

Feasibility and Desirability of Scaling up Community – based Health Insurance (CBHI) in rural communities in Uganda. Lessons from Kisiizi hospital CBHI scheme.

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Research article

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Abstract

Background Community-based health Insurance (CBHI) schemes have been implemented world over as initial steps for National Health Insurance. The CBHI concept developed out of a need for financial protection against catastrophic health expenditure to the poor after failure of other health financing mechanisms. CBHI schemes reduce out-of-pocket payments, and improve access to healthcare services in addition to raising additional revenue for health sector. Kisiizi hospital CBHI scheme has 41,500 registered members since 1996, organised in 210 community associations known as 'Bataka' or 'Engozi' societies. Members pay annual premium fees and a co-payment fee before service utilisation. This Study aimed at exploring the feasibility and desirability of scaling up CBHI in Rubabo County, with objectives of; exploring community perceptions and determining acceptability of CBHI, identifying barriers and enablers to scaling up CBHI and documenting lessons regarding CBHI expansion in a rural community. Method: Explorative study using qualitative methods. Key informant interviews and Focus Group Discussions (FGD) were used in data collection. Twenty two key informant interviews were conducted using semi-structured questionnaires. Three FGD for scheme members and three for non-scheme members were conducted. Data was analysed using thematic approach. Results : Scaling up Kisiizi hospital CBHI is desirable because: it conforms to the government social protection agenda, conforms to society values, offers a comprehensive benefits package, and is a better healthcare financing alternative for many households. Scaling up Kisiizi hospital CBHI is largely feasible because of a strong network of community associations, trusted quality of services at Kisiizi Hospital, affordable insurance fees, and trusted leadership and management systems. Scheme expansion faces a few obstacles: long distances and high transport costs to Kisiizi hospital, low levels of knowledge about insurance, overlapping financial priorities at household level and inability of some households to pay insurance fees. Conclusions CBHI implementation requires the following considerations: Conformity with society values and government priorities, a comprehensive benefits package, trusted quality of healthcare services, affordable fees, and trusted leadership and management systems. Key words Community-based Health Insurance, Universal Health Coverage, Health financing, Enrolment

Background

Community-based health Insurance (CBHI) schemes are famous world over. African countries including Ghana and Rwanda, as well as developed countries including Germany, Japan and China have implemented CBHI schemes as initial steps towards attainment of the National Health Insurance coverage [1]. These schemes are characterised by common principles such as: risk-sharing, voluntary membership, community solidarity and non-profit making agenda [2-3].

The CBHI concept developed out of a need for financial protection against catastrophic health expenditure to the poor; after failure of user fees, tax-based systems and social health insurance systems [4-5]. Certainly, CBHI schemes reduce out-of-pocket payments, improve cost – recovery and to some extent influence quality of care [6]. In addition, the schemes improve access to healthcare services and raise additional revenue for health sector especially in the low-income settings [7].

In Uganda, the first CBHI scheme was set up in 1996 at Kisiizi hospital allowing families to join through community associations or groups of not less than twenty families[8]. Several other similar schemes have since been set in different parts of the country. Membership has been staggering at about 30,000 or so people, estimated at about 2% of the catchment population [8].

Sustainability and expansion of these schemes has been hampered by numerous operational challenges including: small budgets, rising healthcare costs, small risk pools, irregular contributions, and overutilization of services [9]. The other limitations relate to scheme enrolment. These include: (a) inappropriate benefits package, (b) cultural beliefs, (c)

affordability, (d) distance to healthcare facility, (e) lack of adequate legal and policy frameworks to support CBHI, and (f) stringent rules of some CBHI schemes [10].

On the other hand, the registered success has been attributed to: community awareness and understanding of CBHI concept, perceived quality of healthcare services and trust in scheme management [9].

The Kisiizi Hospital CBHI scheme was established in 1996. By the end of 2018, the scheme had 41,500 active members registered through 210 community mutual groups called '*Bataka*' or '*Engozi*' societies in and around Rubabo County. This was an estimate of 30% of the total catchment population. The scheme was a strategy of reducing the unpaid hospital debts which had risen to about 2.5% of the total annual recurrent hospital costs [11]. The scheme members pay annual premiums and a small co-payment fee before service utilisation.

