Building strategies for sustainability and equity of prepayment schemes in Uganda: Bridging the gaps

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Executive summary

In Uganda, community-based health insurance started in 1995; however, the number of schemes has remained small with very low coverage levels. This study examines issues of equity and sustainability in these prepayment schemes; if they are to contribute significantly to health sector financing, the schemes must be equitable and sustainable. The study was implemented under the fair financing theme in the Regional Network for Equity on Health in East and Southern Africa (EQUINET) and co-ordinated by the Health Economics Unit of the University of Cape Town.

A descriptive cross-sectional study employing qualitative techniques was carried out. Key informant interviews, focus group discussions and documents review were used. Data was tape-recorded, transcribed, typed, manually analysed thematically using a master sheet.

Our results showed that the quality of health services received in private health facilities and schemes were reported to be better than those in government facilities, primarily due to factors such as waiting times and congestion. Reasons for not joining schemes were an inability to afford monthly contributions and limited knowledge of the benefits of CHI schemes. Respondents perceived unfairness in schemes in various ways: they noted that non-members were treated better at the hospital than members, members may have to pay premiums for years without falling sick (in other words, without seeing any return on their investment), some members were excluded because they could not afford to pay for the identification photos required for enrolment and schemes refused to cover chronic illnesses such as diabetes and high blood pressure, although they would cover eye and dental problems.

Respondents perceived fairness in the CHI schemes in terms of the fact that they paid very little for the services they received, got fast treatment, and they reported that members paid less than non-members but both got the same treatment. Notably, there was no notable discrimination towards patients at facilities on the grounds of gender, age or social status.

Sustainability of the schemes was limited because they operate on small budgets, have low enrolment figures, high dropout rates and limited coverage. The schemes have not been promoted to communities and government support is lacking.

Abolition of user fees did not have a big effect on enrolment into the schemes. People went for higher quality services, which were perceived to be provided in private health facilities rather than government services. Schemes were perceived to directly contribute towards health financing by providing funds for the procurement of drugs and equipment, allowing people to contribute to their own health care. An indirect benefit is that they would ease the pressure on public facilities by diverting patients from the public health sector. Whereas some thought the contribution of CHI schemes was insignificant due to low enrolment, others felt the schemes needed to be strengthened to build confidence in social health insurance (SHI).

We recommend that government increase funding to maintain the improvement in quality of health care in public facilities. Future health policy needs to address whether or not CHI has a role to play in the Ugandan context and in institutionalising SHI.

1. Introduction

Financing health care in the Sub-Saharan African region remains a pressing concern despite the rapid socio-economic transformations in the health sector that have occurred since the early 1980s (Mwabu, Wang'ombe, Okello and Munish 2004; Criel, 1998). The region implemented a series of reforms in which governments encouraged the use of medical insurance, even at community level, to promote equity in the use of health services (Mwabu et al, 2004).

In Uganda, there is a positive attitude towards the development of insurance schemes; empirical evidence suggests that the Ministry of Health encourages health insurance schemes in the country (Basaza, 2002; Wilson, 2002). In 1995, the Ministry of Health's Planning Department initiated a community health-financing project as a way of developing alternative health financing strategies (Walford, 2000). Uganda's experience with community health insurance (CHI) is limited because it's a relatively new concept in the country. The initiative to create these schemes, in almost all cases, came from private-not-for-profit health care providers, namely church-related district hospitals (Basaza 2002; Derrienic et al, 2004). These hospitals currently provide services reported to have reasonable quality, but serve a limited catchment area. Individuals and households from distant areas cannot access them because of prohibitively high transport costs (Derriennic et al, 2004; Wilson, 2002; Wani, Ssebudde, Katusiimeh and Maguru, 2002; Walford, Basaza, Magezi, Mistake, Noble, Somerwell, Thornberry and Yates, 2000).

The oldest community health insurance (CHI) scheme started in 1995 at Kisiizi Hospital, while the newest was initiated in 2002 at Rugarama Health Centre IV. Today, a number of CHI schemes exist, such as the St Francis Hospital Mutolere in the Kisoro district, the Ishaka Adventist Hospital Health Plan and Mother-to-child Rescue Health Plan in the Bushenyi district, the Kitovu Hospital Prepayment Plan in the Masaka district and Save for Health in the Luwero and Nakasongola districts. Micro Care Health Limited is a health insurance broker company that operates CHI schemes in the Nsambya, Kibuli and Rubaga hospitals around Kampala, as well as other schemes in the countryside. At present, most CHI schemes are based in NGO hospitals. Some schemes, like the Naguru and Nsambya Health Plans in the Kampala district and the Lacor Health Plan in Gulu district, started off well but closed later on mostly due to a lack of donor funding (Derriennic, Wolf and Kiwanuka-Mukiibi, 2004). The indicative performance of the schemes by the end of June 2004 was 28,000 people, which is less than 2% of the population of the primary catchment area of the hospitals concerned (Basaza, 2002).

