WILLINGNESS TO JOIN PRIVATE HEALTH INSURANCE AMONG OUTPATIENTS ATTENDING MUKWAYA GENERAL HOSPITAL, MAKINDYE DIVISION, KAMPALA CITY.

By

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Declaration

I, ***Adyero Filder Claret*** declare that this dissertation is my original work and that it has never been presented for any academic awards or public presentation in this or any other institution. All materials and resources used are duly acknowledged.

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DEDCATION

To Christine Achola my dear late sister, thank you for your selfless love and tireless efforts that gave me a good beginning in my education. May the good Lord keep your soul safely in Heaven.

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LISTS OF ABBREVIATIONS

AAR Air Ambulance Rescue

CBHIS Community-Based Health Insurance Scheme

HMO Health Maintenance Organization

IAA International Air Ambulance

IRAU Insurance Regulatory Authority Uganda

KI Key informant

MGH Mukwaya General Hospital

MOH Ministry of Health

NGO Non-Governmental Organization

NSSF National Social security Fund

OECD Organization for Economic Co-operation and Development

OOP Out- Of- Pocket Payment

PHI Private Health Insurance

UCBHFA Uganda Community-Based Health Financing Association

Ugshs Uganda Shillings

UHSA Uganda Health System Assessment

VHI Voluntary Health Insurance

WDI World Development Index

WHO World Health Organization

WTP Willingness to Pay

OPERATIONAL DEFINITIONS

For the purpose of this study, the following terms will be used in the context defined below.

Adverse selection: This is the enrollment of those who are ill or more prone to illness in an insurance scheme compared to the healthier ones.

Capitation: This is a prospective means of paying health care staff based on the number of people they provide care for.

Catastrophic expenditure: This occurs when health care payments force households to borrow heavily, incur debts or to reduce their other basic expenditures on items like food, housing and clothing. A household is considered to be facing catastrophic financial health expenditure when it's out-of-pocket health payments is equal or more than 40% of its non-subsistence expenditure or health expenditures in excess of 10 percent of total household consumption.

Community-Based Health Insurance: This is a form of health financing which is usually organised at community level and has outstanding features of being run as a not for profit schemes. It targets the informal sectors and applies the basic principles of risk sharing and members participation in the management of the schemes.

Health Insurance policy: This is a contract between an insurance provider (e.g. a private health insurance company and an individual or his/her sponsor e.g. an employer or a community organization). The contract can be renewable (e.g. annually, monthly) or lifelong.

Health Insurance Scheme: This is an insurance operated by a public agency where the premium takes the form of compulsory contribution which is deducted from the payroll as part of earning. Its membership is compulsory, it is run by public bodies either single or multiple organisations, and has redistribution policies.

Health Maintenance Organization (HMO): This is an organization that provides comprehensive care for a fixed, periodic per capita payment.

Out-of-pocket: This is payment made by a patient directly to the provider at the point of service.

Patients' Moral hazards: This is the tendency of the insured persons to unnecessarily consume health services more intensely because the cost of doing so is much less to them than for the non-insured.

Premium: This is the amount of money the policy-holder or his sponsor (e.g. an employer) pays to the health care pre-payment plan to purchase health care coverage of specified benefits.

Private Health Insurance: This is a health care pre-payment plan that is taken up and paid for at the discretion of individuals or employers on behalf of individuals.

Risk- pooling: This is the collection and management of financial resources so that large unpredictable individual financial risk becomes predictable and is distributed among all the members of the pool.

Risk protection: This is the shielding of an individual or household from critical income loses as a result of health care expenditure.

Abstract

Introduction: Private Health Insurance is viewed across the world as an important health financing mechanisms that serves to protect households from the direct financial consequences that comes with out-of-pocket expenditure for health care. This research investigates patients' willingness to join and pay for private health insurance scheme in Mukwaya General Hospital, Makindye Division, Kampala City.

Methods: A cross sectional non-interventionist exploratory study design was used. The study involved both qualitative and quantitative data collection methods. Proportionate probability sampling was done to select 150 out patients to participate in the study and Pearson's Chi square (X^2) test of association was performed to find the association between sets of categorical variables.