The primary purpose of this study was to identify and borrow lessons from Kisiizi hospital CBHI which can be applied in similar communities to implement CBHI.

The article is structured in four parts. First part introduces the CBHI concept and the Kisiizi Hospital CBHI scheme. The second section presents research methodology highlighting the study area, process of data collection, and data management and analysis. Results are presented in the third section. The paper is concluded in the fourth part with a short discussion and points out study implications for Kisiizi hospital and policy makers.

Problem statement

The abolition of user-fees in all government health facilities has not promoted equitable access to healthcare services in Uganda [12]. The poor and vulnerable still have limited access to healthcare services, and cost of services is still a key barrier to access to healthcare services [13]. CBHI is being fronted as a mechanism to address these inequities as well as facilitate introduction of a National Health Insurance scheme.

Main objective

To explore whether scaling up CBHI in Rubabo County, Rukungiri District is feasible and desirable considering local community dynamics including funding constraints and society values.

Specific objectives of the study

- i. To explore perceptions and determine acceptability of CBHI by community members and leaders.
- ii. To identify major barriers and enablers to scaling up CBHI across Rubabo county in Rukungiri district.
- iii. To document lessons learnt regarding CBHI expansion in rural communities in Rubabo county, Rukungiri district.

Summary of existing Literature

Scholars suggest a number of frameworks that can be applied to study feasibility and desirability of scaling up a CBHI. One framework emphasize assessment of the conditions in the community, providing critical considerations for making decisions to introduce health insurance (Figure 1) [14]. The other suggests that scaling up health insurance requires an assessment of social-economic and political situation of the country such as; the size of the informal sector, administrative and management capacities of the health sector, social capital and the existing health infrastructure [15]. In another study, it was suggested that assessment of feasibility and desirability of health insurance requires generating answers to the following questions; (i) How well does the current financing strategy meet the country's overall goals? (ii) Will health insurance help improve achievement of the overall goals, including improving risk pooling

and financial protection, and improving citizen's satisfaction? (iii) Will health insurance improve efficiency and equity in financing and service delivery? (iv) What other options exist for improving healthcare financing, and how do they compare with the introduction of health insurance? [16]

In another perspective, some scholars have proposed general areas of focus that should be addressed in feasibility studies, including; Acceptability, Practicality and Expansion [17].

This paper adapts a framework developed by Normand and Weber (1994) and applies the considerations highlighted in the decision making phase, in conjunction with the Bowen's key areas of focus to assess the feasibility and desirability of scaling up a CBHI in Rubabo County, Rukungiri district.

Significance for the study

First, the study is expected to contribute to the body of knowledge that other researchers might find helpful in designing their studies. Secondly, the information generated could be valuable to policy makers and technocrats in designing and implementing successful CBHI. Thirdly, the information generated could be used in development of appropriate health financing policies that promote universal health access. Communities in Uganda could benefit because the subsequent policies and interventions that would be developed could be more responsive to their needs and aligned to their circumstances and contexts.

Methods

The study was descriptive in nature, exploring the possibility and attractiveness of CBHI in a rural community, employing qualitative research methods. The explorative approach allowed for gathering in-depth information since health insurance is fairly a new concept in Uganda.

The study was carried out in Rubabo county, Rukungiri district, South Western Uganda. The county forms the primary catchment area of Kisiizi hospital. The area has an estimated population of 136,200 people, served by one private-not-for-profit hospital and thirty three lower health facilities [18].

The study population included: members and non-members of the scheme, local leaders/ opinion leaders, staff and managers of the scheme, and managers of the District Health department.

Participants were selected from three villages with different levels of insurance coverage, classified as: 'Very low coverage' (up to 19% insurance coverage), 'low coverage' (20 – 39 % insurance coverage) and 'moderate coverage' (40 – 50 % insurance coverage). None of the villages had an insurance coverage of above 50% [19]. The inclusion of participants from a variety of settings aimed at increasing the validity and credibility of the findings [20]. Data analysis was based on the individual participant opinions and perceptions of the scheme.