In this study, we will assess whether or not CHI schemes are equitable and sustainable. What is meant by these two terms? *Equity* in health requires us to address differences in health status that are unnecessary, avoidable and unfair. Equity-motivated interventions seek to allocate resources preferentially to those with the lowest health status, which requires us to understand and influence the redistribution of social and economic resources for equity-oriented interventions, and understand and inform the power and ability that people (and social groups) have to make choices over health inputs and use these choices for their better health (EQUINET /TARSC, 1998). *Sustainability* may be defined as the capacity of the schemes to cover their costs of continued operation, without requiring external subsidies (Magezi, Matsiko and Wheeler, 2002). The key elements are financial and administrative or managerial sustainability (Magezi et al,

2002; Bennett, Creese and Monasch, 1998). Financial viability has of course been an issue of concern as a result of low levels of funding, despite the important social component of CHI schemes (Derriennic et al, 2004; Magezi et al, 2002; Walford et al, 2000; Wilson, 2002; Musau, 1999; Bennett et al 1998; Criel, 1998).

In this study, we assessed CHI schemes according to equity and sustainability by examining community perceptions of these two issues and distinguishing whether these perceptions reflected a desire for equal health care for all people (horizontal equity) or a desire for more health care for those with greater needs (vertical equity). We looked at peoples' perceptions of equity when joining CHI schemes and accessing health care services and their perceptions of sustainability with regard to the role of CHI schemes after the abolition of user fees, including dropout levels, coverage levels, revenue contributions and expenditures, and their role in financing health services and thereby moving towards social health insurance (SHI).

While community-health financing has been in Uganda for over ten years, there appear to be only seven CHI schemes in total, which are operating in seven districts. Evidence regarding the extent to which the existing schemes have been equitable is lacking and we could not locate any studies of the factors influencing this area of health equity. Yet the poor still appear to face equity barriers in accessing health care services, which we address later in this paper. There is generally a lack of evidence regarding the extent to which the existing schemes have been equitable and sustainable.

This study complements existing efforts to address equity issues within the context of the Millennium Development Goals (MGD) on human development, which talk of "access to health by all". Some previous studies (such as Mwabu et al, 2004; Wilson, 2002; Musau, 1999) suggest that there is a need to investigate equity in health insurance schemes. For instance, Musau highlighted that the impact of prepayment schemes on the poorer members of the community has not been fully investigated. Further, previous studies did not include a broad spectrum of other stakeholders, such as Criel and Waelkens' study (2003), which exclusively used focus group discussions. In our study, both key informant interviews and focus group discussions were used. Other studies have also not reported on strategies for improving the sustainability of CHI schemes. Here, we attempt to close some of the gaps in existing research and develop a deeper analysis of the prevailing challenges in achieving sustainability and equity in prepayment schemes.

2. Methodology and research objectives

We employed a cross-sectional design and used qualitative data collection methods, which included focus group discussions and key informant interviews. The methods were an important means for validating verbal information on key issues of equity and sustainability.

Sampling was purposive, with eight focus group discussions (FGDs) consisting of members of CHI schemes and seven FGDs consisting of non-members. The non-members were subdivided into those who dropped out of the schemes (four FGDs) and those who had never joined the schemes (three FGDS). (One group of those who had never joined the schemes unfortunately could not make themselves available for a discussion.) The three categories of groups were interviewed separately to get a better

comparative analysis of people's views. For the scheme members, men and women were interviewed separately in order to capture any gender dynamics on equity and sustainability while, for the non-members, men and women were mixed. One group discussion of members consisted of secondary school children, while the rest of the discussions were held with adults above the age of eighteen. The group of schoolchildren was included because it was the only school group registered in a CHI scheme in the district, which made it a unique case.

All FGD participants were drawn from the catchment areas of the CHI schemes located in three districts. One was an NGO-based CHI scheme, one was a purely community-based health insurance scheme and two were private hospital-based CHI schemes that, at the time of the interviews, were in the process of becoming community-based schemes. The rationale for grouping the schemes in this manner was to capture variations in equity and sustainability issues. Most schemes in Uganda are private hospital-based schemes, which is why we chose more from this category than from the other two.