Results: There is low level of knowledge and understanding of PHI with women (71.4%), Catholics (62.3%) and those not in formal employments (32.6%) less knowledgeable. Seventy eight (78%) of the respondents were not insured and they mentioned lack of knowledge and high premium as barriers to enrollment for PHI. Eighty three percent (83.8%) of the respondents were willing to join PHI and most of them were willing to pay less Ugshs 100,000 ($38.5) per person annually.

Conclusion and recommendation: Level of knowledge and coverage of PHI s still low. Most patients were willing to join private health insurance. PHI companies and HMOs need to intensify public awareness campaigns especially in the informal sector. Varied and flexible forms of payment and improved quality services should be encouraged in order to attract and retain new subscribers.

CHAPTER ONE

INTRODUCTION

Introduction

Private Health Insurance or Voluntary Health Insurance also (PHI or VHI) is a financial cover against the risk of incurring medical expenses among individuals where the medical bill is paid in advance to the insurance company (Foubister et al, 2006). By estimating the overall risk of expenses among a targeted group or individuals, an insurer can develop a monthly or yearly premium payment, so that money is made available to pay for the health care services specified in the insurance agreement or policy (Zikuzooka & Kyomuhangi 2008; Wonderling et al., 2005). PHI is voluntary, provides financial protection and can help those insured to escape out-of-pocket expenditures. It also mobilises financial resources for health care where tax based revenue is inadequate and supplement other financing mechanisms. A problem may arise when PHI is poorly regulated. This problem may be in the form of an increased inequality like inaccessibility of health care (Sakhri and savedoff, 2000 ; Basaza (2011), and others such as adverse selection, moral hazards, escalating costs and cream skimming (Gustafsson-Wright, et al., 2009).

Community-Based Health Insurance Scheme

This is another form of health financing mechanism used in Uganda. There are over 25 community-based health insurance (CBHI) schemes registered in Uganda (UCBHFA, 2013). These are coordinated by the umbrella organization called the Uganda Community Based Health Financing Association (UCBHFA) with a strong collaboration with the MOH and overseen by

the NGO Board. Most of the current schemes are hospital-based but are owned and managed by the community members themselves with small population coverage (UHSA-MOH, 2011).

Proposed National Health Insurance Scheme

This is also another form of health financing which has not yet taken root in Uganda but it is in the process since the bill has been drafted by the Ministry of Justice and is soon to be tabled in Parliament. To counter the problem of inequalities and inequity which might result from PHI, and CBHIS, the Ugandan government through the Ministry of Health is in the process of introducing the National Health Insurance Scheme (NHIS). The proposed NHIS will cover those in the formal sector where they will have to part with 8% of their monthly gross salaries besides Pay-As-You-Earn and/or National Social Security Fund contribution (NSSF). Like NSSF, the employers will make a 4% contribution and the employees will contribute the other 4% to make an 8% total contribution towards the scheme. It is hoped that the scheme will bring additional financial resources for the Ugandan health sector and that its introduction will improve equity in access because risk is pooled, therefore, more people are likely to access health services that they would have not ordinarily been able to access given their income levels (Zikuzooka & Kyomuhangi; 2008).

Health financing in Uganda

Uganda is a signatory to the Abuja declaration which resulted from a summit of African Heads of States in 2001 where they pledged to increase national spending on health to at least 15% of the national budget, (Govender et al.,2008 ; OAU). However, the total government spending on health was at only 9% on average in 2010 – 2011(MOH 2011; WHO 2011), with only US$15 per capita public health expenditure which is quite below the estimate that would deliver a minimum

