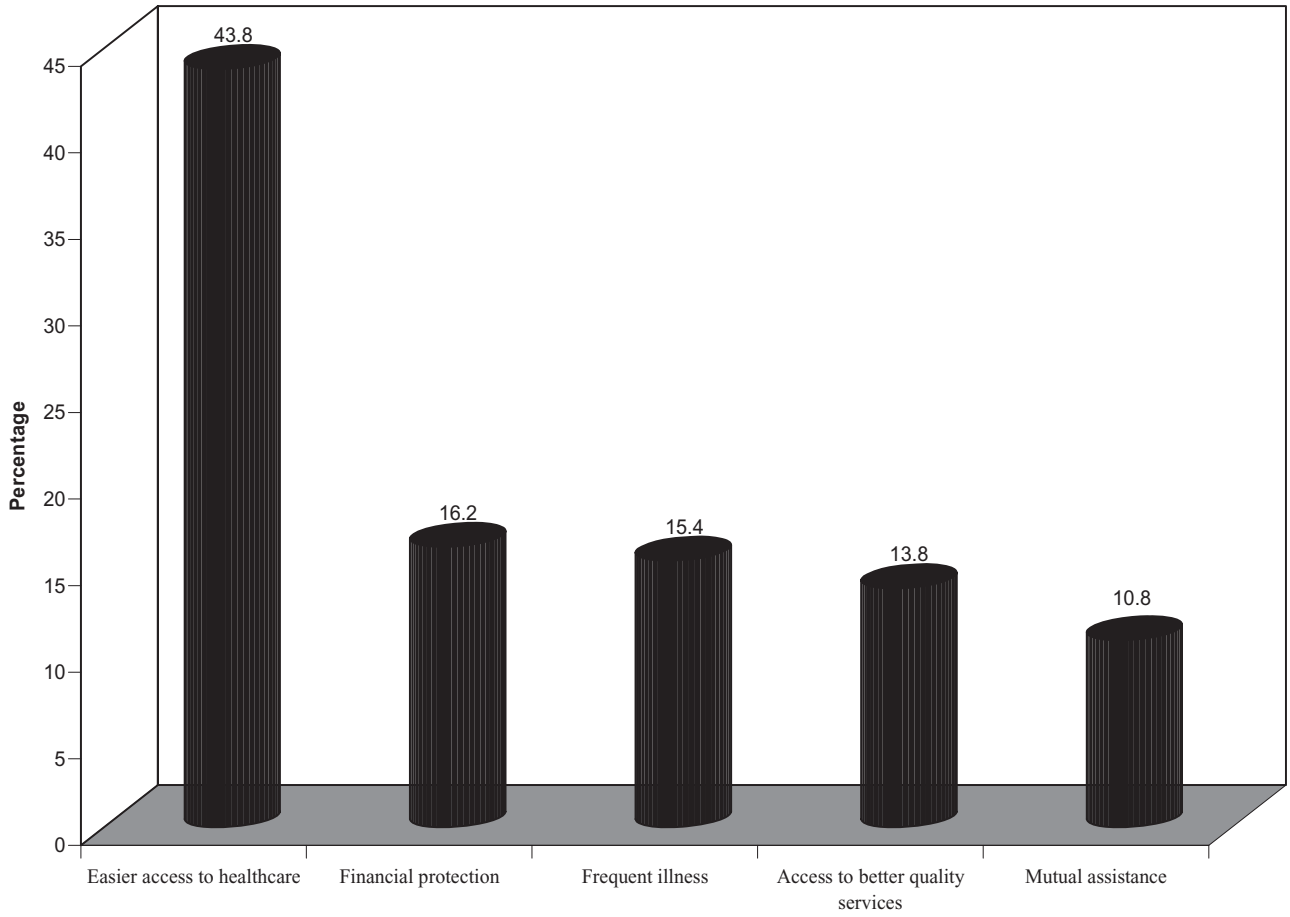

Figure 2. Major reasons for enrolment in the community health insurance scheme (n = 130).
Source: Field data, September, 2007.

Why people opt to enrol in CHI

In the year 2007, scheme membership comprised 3,976 households (20,624 individuals) out of a target population of 11,000 households (UBOS, 2007). The hospital records also indicated that about 30 per cent of both outpatient (8,554 out of 29,902) and inpatient cases (3,958 out of 10,583) were members of CHI (Kisiizi Hospital, 2007). This implies that scheme membership covered about a third of the target population. Nevertheless, there were positive trends in enrolment levels, indicating the potential of the CHI scheme to realise sustained growth. Scheme members were asked to state the most important reason for enrolling in CHI despite the free healthcare (Figure 2).