Key informant interviews (KIs) were held with people who were assumed to be knowledgeable about the operations of CHI schemes, such as the managers of the schemes, officials from the Ministry of Health (MoH), and staff from the Districts and Uganda Protestant Medical Bureau, a faith-based NGO. A total of eighteen people were interviewed. We also reviewed existing literature on the equity and sustainability of CHI schemes, including financial and managerial data. Literature included Ministry of Health studies, policy documents, research reports and other relevant documents that the team accessed from the schemes.

To ensure quality control, data collection tools were pre-tested and research assistants were trained and supervised. During data collection, debriefing meetings were held at the end of each day to review data and identify any omissions and errors. Data management included audio-taping all interviews and transcribing and typing them as Microsoft Word documents. Data was coded and grouped according to the study themes. Labels were developed after a review of the data and data that belonged to the same code was listed together under the respective label. Our analysis was conducted using a master sheet along the main themes of the study. Key concepts per theme were synthesised and the numbers of FGDs and key informants who reported each concept were noted and majority responses were identified. Deductions from the synthesised data were made and verbatim key quotations from informants were incorporated to enrich the analysis, after which discussions followed.

Ethical approval was sought from the Makerere University Institute of Public Health Higher Degrees Research and Ethics Committee and from the Uganda National Council of Science and Technology. Permission to carry out the research was received from the relevant district local governments. Informed consent was sought from all study participants. *Table 1* lists the various study sites and the respondents in the FGDs and key informant interviews.

Table 1: Study sites, focus group discussions and key informants for this study

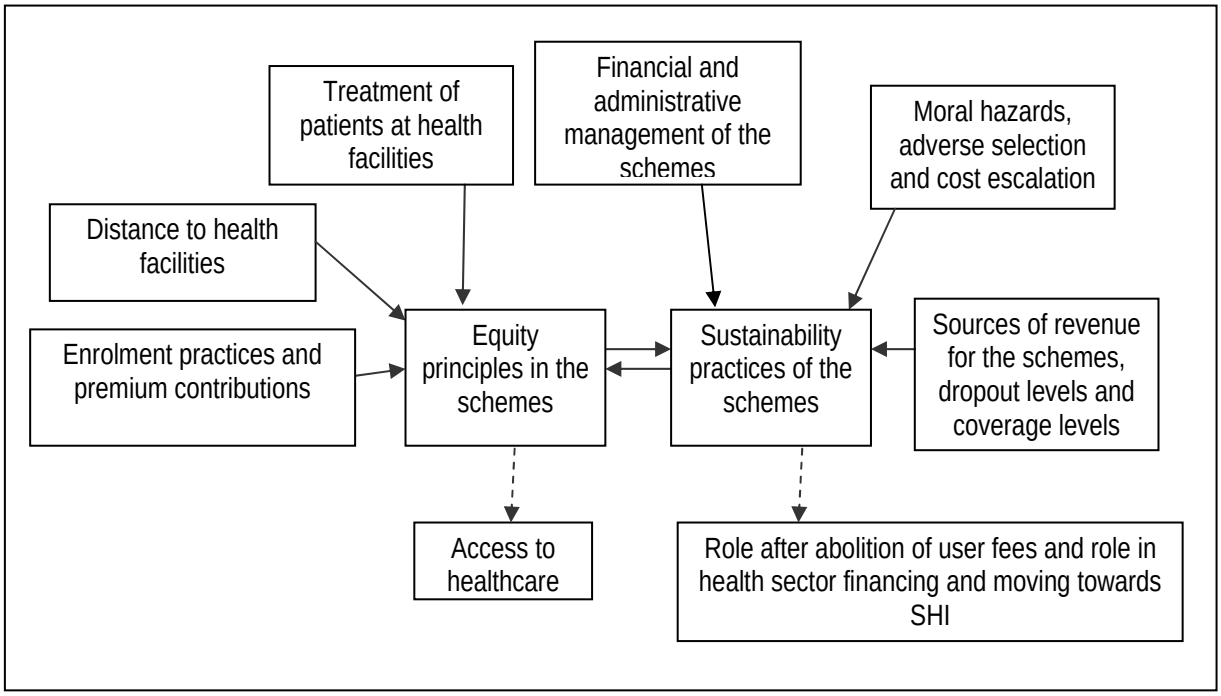
Study sites	Focus group discussions	Key informants
Masaka district		
Kitovu Hospital Prepayment Health Plan	· Two FGDs for members (one with men and one with women) · Two FGDs for non-members (one with dropouts and one with those who never joined – men and women mixed)	· District health inspector · Scheme manager
Bushenyi district		
Ishaka Hospital Adventist Health Plan	· Two FGDs for members (one for men and one for women) · Two FDGs for non-members (one with dropouts and one with those who never joined – men and women mixed)	· District health inspector · District senior nursing officer · Medical superintendent, Ishaka Hospital · Scheme manager
Mother-to-child Rescue Health Plan	· One FGD for members (men and women mixed) · Two FDGs for non-members (one with dropouts and one with those who never joined – men and women mixed)	· Person in charge of the community health facility · Parish chief · Scheme manager
Luwero district		
Save for Health, Uganda	· Two FDGs for members (men and women mixed) · One FDG for non-members (those never joined – men and women mixed)	· District health inspector · Deputy district health officer · District senior nursing officer · Medical superintendent, Kiwoko Hospital · Senior nursing officer, Kiwoko Hospital · Scheme manager
Kampala district		
Ministry of Health officials and others	None	· Commissioner, Department of Planning, Ministry of Health · Senior health planner, Department of Planning, Ministry of Health · Person in charge of the Uganda Catholic Medical Bureau · Person in charge of the Uganda Protestant Medical Bureau