Participants were further selected purposively, using criterion sampling technique. The criteria for selection of Focus Group Discussions (FGD) participants was that; one must have lived in the selected village for at least two years. Selection of key informants was based on leadership positions in the target office or in the community and availability and willingness to give detailed interviews.

Face - to - face key informant interviews (KI) were conducted, using semi-structured questionnaires. Participants included; officers from the District Health department, local leaders /community opinion leaders and staff and managers of the scheme.

Mixed gender FGD were conducted. One FGD for scheme members and another for non- scheme members were conducted in each of the villages. Each FGD was composed of six-eight participants.

Ethical considerations

First, the Kisiizi Hospital research and Ethics committee approved the study. Secondly, prior to the interviews, an explanation was given in verbal form to each of the study participants and an informed consent was attained. The participants were informed that the information provided would be used by Kisiizi hospital CBHI leadership to design appropriate strategies to scale up CBHI in the local community. The participants were informed of their right to walk out of the interview if they wished to withdraw. The participants were also informed of the likelihood of publishing the results of this study in international journals. Finally, both the researcher and the participant appended their signatures on the consent form.

Process of data collection

Seventeen (17) face - to - face key informant interviews and six Focus group discussions were conducted. Each FGD had six-eight participants (n = 47) and discussions were held at community centres. The key informant interviews were held at the offices of the respective participants.

The discussions were moderated by the research assistant who introduced himself and the goal of the project before the discussion. The participants were assured of anonymity in the use of the collected data. Informed consent was attained prior to the interviews. Both the research assistant and the participant appended their signatures on the consent form. The discussions were 1-2 hours long, were audio recorded and were later transcribed. The whole process of data collection took place from 11th December 2018 to 20th March, 2019.

The researcher used a grounded theory in coming up with research tools. This study focussed on appropriate key areas for conducting feasibility studies, especially; acceptability, practicality and expansion [17]. The grounded theory approach helped the researcher in exploring the participants' perceptions and understanding of the scheme processes, motivations and systems.

Research tools were pre-tested in Rugarama sub-county, Ntungamo district. This village was chosen because; (a) it is close to Kisiizi hospital and falls outside the study area, (b) it represents both scheme members and non- scheme members.

Data management, analysis and interpretation

Data analysis followed the process of transcribing and checking, open coding, identification of patterns/themes and finally summarising the data [22]. The audio-recorded data was converted into written text to facilitate analysis. Coding was done manually. The researcher read through the texts several times so as to make meaning of the entire story before breaking it into parts. The researcher made memos in the margins which helped to identify common words/phrases, and the differences which helped to generate common themes, patterns within the responses. The generated themes were then linked to the study objectives, researcher's views and also in comparison with findings of previous studies.

The researcher chose to present empirical data with both quotes from individual participants as well as with excerpts of the discussions between the participants. This was aimed at making the results a more valid reflection of the empirical data. The researcher decided to mark the excerpts from the discussions 'Member FGD' or 'Non-Member FGD' to represent Focus Group Discussions for insurance members or Non – insurance members respectively. In addition, pseudo names of participants were used, in order to maintain the anonymity of the participants.

Quality control methods

First, the strategy of member checking was applied, where the researcher would recite back the responses in order to seek participant's clarification before the end of the interview. The second strategy was participant review, where, transcribed information was sent back to some of the participants to seek for their approval if that was a true copy of what was discussed. Thirdly, the researcher adopted a strategy of bracketing, where the researcher's experiences, beliefs, values and feelings were deliberately put aside in order to accurately describe participants' opinions and perceptions.

Ethical approval and consent to participate

The study was submitted to and was approved by the Kisiizi Hospital research committee.

Prior to the interviews, an explanation was given in verbal form to each of the study participants and an informed consent was attained. The participants were informed that the information provided would be used by Kisiizi hospital CBHI leadership to design appropriate strategies to scale up CBHI in the local community. The participants were informed of their right to walk out of the interview if they wished to withdraw. Both the researcher and the participant appended their signatures on the consent form.