Almost a half of all the scheme members interviewed indicated that they joined the scheme because they believed that it provided more effective access to healthcare. This was confirmed by data from the FGD:

> *. . . there are complicated illnesses, which private clinics cannot handle . . . It is not easy to get help from elsewhere. Or if you get an accident, you'll have to go to Kisiizi. If you go there without insurance you pay something like 300,000 Uganda shillings which we do not have. So if you are in the scheme it helps a lot.* (Scheme members' FGD, April, 2008)

Other key reasons for enrolment included financial protection against the cost of illness (16.2%), frequent illness (15.4%), access to better quality care (13.8%) and mutual assistance (10.8%). Financial protection against the cost of illness was interpreted mainly in terms of the ability of a household to utilise medical care without being forced to sell a household asset such as land, bicycle or other assets. This protected the household from being plunged into deeper poverty.

The identification of frequent illness as a major reason for enrolment (15.4%) indicates that households or individuals were able to estimate health risk and base their decisions on that. This was also highlighted in the responses from the FGDs:

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I have a big family and am poor. I do not always have money to access medical care whenever needed. The scheme allows me to pay before so that I can go to hospital whenever need arises. That helps me a lot. (Scheme member, Ndago parish, Nyarushanje sub-county, September, 2007)

The constant reference to payments indicates that the majority of households were still paying for healthcare despite the government's free healthcare policy. Without the scheme, such families would have had to make OOP payments for every illness episode in the household.

Some of the obstacles to utilising services through CHI included the cost of the insurance premium; the limited number of health service providers of an acceptable quality; unpopular design features of the programme, such as excluding some conditions from the benefits package; and rigidities in the enrolment procedure, for example, the refusal to enrol individual households. Despite these limitations, CHI was perceived as an easier and relatively secure option in meeting the healthcare needs of households.

Discussion

The findings indicate a very high level of illness among the population and hence a dire need for health services. This calls for concerted effort by the government and other key players not only in addressing the causes of illness, but also in devising means of improving access to effective healthcare. There is an indication that people are willing to utilise modern healthcare (as reflected in the percentage of respondents that sought formal treatment for an episode of illness), though sometimes there is reported delay. The government therefore needs to address the obstacles that lead to delayed healthcare-seeking behaviour in order to realise better health outcomes.

The findings confirm that the population has a very high preference for the PNFP health facility compared with the government health facility. Other studies, conducted in different parts of Uganda, have indicated similar results (Reinikka & Svensson, 2003). One could conclude that the predominant consideration for the choice of a healthcare source is the quality of care. The findings confirm an earlier argument (Alderman & Lavy, 1996; Nabyonga et al., 2005) that people value good health services and are willing to make some financial contribution to get them. However, this willingness to pay does not always mean an ability to pay (Deininger & Mpuga, 2004), which is why there are differences between the preferred and the usual source of healthcare as shown in this study (Table 3). Practical programmes that enable people to access better healthcare while at the same time protecting them from the burden of OOP payments need to be further explored. It is argued in this article that CHI provides such an opportunity.

There is generally a very low level of utilisation of government-provided free healthcare within the study population, signifying a general dissatisfaction with the quality of services. Previous research has shown that utilisation of public health services in Uganda increased especially for the poor after the abolition of user fees in 2001 (Burnham et al., 2004; Deininger & Mpuga, 2004; Meessen et al., 2006; Mpuga, 2002; Nabyonga et al., 2005). However, other studies (Burnham et al., 2004; Poirier, 2006; Uganda, 2007a; World Bank, 2003; Xu et al., 2005) indicated that this has not resulted in effective access to the services. The results of the present study are also consistent with those contained in two key government publications – the National Household Survey, 2005/2006 (UBOS, 2006) and the Annual Health Sector Performance Report, 2006/2007 (Uganda) – which indicate that the majority of people still seek care from private service providers despite the government's free services. Another contradiction is that although the use of health services by the poor was reported to have increased since the removal of user fees (Deininger & Mpuga, 2004; Nabyonga et al., 2005), out-of-pocket expenses have increased, requiring poor patients to buy drugs from the private sector or go directly to the private sector for healthcare (Burnham et al., 2004; Poirier, 2006; Xu et al., 2005). It should be noted that people do not just shun free healthcare but, rather, that they are forced to seek alternative care from private providers because of the poor quality of the government-provided free health services, characterised by the shortage of drugs and basic equipment, and the unavailability of health workers.

In essence, free healthcare exists in principle but not in practice. While physical structures exist relatively closer to the population, the quality of services has been compromised to an extent that few people are actually able to benefit. Frequent drug stock-outs, unavailable health workers, and lack of basic equipment and services constitute serious obstacles to access. People are left with no choice but to seek expensive care from the private providers (both for-profit and not-for-profit), where the quality of care is perceived as relatively better than the free healthcare in the public sector. Though there was an attempt to increase drug supplies to health centres after the abolition of user fees (Nabyonga-Orem et al., 2008), it appears that the increase did not match the demand for the drugs, leading to frequent stock-outs. Xu et al. (2005) contended that a reduction in expenditure on fees could be offset by increases in payments for

other services that are no longer available in the public sector.