The main objective of this study was to establish common factors that influence the implementation of sustainable and equitable schemes with a view to documenting best practices. More specifically, we aimed to:

- examine the community's perceptions of the sustainability and equity of selected prepayment schemes (such as fair financing and the utilisation of and access to facilities);
- explore the role of CHI schemes after the abolition of user fees;
- investigate the role of prepayment/CHI schemes in financing health services and in
- moving towards social health insurance in Uganda;
- find out the coverage levels and dropout rates of prepayment/CHI schemes; and
- examine the existing mechanisms for equity and sustainability in prepayment/CHI schemes in Uganda and to document possible interventions.

In this paper, we will focus on the strategies for equity and sustainability in the schemes. The conceptual framework of our study (*Figure 1*) shows that equity can be influenced by unfair enrolment practices in the schemes (such as using unfair criteria for eligibility), charging premiums that are unaffordable, making patients travel long distances to health facilities and offering a package of services that does not cover chronic diseases such as HIV/AIDS. The sustainability of schemes is influenced by their sources of revenue, degree of expenditure of the generated revenue, dropout levels, coverage levels, their changed role after the abolition of user fees, their role in health care financing and promoting SHI, and how they are managed financially and administratively to deal with adverse selection, moral hazards and escalation of costs. Changes in all of these factors can negatively affect the schemes.

Figure 1: Conceptual framework of this study



3. Results

3.1 Geographical coverage of prepayment schemes and dropout rates

The geographical coverage of CHI schemes was found to be limited and we could not establish why. The schemes we visited were all operating within a radius of 20 to 25 kilometres, which is a catchment area of approximately one sub-county. In addition, there were no available statistics on the total populations of the catchment areas to help us calculate the proportion of scheme members to the total population. Our main observation was that CHI schemes have low levels of enrolment and are unevenly distributed, with the majority being in western Uganda, a few in the central area and none in the northern and eastern parts of the country.

Membership in the schemes varied and so did dropout rates, and these affected revenue contributions and expenditures of the schemes. *Table 2* presents the membership levels, dropout rates, revenue contributions and expenditures of the various schemes we surveyed. The year 2004 was used as a baseline for some of the schemes because they did not have readily available data for the years preceding 2004; management had changed and records were not properly maintained. Please note that the figures marked with an asterisk in the table show the years when the schemes (apart from Save for Health) were operating on a deficit.