health care package in Uganda currently standing at about US$28 (Okwero et al., 2010). The rising OOPs still account for about 53% of the total health expenditure and 65.44% of the total private expenditure in Uganda (WDI, 2011). The percentage of households with catastrophic health expenditure from 1997 to 2007 was at 28% and was mostly concentrated in poor households (Providing for Health, 2010). About 2.3% of all households are said to be newly impoverished as a result of OOPs spending (Providing for Health, 2010) due to its inequity as well as increased incidence of catastrophic health expenditure among the poor despite the abolition of user fees(MOH, 2011). This, in part was attributed to the great use of private health providers by the poor and frequent stock-out of medicines in public facilities (Pariyo et al, 2009; Basaza et al, 2007) which forced health care seekers to pay higher prices to acquire drugs at private pharmacies. Important to note is the absence of a comprehensive social protection strategy in Uganda (Zikuzooka, 2007). Although the NHIS is currently in the policy dialogue (Orem and Zikuzooka, 2010), there are minimal financial protections from catastrophic OOP with only a few CBHI and PHI schemes covering 5-10% (in areas where they exist) and 1% of the Ugandan population respectively (Basaza et al, 2010).The absence of risk-pooling therefore, is an obstacle to access to equitable and sustainable health care, as well as protection from the threat of catastrophic OOP payments in the event of illness (MOH-UHSA , 2012).

1.0 Background to the study

Socio-economic status and knowledge according to Kaur-Bawa and Ruchita (2011), usually affect the health of the community and it is not easy to achieve one without the other, that is, one cannot be achieved in isolation. The same study continued to note that to a large extent the health

indices of a country were determined with reference to the ways with which its health care gets financed.

Currently, there is an on- going heated debate concerning the potential benefits of PHI for low- and middle-income countries with both those for and against PHI emphasizing the merits and demerits to this form of healthcare financing respectively. Those in favour of PHI; are advocating for the potential gains in health service efficiency, the need to eliminate the financial shocks that comes with OOP health expenditures, as well as to address the issues of poor quality service of the public health systems (Gustafsson-Wright et al., 2009) in countries like Uganda. On the other hand, those against PHI point out the issues of adverse selection, moral hazards, escalating costs, cream skimming, and increasing inequality which is quite common with this kind of health care financing (Gustafsson-Wright et al, 2009). However, despite all the above arguments both for and against, a Joint NGO discussion briefing paper indicates that PHI has always been viewed across the world as an important health financing policy that serves to protect households from the direct financial consequences that comes with OOP for health care (Joint NGO Briefing, 2008).

In developing countries, multilateral agencies (particularly the World Bank, the International Finance Corporation, the International Labour Organization, & the World Health Organization), and other donor countries (e.g. France, Germany, & the Netherlands) have shown an increased interest in PHI as a mechanism to collect and distribute resources for the health sector in a more equitable way, with pre-payment and risk pooling being considered as preferable to payment at the point of service (Berkhout & Oostingh 2008). In both developed and developing countries, PHI is becoming more prevalent and is considered by some to have great potential in Africa with

the World Bank in particular being influential in driving the growth of Private Health Insurance markets in Latin America, Eastern Europe, and Central Asia (Sakhri & Savedoff, 2004). In sub-Saharan Africa where Uganda belongs, PHI is still looked at as a new mode of health care financing with the exception of some rare cases, where health insurance occurs mainly in the Community level. Here, PHI spending compared to total health care spending in all the 21 countries increased by 23.1% (Preker et al 2010).

Uganda's health sector however, remains significantly under-funded, mainly relying on private sources of financing, most especially OOP spending. At about 8.3% of total government expenditure in the financial year 2011/2012 down from the previous 8.9% in financial year 2010/2011 (AHSPR, 2011/2012), public spending on health in the country is in a downward negative trend, far below the Health Sector Strategic Investment Plan (HSSIP) target for the same financial by 0.3%. If this is compared to the Abuja target of 15% where African leaders, Uganda inclusive, committed themselves to ensure that the needed financial resources were made available, efficiently and effectively utilized, there is still a wide gap to be filled. Looking at the decreasing trend in public health financing, Uganda is still far from achieving the Abuja target (WHO, 2013).