Consent for Publication

Participants were informed of the likelihood of publishing the results of this study in international journals.

Results

Background characteristics of participants

A total of 64 participants took part in this study. Up to 26.6% (17) were key informants and 73.4% (47) participated in the focus group discussions. Up to 29.7% (19) were males and 70.3% (45) were females. Key informants ranged in age from 27 to 69 (mean = 48).

Table 1: Summary of the participants' background characteristics

Gender	No.	%age
Male	19	29.7
Female	45	70.3
Type of Participant		
KI	17	26.6
FGD	47	73.4
Employment status of Participants		
Formal employment	10	15.6
Informal employment	54	84.4
Educational level of Key Informants		
Primary level	3	17.6
Secondary level	4	23.5
Tertiary/University level	10	58.8
Occupation of Key informants		
Peasant farmers	8	47.1
Vendors	3	17.6
Health Managers	6	35.3
Age of Key Informants		
20- 29	2	11.8
30-39	4	23.5
40-49	6	35.3
50 and above	5	29.4
FGD Participants		
Scheme Members	22	46.8
Non-Scheme members	25	53.2
Village participation		
Moderate Insurance coverage	18	38.3
Low Insurance coverage	16	34.0
Very low Insurance coverage	13	27.7

Key informants included three (03) health managers of the District health department, (03) managers and staff Kisiizi hospital CBHI scheme and eleven (11) community leaders.

Up to 46.8 % (22) of the participants in the FGDs were members of the Kisiizi Hospital Health Insurance Scheme for at least 2 years and 53.1% (25) were Non-scheme members.

Up to 38.3% (18) were from a village with moderate insurance coverage, 34% (16) and 27.6% (13) were from villages with low insurance coverage and very low coverage respectively.

Assessing desirability of scaling up the Kisiizi Hospital CBHI scheme

This section presents findings on ability of the scheme to attract popular support from the local communities. The following parameters were assessed and presented hereinafter: acceptability and support to the scheme; conformity with national health policies/guidelines; conformity with society values and culture; acceptability of the benefits package; and availability of other health financing alternatives.

Community acceptability and support to the Kisiizi Hospital CBHI scheme

Participants expressed support for the scheme, linked to the scheme's objective of extending financial support to the members to fund hospital care.

For instance, in Member FGD 1, Joseline mentioned that;

“The scheme helped us to clear a bigger part of the hospital bill when my daughter delivered by ceasarian section”.

On the same note some opinion leaders stated that;

“We have seen the scheme helping some people who would not have managed to pay hospital bills especially for complicated healthcare services” (KI 5). “Most of the people in this community no longer sell family land or borrow from dubious money lenders to finance hospital care”(KI 8).

Conformity with national health policies/guidelines

Participants stated that the scheme’s objective of promoting access to quality healthcare services at low cost, is in line with local and national government priority of promoting universal health coverage.

For instance, Key informants 2, 3, and 5 mentioned that;

“The government priority is to promote universal health coverage. The people should be able to access quality healthcare service at low cost”.

In addition, Key informant 7 mentioned that;

“The Kisiizi hospital CBHI provides an opportunity to all people especially the very poor to get quality services at Kisiizi hospital, at a very low cost”

Conformity with society values and culture

Participants uniformly stated that the scheme’s ideology and methods of work are very similar to the methods, practices and objectives of the local community associations which offer financial and material support to grieving families in times of death of loved ones or even in times of illness.

In support of the scheme, key informant 11 (Opinion leader) mentioned that,

“The scheme works more like our engozi groups, where we support each other with finances and food items during funerals”.

Acceptability of the benefits package

Most of the participants mentioned that the scheme offers insurance cover for common acute illness, accidents/ trauma and maternity services. It was also mentioned that the scheme does not offer cover for high blood pressure and diabetes services. For instance, Anna in FGD2 stated that *“Members with hypertension and diabetes should also be given a significant subsidy”.* Most participants described that, the benefits package meets healthcare needs of most of the people in local communities.