Table 2: Membership, dropout rates, revenues and expenditure for four CHI schemes

Year	Levels of membership	No. and % of dropouts	Revenue contributions (Ugandan shillings)	Expenditure (Ugandan shillings)
Scheme 1: Mother-to-child Rescue Health Plan				
2004	372	64 (17%)	5,580,000	6,500,000*
2005	284	152 (52.5%)*	4,260,000	5,400,000*
2006	484	20 (4.1%)	7,260,000	7,750,000*
2007	556	0	8,340,000	8,840,000*
Scheme 2: Kitovu Prepayment Plan				
2004	1,593	46 (2.9%)	3,467,875	4,933,953*
2005	1,236	242 (19.6%)*	2,947,775	4,788,189*
2006	884	78 (8.8%) (only for one quarter)	2,308,900	3,230,772*
2007	N/A	–	–	–
Scheme 3: Save for Health Uganda Scheme				
2004	2,156	258 (12%)	5,965,700	2,290,950
2005	3,806	268 (7%)	10,255,700	4,860,650
2006	4,077	281 (6.9%)	11,040,900	6,782,500
2007	5,118	N/A	14,185,600	6,393,700
Scheme 4: Ishaka Adventist Health Plan				
2004	1,345	145 (10.8%)	16,948,895	26,331,291**
2005	1,145	200 (17.5%)	14,308,542	25,772,061**
2006	1,246	0**	14,571,362	16,115,760**
2007	1,030	216 (21%)	12,459,650	12,359,650

Source: Managerial and financial records of CHI schemes, 2004-2007

As can be noted from the table, membership has been increasing for schemes 1, 2 and 3 and fluctuating for scheme 4. There were high dropout rates registered in 2005 under scheme 1 and it was reported this was caused when the scheme changed from a non-governmental one to a community-based one. Scheme 3 has steadily reduced its dropout rates, while the opposite has occurred with scheme 4. However, scheme 4 did not have any dropouts in the year 2006 and this was reported to be a result of the fact that foreigners visited the scheme that year and raised the confidence of members in their scheme, because they felt that they had support from outside the country. Dropout rates for scheme 2 were high in 2005, when schools were no longer allowed to enrol as members.

3.2 Sustainability and equity of CHI schemes: Community perceptions

Respondents in the FGDs and key informant interviews had a range of views about how fair enrolment procedures were for those wanting to become members of CHI schemes. Throughout, fairness was perceived in terms of non-discriminatory and voluntary joining of the scheme, allowing people to join irrespective of the number of people in a family:

> *The scheme should operate in such a way that all people in the household are able to join, in other words, if the household has 10 or more members, all of them should be able to join (key informant interview – Uganda Protestant Medical Bureau).*

In addition, it was mentioned that the different households paid the same amount of premium, irrespective of whether they were rich or poor, which some participants felt was unfair:

> *But on the other hand, they are not equitable because a rich man in the village pays the same amount as the poor man (key informant interview – Ministry of Health).*

Photos are required when applying for membership to reduce the chances of cheating and bringing unregistered people for treatment, but unfairness was shown by denying treatment to the poor who paid the premium but could not afford to pay for photos. Some respondents complained that scheme managers also did not allow individuals without families to join and they expected members to continue paying premiums even when they were not sick. A further problem exists: for members to enrol, they need to be members of an already existing community-based organisation and at least 60% of the organisation's members have to join before they can start accessing health services. If they cannot meet the 60% quota, they are excluded from health care when they fall sick.

Another inequity was perceived in the limit imposed on families, who may register no more than four members in their insurance contracts, which is clearly prejudicial against big families. Others felt excluded from CHI because they did not receive a regular monthly salary, one of the conditions of scheme membership:

> *The targets at the time I wanted to join were tea growers because they had a monthly income and others were those who held bank accounts (FGD, participant who has never joined a CHI scheme – Mother-to-child Rescue Health Plan).*

Money remains the major barrier to accessing medical insurance. Even the most vulnerable and needy members of society, such as orphans, the elderly and the disabled, are not exempt from payment, despite the fact that they usually have greater

health needs than the rest of the population. This means that the schemes are not meeting the vertical equity objective of providing health care according to need, in other words providing more health care to those that need it more.

Respondents also perceived unfairness in the way non-members were often given better treatment than members in PPS health facilities because non-members pay cash for treatment and usually pay more than members, so health workers feel they should be given first priority in treatment:

> *We should not be made to wait to get treatment simply because we pay less money than non-members. We all deserve equal treatment in accessing health care (FGD, scheme member participant – Ishaka Adventist scheme).*

Members said that, at times, they would have to wait from morning to evening while non-members were served first. This problem was significantly reported on in all four group discussions in the hospital-based CHI scheme in Ishaka.

A unique group of CHI members was the one that consisted of students. At their school, enrolment in the scheme was mandatory to help them prevent incurring high costs when they fell sick, but the students saw it as unfair. Their concern was that the process was undemocratic because they were enrolled without their consent or their parents' consent. The problem is compounded because the premium is deducted from their school fees, which means they are excluded from treatment at the scheme's health facility if they have not paid their fees in full.