CHI is one of the mechanisms through which people are seeking better healthcare. Key reasons for enrolment in CHI, such as the need to access better quality services from private providers and to secure financial protection against the cost of illness, underscore the fact that community members are not just passive recipients of services. They can make rational decisions, evaluate the quality of services and are willing to make some financial contribution for better quality services. The present study has shown that there is a segment of the population that can afford to participate in CHI schemes. This is indicated by positive trends in enrolment, with more than 30 per cent of the target population enrolled in the scheme and with more than a half of the households interviewed utilising private healthcare for which they have to pay. This calls for the government to strengthen the role of the community in the organisation and delivery of health services. It is recognised that CHI has limitations. The cost of the premium and some of the design aspects of CHI prevent some people from enrolling, and these factors need to be carefully considered in the design of CHI schemes.

Policy implications

Based on the foregoing discussion, the article has highlighted the following policy implications. First, people are dissatisfied with government health services because of their poor quality despite their being free of charge. This is why there is underutilisation of these services. In a bid to ensure universal access, the quality of healthcare has been severely compromised. It is therefore suggested that selective provisioning be considered instead of universal access. Policy makers might consider targeting free healthcare services to those who are unable to pay, that is, a particular category of the population based on either geographical location or other socio-economic indicators.

Second, it is clear that community members appreciate the advantages of CHI, namely, reduced OOP expenditure and timely access to healthcare. The fact that people do not wait to fall sick in order to mobilise resources but instead contribute to the scheme beforehand means that they are not, for example, under pressure to sell their meagre assets in order to meet the cost of care. Also, many people contribute to a pool, and only those who fall sick in a given period benefit from these contributions. People are willing to enrol in CHI because it enhances their access to healthcare of a relatively better quality. It is therefore crucial for health policy to further investigate how to make CHI more effective and affordable. A systematic promotion of CHI would ensure that those who are in position to pay for healthcare would use the insurance schemes so as to avoid the difficulties presented by OOP expenditures for healthcare.

Third, while this study has demonstrated a positive perception of CHI and the community's willingness to join the scheme, these positive aspects alone cannot lead to CHI's sustained development. The predominance of poverty, the presence of vulnerable groups and the high prevalence of disease all imply that the development of CHI cannot be left to the local community alone. There is a need for concerted support from key stakeholders, including government, donors, civil society and the community. It is urgent that the government develop a policy framework for CHI in order to promote its development. Financial and technical support is also required in building the administrative capacity of the schemes and in providing subsidies to reduce the premium and to make schemes more affordable for more households. There are also elements of the design of a CHI scheme that, despite their technical rationality, can adversely affect its viability through their negative impact on enrolment. Two key features that need improvement are the benefits package and the provider options. More community dialogue is needed in determining the benefits package to make it more universally acceptable. To address the question of provider options, there is a need to carefully develop a referral system for the CHI in order to minimise inefficient use of health resources at hospital level.

Fourth, the poorest segment of the population is unable to participate in the CHI, and the government must assume the responsibility of meeting their health needs, through either free healthcare or targeted subsidies. Although CHI schemes are largely able to enrol people from low socio-economic categories, the *poorest of the poor* are unable to enrol without some form of subsidy. While the difficulties in selecting and targeting the very poor are acknowledged, the process could be eased by adopting generally visible characteristics such as orphanhood, landlessness or geographical locality.

Lastly, in light of these findings, it is argued that the policy of universal free healthcare is ineffective and needs to be redesigned. While this article does not call for outright scrapping of the policy, the government must consider targeting free healthcare to the most vulnerable sections of the population so that its resources are not constrained through overspreading the services. Those who are able to pay should contribute directly to healthcare costs. The advantage of this approach is that those most in need could access the free healthcare, while those able to pay could contribute to resources to build a more responsive healthcare system.

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Appendix

Acronyms

AHSPR	Annual Health Sector Performance Report
AIDS	Acquired Immune-Deficiency Syndrome
CHI	Community Health Insurance
DFID	Department for International Development
FGD	Focus Group Discussion
HC III	Health Centre Three
HIV	Human Immune-Deficiency Virus
IMR	Infant Mortality Rate
KI	Key Informant
MMR	Maternal Mortality Ratio
PFP	Private-for-Profit (sector)
PNFP	Private-Not-for-Profit
TFR	Total Fertility Rate
THETA	Traditional and Modern Health Practitioners Together Against (HIV) AIDS and Other Diseases
U5MR	Under 5 Mortality Rate
UAC	Uganda AIDS Commission
UBOS	Uganda Bureau of Statistics
UDHS	Uganda Demographic and Health Survey
UNDP	United Nations Development Programme
WHO	World Health Organization

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