Available alternative health financing mechanisms

Participants mentioned that free basic healthcare services can be accessed from a number of lower health facilities. Most participants uniformly stated that advanced health care services are easily accessed at Kisiizi hospital, where patients pay user fees.

It was mentioned in Non-member FGD 1 that

“For simple illness, we visit local health centre III, and for illness that requires advanced care, we normally go to Kisiizi hospital”.

In agreement, Key informant 5, 8 & 9 mentioned that

“There is a strong network of government and non-government owned lower health facilities in Rubabo County, and only one general private-not-for profit hospital”.

Concerning households' mechanisms to mobilise funds for healthcare, it was mentioned that most families either borrow or sell family property especially land.

For instance, in Non-member FGD 2, it was mentioned that

“It is difficult to raise adequate funds to pay off hospital bills without borrowing or selling family property”.

In a similar way, Asaph, participant in non-member FGD 3 mentioned that

“I had to sell part of my banana plantation to settle hospital bills when my wife delivered our first borne”.

Assessing feasibility of scaling up the Kisiizi Hospital CBHI scheme.

This section presents findings on the practicability of CBHI implementation amidst existing constraints. Feasibility considerations were categorised as either enablers or barriers.

Enablers to scaling up Kisiizi hospital CBHI scheme in local communities

Existing community associations or groups

Participants mentioned that the scheme worked through and with the existing *Bataka /Engozi* groups to promote the health insurance agenda and to enrol members. For instance, Key informant 2 mentioned that;

“It was easy to penetrate the community through the “Engozi” groups, which had to add health insurance into their development agenda”

Trusted Quality of services at Kisiizi hospital

Most participants mentioned that Kisiizi hospital offers good quality services. For instance, Benard in Member FGD 1 mentioned that,

“Kisiizi hospital offers the best healthcare services in and around Kigezi region”.

In the same way, Justus in Non-member FGD 3, mentioned that

“Kisiizi hospital has good doctors and machines. Most people get healed from Kisiizi hospital”

According to Key informant 2,

“Trust in the quality of services offered by Kisiizi hospital has been a key factor to the success of the scheme”.

Affordable premium fees and co-payment fees

It was established that the scheme members pay annual premium fees and the co-payment fees. Premium fees range from 11,000 ugx – 17,000 ugx (USD 3 – 4.7) per year for each member. In addition, the members were required to

contribute a co-payment fee of 3,000 ugx (USD 0.8) for out-patient visit, 150,000 ugx (USD 41.7) for Major surgery including a caesarean section, 10,000 ugx (USD 2.8) for paediatric admissions and 30,000 ugx (USD 8.3) for non-surgical adult admissions.

Most participants stated that the premium fees are largely affordable. For instance, Joseph in Member FGD 3 mentioned that,

“The premium fees are affordable to many families in this village”.

Some participants also mentioned that the scheme members actively participate in setting the fees. Key informant 3 mentioned that,

“All insurance fees are set by the executive committee in collaboration with hospital management, but approved by the Annual general assembly of members, with an agreement that the set fees are affordable to majority of the households in our catchment area”.

Strong governance and management structures

It was established that the Kisiizi hospital CBHI scheme is governed by scheme members through an elected executive committee of eleven members. The main responsibilities of the executive committee include: making policies, evaluating proposals for insurance fees reviews, auditing scheme finances, and providing regular feedback about the services.

For instance it was mentioned that,

“The scheme belongs to the members and Kisiizi hospital helps to administer it” (Key informant 1).

In addition Key informant 7, mentioned that

“The hospital management consults with the executive committee in case of need to review fees. Secondly, all fees changes are presented to the members in the annual general meeting for approval”.

It was also established that the scheme office operates an electronic data management system which facilitates member registration, member verification, report processing and control of fraud.