Perceptions of sustainability by different key informants and FGDs were all about two key aspects: continuity and members' sense of ownership of their health programmes. Informants wanted schemes that were vigilant in their implementation and operated as long as possible, allowing members to take ownership of their programmes without it being forced on them. In contrast, they noted that continuity also was dependent on high membership enrolment levels, which are still too low due to a poor understanding among communities of the concept of pooling risks – communities need to be sensitised to this concept.

In addition, most respondents replied that schemes would be sustainable if they could run on their own, start income-generating activities, show credible leadership and inspire public trust (companies and businesspeople with no prior record of fraud), and if they trained health workers to have a more positive attitude towards their patients. This would attract more people to join. Participants were concerned about schemes operating on small budgets and not involving members when planning scheme activities. They felt that these issues could be resolved through government support and participatory planning.

3.3 The role of CHI schemes after the abolition of user fees

Participants were asked to give their views about free services in government health facilities and paying money in the schemes. All the group discussions and key informants generally reported that the abolition of user fees in government health facilities did not negatively impact on enrolment into the schemes. However, one scheme, in Zirobwe, which was based in a government health facility, had to close because it could not compete with the free services being offered in the same facility. Other CHI schemes lost members to government health facilities for the first few months

after fees were scrapped, but soon returned because the quality of service in government health facilities was reported to be poorer, with congestion, long queues and lack of staff reported. For instance, in the Mother-to-child Rescue Health Plan, it was reported that the number of scheme members actually increased from 25 to 112 during the year of the abolition of user fees. Two participants explained why:

> *Many people joined the schemes because when the services became free in government health facilities, the number of patients increased and the quality of services became poor and this forced people to join CHI schemes because they had preferably better services (FGD, participant who has never joined a CHI scheme – Mother-to-child Rescue Health Plan).*
>
> *People are willing to pay if assured of getting quality and good services (key informant – Uganda Medical Protestant Bureau).*

3.4 Role of prepayment schemes in financing health and moving towards SHI in Uganda

Key informants had diverse opinions about the contribution of the CHI schemes towards health sector financing. The contribution was thought to be direct and indirect: directly, members contribute to their own health care and, indirectly, to those who use government health facilities elsewhere – they reduce congestion and levels of utilisation of those services. Further, schemes provide some funds for the procurement of drugs and payment of equipment for the health facilities to which they are attached. This local subsidy enables the provision of good health care services. Public health facilities do not provide all the health needs of the people and so organising the communities to pay for their own health care was thought to be a significant contribution to health care financing.

However, some key informants felt that the contribution of schemes remains insignificant. Since the schemes started in 1994, enrolment has remained low, with contributions too small to have any real impact on health financing. Still, participants felt that they could be a potential source of health care financing if levels of enrolment increased.

Others believed that the main way to enhance the contribution of CHI schemes towards health care financing was to make everybody realise that government cannot pay for all health care and that policies must be designed to address that issue. The government should rather help people to pay for their own health in an organised manner by encouraging them to participate in CHI schemes. Through discussion with health providers in rural communities, people can look at schemes as a possible way of financing their health and it is the duty of the government to provide the initial technical support to facilitate and provide some of the supplies to help the schemes take off, as one respondent noted:

> *That is the only way we can ignite it, otherwise people cannot dream about it and they start it the following day. There must be some technical assistance to show how it can start (key informant – Ministry of Health).*

CHI has a role to play in moving Uganda towards SHI because members in CHI already understand and appreciate the benefits of health insurance. They have experience because CHI has been in operation for some time now and people know the challenges, have experienced some successes and can learn how to help communities embrace

health insurance. Therefore, it was suggested that SHI should be a community health programme in partnership with government to design policies and guidelines and clearly define the roles of CHI and SHI:

> *The CHI schemes should be the ones feeding the SHI on what is being done at community level. The SHI should be facilitating the CHI (key informant – Masaka district).*

One key informant noted that national health insurance has three components: social health insurance for the formal sector, community health insurance and private commercial health insurance. All three are being promoted at once and can run independently and this respondent felt they will merge successfully in future. Other respondents felt that, with the introduction of SHI, CHI would collapse because all members would leave, except for those without regular incomes:

> *National health insurance is likely to affect schemes negatively because the potential members will, instead, be enrolled in national health insurance. Schemes have been depending on certain cadres of people like teachers and upcountry-based civil servants; with SHI these will be lost by CHI (key informant – Luweero).*

It was also predicted that many people might see SHI as a tax and not as a means to save for their health. Respondents were concerned that people may be forced to choose between CHI and SHI and end up choosing the one that is offering better services at the time, leading to a weakening of CHI. According to the Health Insurance Bill of 2007, one can currently subscribe to both the schemes.

4. Discussion of results

The discussion here is based on the key issues of equity and sustainability arising from the research. Please note that the community's understanding of equity (fairness) and inequity (unfairness) is not quite the same as the technical definitions of the two concepts, as outlined earlier in section 1 of this paper. We will use the different meanings interchangeably.

The initial inequitable practices uncovered by our study were that the rich and the poor pay the same insurance premiums, with no regard for age, gender and social status during the process of enrolment. These practices directly contravene the notion of vertical equity in health care financing and provision because the poor have greater health needs but less money to pay for them than the rich do. Those who can pay more, should do so; in other words, the rich should pay higher premiums than the poor. Sufferers of chronic and serious ailments, such as diabetics, those with high blood pressure, dental problems and eye problems, all have different health needs and so should get appropriately different care. Our results confirm those of Carrin, Waelkens and Criel (2005), who found that premiums that are levied as a flat sum pose a disadvantage to the poorest – flat contributions are, therefore, regressive, meaning they do not favour low income earners and those with diseases that are expensive to treat.

Other inequitable practices were found: Large families were discriminated against when joining, because only four family members would be covered by the scheme. A lack of exemptions for the very poor and restricted geographical coverage for the schemes

disadvantaged those who did not live within easy travelling distance of facilities. Individuals with no families were also excluded, even if they could afford the premiums.

It is true that the practice of giving treatment to non-members first before members is unfair, according to members, but this is more of a problem with the attitude of health care providers than an actual issue of health inequity because it involves non-members, in other words those who do not have a stake in the schemes. In contrast, it would be a serious equity issue if some scheme members received preferential treatment over other scheme members.

In terms of equitable practices, it was observed that, in the schemes, no discrimination existed towards members on the basis of age, social status and gender in accessing health care services. This is commendable and is a healthy practice that may attract members into the schemes.

According to participants, schemes confuse the concept of sustainability with longevity; the difference is that sustainability refers to the capacity of a scheme to cover its costs for continued operation *without* any external subsidy. Sustainability also requires the scheme to ensure that revenues from premium contributions can actually cover its benefit packages (expenditures). Over the years, the expenditures of some schemes have been higher than their contributions as a result of low enrolment and high dropout rates, leading to a small risk pool within the scheme. Often, this means the only members left are the high-risk ones who need to use the health services frequently, increasing the scheme's operational costs. Schemes that run on deficits, do not ensure members' complete involvement in decision-making, and have insufficient management skills and a lack of government support are a threat to sustainability of CHI and, in turn, SHI. Notermann, Criel, Kegel and Isu (1995) suggest that communities should be involved in decision-making regarding their schemes, especially about the criteria for exemption.

Community health insurance schemes have not died out since the introduction of free services in government health facilities, which implies they may still have a role to play in national health service provision. Private health services are perceived to be better than government ones by most Ugandans and patients tend to use private health facilities because of this perception, despite the availability of free health care services in public facilities. Our findings support earlier findings by Xu, Evans, Kadama, Nabyoga, Ogwal and Aguilar (2005), which reveal that the removal of user fees from public sector facilities has not necessarily improved access. Official fees may have been removed, but there are still problems, such as unofficial fees, drug stock-outs and overworked staff, who are too tired to provide quality service.

Some respondents perceived CHI schemes as a form of health care financing that allows people to contribute to their own health care, which is positive. Sadly, the perception that schemes may have reduced the government's health burden by diverting demand from government facilities, thereby freeing up additional government funding to improve public health care services, may be an unrealistic perception and does not seem to have been realised. Perceptions of service in the public health sector remain negative and respondents were reported to have returned to CHI schemes because they experienced poor service in public facilities.

Participants suggest that the role of CHI schemes in moving towards social health insurance in Uganda can be significant if CHI and SHI are able to co-exist, this is contrary to the available literature and the results of our study, which reveal that CHIs have risk pools that are too small to service the claims of their members via contribution revenues. There are therefore doubts as to whether or not CHI schemes are worthwhile investing in, unless they are clearly linked to a broader strategy to ensure universal insurance coverage.