For instance, *“We use an electronic system to register and identify valid members whenever they come to the hospital for healthcare services. We are also able to monitor prescription patterns which is key in controlling unnecessary use of services through this electronic system” (Key informant 4).*

Barriers to scaling up the Kisiizi hospital CBHI scheme in local communities

Long distance and high transport costs to Kisiizi hospital

It was established that Kisiizi hospital is located over 30 Km away from the main road and over 50 Km from the urban centre. Participants uniformly mentioned that it is difficult to travel to and from Kisiizi hospital due to unreliable public transport means. For instance Shallon in non-member FGD 2 mentioned that *“It is difficult to travel to and from Kisiizi in the afternoon and night hours”.* In non-member FGD 3, Timothy mentioned that;

“Public transport costs to Kisiizi Hospital for a patient and one care taker are higher than costs of medical care in a nearby clinic”

Low levels of knowledge, negative attitude and beliefs about health insurance

Some participants questioned the motive of pooling funds annually and expressed fears in the accountability of these funds. For instance, Miriam and Tina in Non-member FGD 1, asked that *“Where does the money go if one does not get sick throughout the year?”*

In addition, a few participants claimed to have witnessed segregation of insurance patients from cash –paying patients at Kisiizi hospital. For instance, in Non-member FGD 1, George mentioned that *“The health workers at Kisiizi hospital offer better services to patients who pay cash than those in health insurance”*.

Inability to pay Premium and co-payment fees.

Participants stated that a few families in the local communities have failed to enrol into the scheme due to failure to raise premium fees. Key informant 6 mentioned that *“The very poor families especially those that do not belong to community associations cannot afford to pay premium fees”*.

Secondly, overlapping of school fees periods with membership renewal period was mentioned as another factor for failure to renew scheme membership. Key informant 3, 5, 7 and 11, mentioned that

“Some families have dropped out of the scheme due to failure to pay premium fees, especially during periods when children are returning to school”.

Discussion

Desirability of scaling up the Kisiizi Hospital CBHI scheme

First, the participants revealed acceptability and support for the scheme, linked to the scheme’s ability to offer financial support to clear hospital bills. Participants testified of having benefited from the financial support from the scheme. It was revealed that the scheme has created an opportunity for the poor to access quality hospital care, which they could not have managed to pay for out –of –pocket. Participants further revealed that scheme members no longer sell family land or borrow funds at high interests in order to settle hospital bills. The study findings agree with previous studies that 53% of the patients getting surgery in Ugandan hospitals borrow money to finance their care and 21% sell family property [23].

Secondly, participants stated that the scheme objectives and processes are in conformity with and contribute towards attainment of the government agenda of promoting universal access to health care services at low cost. The findings of this study are supported by national policies and strategic plans. For instance, the Uganda Vision 2040, identifies health insurance as one of the key strategies for alleviating high costs on health care by households and enhancing access to affordable health services for all [24].

Thirdly, participants unanimously agreed that the Kisiizi hospital CBHI ideology and methods of work are in line with the practices and objectives of the local community associations, (*‘Engozi groups’*), which are part of the society norms. These associations offer financial and material support to grieving families in times of death of loved ones or even in times of illness. The schemes promotes solidarity, trust and social cohesion within the local community with the aim of eliminating financial barriers to accessing health care. The findings of this study agree with previous research that community social capital enables better access to care [25].

Concerning the benefits package, participants largely agreed that the scheme meets healthcare needs of the majority. It offers cover for common illnesses/health conditions. However, participants recommended for introduction of a subsidy

for hypertension and diabetes care. The findings of this study agree with the findings of previous studies that people in rural areas preferred a benefit package which is comprehensive in nature, offering inpatient, outpatient and emergencies services [26].

Regarding the available health financing alternatives, participants revealed that free basic healthcare services are readily available at lower health facilities. However, hospital level services can easily be accessed at Kisiizi hospital which charges user fees. The participants further revealed that, most families raise the required hospital finances through sell of land or property. These findings agree with existing literature that user fees deter utilisation of services, whereas prepayment or insurance schemes offer potential for improving access [27].

Feasibility of scaling up the Kisiizi Hospital CBHI scheme.

First, participants acknowledged that numerous *Engozi groups* do exist in the local community. The scheme operates through these local associations to promote the Health insurance agenda and enrol members. This was considered as key factor in the success of this scheme. The findings of this study agrees with previous studies that CBHI schemes can build on existing social capital to increase coverage by enrolling households through community associations [25].

Secondly, it was revealed that the local community trusts the quality of services at Kisiizi Hospital. Most participants were comfortable with the level of quality of services at Kisiizi hospital. Previous studies indicate that perceptions, attitudes and beliefs about service providers strongly influence the households' decisions to enrol and remain enrolled into the scheme [26].

Thirdly, participants revealed that insurance fees are affordable to many households in the local community. It was further shown that, the fees were set by members and administrators of the scheme basing on affordability as a key factor. Existing literature indicates that ability to pay premium and co-payment fees is a strong enabling factor to scheme enrolment [8].

In addition, results indicated that the members are actively involved in the management of the scheme through an elected executive committee. The management systems are enhanced with a robust electronic data management system. Previous studies have indicated that; trust in the management of the scheme especially the integrity of the scheme managers strongly influences a household's decision to enrol into the scheme [28], and having robust management or administrative structures is essential to scheme implementation and influences sustainability of the CBHI schemes [9].

Irrespective of the above, expansion of the Kisiizi hospital CBHI scheme continues to face a number of deterrents.

First, most participants mentioned long distances associated with high transport costs to Kisiizi hospital as a key barrier to enrolment especially for distant communities. The high transport costs to and from the hospital masks the visible advantages of scheme membership. This finding is in line with existing literature that large distance to in-network health facilities constitutes a significant obstacle to enrolment, and even a reason for non-renewal of membership into CBHI schemes [9].

Secondly, a few participants were not very convinced of the reasons for pooling funds in preparation for unforeseen illness, and the subsequent accountability of the funds at the end of a financial year. These statements depict lack of knowledge on the concept of health insurance, especially among non-insured community members. Existing literature indicates that; low levels of knowledge leads to doubt and influences negative attitudes towards CBHI schemes [29], while consumer awareness and understanding of the concept of health insurance are significant determinants of scheme uptake [9].

Lastly, it was revealed that some families are not able to raise premium fees and have failed to enrol into the scheme. It was also discovered that some families drop out of the scheme whenever renewal period overlaps with period when children are returning to school. In the same way, existing literature indicates that families drop out of CBHI schemes due to difficulties to meet subscription fees [30], and the policy to pay annual premiums fees in one payment is a significant obstacle for some families [9].

Strengths and Limitations of the study

The strength of the methodology applied in this research include; involving participants from different communities with different insurance coverage and following the Consolidated criteria for reporting qualitative research – COREQ [31].

This study had several limitations. First, the researcher was new in this field of qualitative research. However the researcher was able to get guidance from existing literature on qualitative studies. Secondly, the researcher never had adequate funds for the study. This study did not receive any external funding. However, the researcher exercised strict budget control on the available funds. The transcripts were translated into and coded in English language. However, all translations were conducted by a researcher Assistant who is fluent in both local and English languages. The translations were later reviewed by the researcher who is also fluent in both languages.

Implications for policy and practice

CBHI implementation fills the health financing gap in communities with limited free healthcare. However, the following considerations are critical to CBHI implementation and scale up.

First, Policymakers and Scheme implementers should ensure that the scheme objectives and policies are in conformity with culture, society values and government priorities. It also requires a benefits package that observes population preferences and meets the healthcare needs of the majority of the population.

Second, Scheme members must be given opportunities to actively participate in decisions. This approach enhances trust, accountability, and scheme ownership. Insurance fees should be in ranges affordable to the majority of the community members. Ability to pay insurance fees is a strong enabling factor to scheme enrolment. More to that, communities must be sensitized on CBHI concepts to inform individuals about the scheme and its motivations. Furthermore, the quality of services must be trusted. Perceptions, attitudes and beliefs about services and service providers strongly influence decisions to enrol and remain enrolled into the scheme. This should be enhanced with a large network of service providers/health facilities to allow easy access to care.