5. Conclusion and recommendations

Many of the community-based health insurance schemes we studied were inequitable in their practices. In most of the schemes, the rich and poor paid a flat premium and no exemptions were given to the most vulnerable members of the community, such as the poor, the elderly and orphans. In some schemes, enrolment was limited to four household members, so larger families were effectively excluded from the scheme. In terms of geographical coverage, some of the schemes operated only within a radius of 20 km, so those who lived further away than 20 km were excluded. In contrast, some schemes laudably demonstrated equity, for example, by treating all members in the same way and showing no discrimination according to age, gender and social status at their health facilities.

Community-based health insurance schemes have tried to generate additional funds for the health sector, even in an environment where user fees have been abolished. After user fees were abolished, levels of utilisation of public health facilities increased, which is why respondents in our study perceived the quality of services to have deteriorated. They referred to problems such as a lack of drugs, understaffing of facilities, long waiting times and illegal 'under-the-counter' payments and bribes. They would rather pay money into a community-based health insurance scheme and get quality treatment than get poor quality services for free or have to make illegal payments, which some said may eventually add up to more than they would have paid in premiums.

Most of the community-based health insurance schemes that we studied are not sustainable because they need funding from other sources, such as donor agencies. They are also not sustainable because they mostly serve the poor, and so they are unable to raise sufficient funds due to low membership enrolment and small risk pools. Additional funds could come from government subsidies but this may put strain on government, which should be using all its resources to improve the quality of free health care in public facilities. In addition, most of the schemes have managers with limited financial and administrative abilities, with poor designs and no means of investing their resources. These constraints cast doubt on the feasibility of putting more money in the schemes from other sources – will it really make any difference in improving their sustainability?

Furthermore, the imposition of stringent requirements for membership, such as the minimum 60% membership rule for community organisations wanting to join, the inability to cater for those with diabetes, high blood pressure, dental problems and other aliments, coupled with the lack of a legal framework and policy to govern CHI schemes, have all deterred many from enrolling and encouraged existing members to leave, resulting in low figures for enrolment and retention. Most schemes have therefore

continued to operate on deficits, raising serious concerns about their future sustainability.

To end on a positive note, CHI schemes may still have some role to play in the development of SHI because, so far, government has not been able to channel sufficient resources into the public health system, so people are opting to use private sector services, but they find it difficult to cover the costs out-of-pocket and CHI can help in this respect. However, the evidence presented in the Results section of this paper shows clearly that sustainability is a major problem in CHI schemes. Most are operating on a large deficit, management capacity is poor and risk pools are too small to cover expenditure in the form of insurance claims.

We recommend that government funding of health services should increase to ensure that quality of care does not deteriorate in the context of increased utilisation after removal of user fees, and it needs to step in to deal with problems such as 'unofficial' fees. If it can do this, then this will reduce the pressure on CHI to play such a big role in health provision, as communities will be able to access free, good quality services at public sector facilities.

There needs to be extensive technical and policy considerations about whether or not CHI schemes have a role to play in the Ugandan health system. CHI schemes may become the basis for providing health services to the informal sector if universal insurance coverage is envisaged (as has been done in other countries, such as Ghana). This will help address the problem of small risk pools and CHI schemes will need substantial support to build management capacity and will need to be larger than they currently are (that is, not restricted to a 20 km radius). Government will have to subsidise contributions for the poor.

The government does not have many alternatives to the above vision of providing universal insurance coverage. Either it can institute SHI that covers only the formal sector and continue to provide free care at public facilities for everyone else (that is, have a two-tier health system) or it can avoid the insurance route and devote substantial resources into improving the capacity of public sector facilities in areas where there are no government health facilities.

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Acronyms

CBHI	Community-based health insurance
UCBHFA	Uganda Community-based Health Financing Association
CHI	Community health insurance, which is used synonymously with prepayment schemes
FGD	Focus group discussion
KI	Key informant
MDG	Millenium Development Goal
PFP	Private for-profit
PNFP	Private not-for-profit
PPS	Prepayment scheme
SHI	Social health insurance

Equity in health implies addressing differences in health status that are unnecessary, avoidable and unfair. In southern Africa, these typically relate to disparities across racial groups, rural/urban status, socio-economic status, gender, age and geographical region. EQUINET is primarily concerned with equity motivated interventions that seek to allocate resources preferentially to those with the worst health status (vertical equity). EQUINET seeks to understand and influence the redistribution of social and economic resources for equity oriented interventions, EQUINET also seeks to understand and inform the power and ability people (and social groups) have to make choices over health inputs and their capacity to use these choices towards health.

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