Third, strategies to mitigate potential inequities that might result from enrolment or access to services should be put in place. Such strategies might include: Subsidies or fees exemptions especially for the very poor and vulnerable people; and flexible fees payment or renewal policies that are tailored to the context.

Conclusions

CBHI implementation fills the health financing gap in communities with limited free healthcare. However, scheme implementation requires the following considerations: the scheme objectives and policies must conform to culture, society values and government priorities; the benefits package should be in line with population preferences, covering healthcare needs of the majority. Scheme members should actively participate in making decisions. The insurance fees should be affordable to the majority. Importantly, the service providers and the quality of services must be trusted.

Finally, potential inequities must be mitigated through flexible fees policies and where possible through subsidies for the poor and vulnerable people.

Abbreviations

CBHI: Community –Based Health Insurance;

FGD: Focus Group Discussion; KI: Key Informant; UBOS: Uganda Bureau of Statistics

Ugx: Ugandan Shillings; USD: United states Dollars

Declarations

Ethical approval and consent to participate

The study was submitted for approval to the Kisiizi Hospital research committee. Written consent was obtained from all participants before the interview. The participants were informed that the information provided would be used by Kisiizi hospital CBHI leadership to design appropriate strategies to scale up CBHI in the local community. The participants were informed of their right to walk out of the interview if they wished to withdraw.

Consent for Publication

Participants were also informed of the likelihood of publishing the results of this study in international journals.

Availability of data and material

The datasets used and /or analysed during the study are available from the corresponding author on reasonable request.

Competing interests

The author declares that he has no competing interests.

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Authors' contributions

AK analysed the data and interpreted the results, and was a major contributor to the writing of the manuscript. The author read and approved the final manuscript.

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Figures

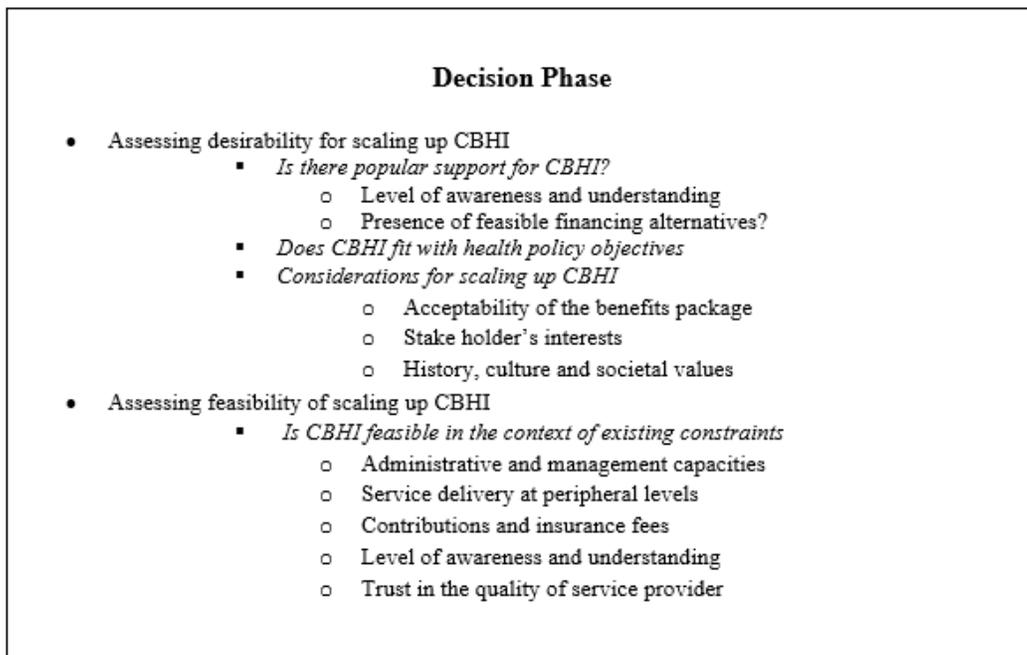


Figure 1 is adapted from Normand & Weber (1994)

Figure 1

Issues to consider when making a decision to scale up community-Based Health Insurance