It has further been noted that health care pre-payments is limited and forms a small proportion of funding for Uganda's health sector which leads to limited cross subsidization and high fragmentation within and between health financing mechanisms. This has resulted in high reliance on OOP as well as limited prepayment mechanisms like PHI. Also without compulsory Health Insurance and low coverage of PHI, Uganda has limited resource pooling mechanisms

and hence minimal cross-subsidization (Zikuzooka & Kyomuhangi, 2008). Furthermore, very few Ugandans are insured. This explains why Uganda still lags far behind in East Africa compared to Rwanda at almost 98%, Kenya at about 35%, Burundi 34% and Tanzania at 15% coverage (Walubiri, 2011). As such, the country still has a long way to go in order to increase its coverage and maximize the benefits of PHI. Looking at the few available studies on Private Health Insurance (PHI), little is known about the level of knowledge of the population and their willingness to join PHI. There is also no clear documented study on the extent of coverage of PHI in Uganda. This study will investigate these factors and the results will then help to identify some key issues that are influencing the population's willingness to join Private Health Insurance in Uganda.

1.1 Background to the study area

The study was conducted in Mukwaya General Hospital located in Makindye Division, in the service area of Kampala City, Uganda. It is a general hospital with Makindye Division as its primary catchment area. However, its service area is widening beyond Kampala. The Hospital currently has a bed capacity of 54 beds (still under construction) with an average bed occupancy rate of about seventy-five percent (75%). It has about 12 Nurses, 7 Midwives, 4 Clinical Officers, 4 Laboratory Technicians, 1 Laboratory Technologist and 3 Medical Officers. There are also 4 specialists in gynaecology, paediatrics, surgery and internal medicine respectively besides support staffs. The hospital provides preventive, promotive, curative, inpatient and outpatient services as well as outreach services in and around Kampala. The hospital, under Nsambya Health Network, provides prepaid services which serves all categories of people irrespective of

their socio-economic, demographic and/or political affiliations, however majority of the hospital's clients access services through out-of- pocket payment.

1.2 Problem statement

Health Insurance has been viewed across the world as an important health policy that serves to protect households from the direct financial shocks when sickness occurs (Osei-Akoto and Adamba, 2011), but unfortunately according to a report by the Ugandan MOH (2012) and Basaza et al (2009), the share of Private Health Insurance is negligible in Uganda; at about 1 percent of the country's total health expenditure. The absence of adequate risk-pooling arrangements is another obstacle to both ensuring greater access of individuals to needed health care, as well as protecting them against the threat of catastrophic out-of-pocket payments in the event of illness.

Very few Ugandans are taking up PHI products (policies or plans) apart from a few schemes that are mainly funded by employers on behalf of their employees. This leaves the biggest part of the population, especially the informal sector who cannot afford the highly priced medical packages to languish in abject poverty due to poorly managed illnesses. As a result, it becomes even harder for the Ugandan Ministry of Health to achieve its objective of having a productive population for socio-economic development.

There is very few data and studies to explain the populations' willingness to join Private Health Insurance (PHI) despite its great importance as a mechanism of health financing. This research will shed more light on factors that influence willingness to join PHI. The Ugandan government

is also in the process of a gradual introduction of National Health Insurance Scheme and this study will inform this policy agenda.

1.3 General Research question

Are the patients in Mukwaya General Hospital willing to join private health insurance?

1.4 OBJECTIVES

1.4.1 General objective

To assess patients' willingness to join private health insurance scheme in Mukwaya General Hospital, Makindye Division, Kampala City.

1.4.2 Specific objectives

1. To establish the level of patients' knowledge on private health insurance at Mukwaya General Hospital.
2. To establish the level of private health insurance's coverage in Mukwaya General Hospital.
3. To establish the willingness of patients in Mukwaya General Hospital to join and pay for private health insurance policies/plan.

1.5 Research Questions

a) What is the level of patients' knowledge on private health insurance at Mukwaya General Hospital?
b) What is the level of private health insurance's coverage in Mukwaya General Hospital?
c) Are the patients in Mukwaya General Hospital willingness to pay for Private Health Insurance? If yes, how much are they willing to pay in order to enrol/subscribe in PHI schemes?

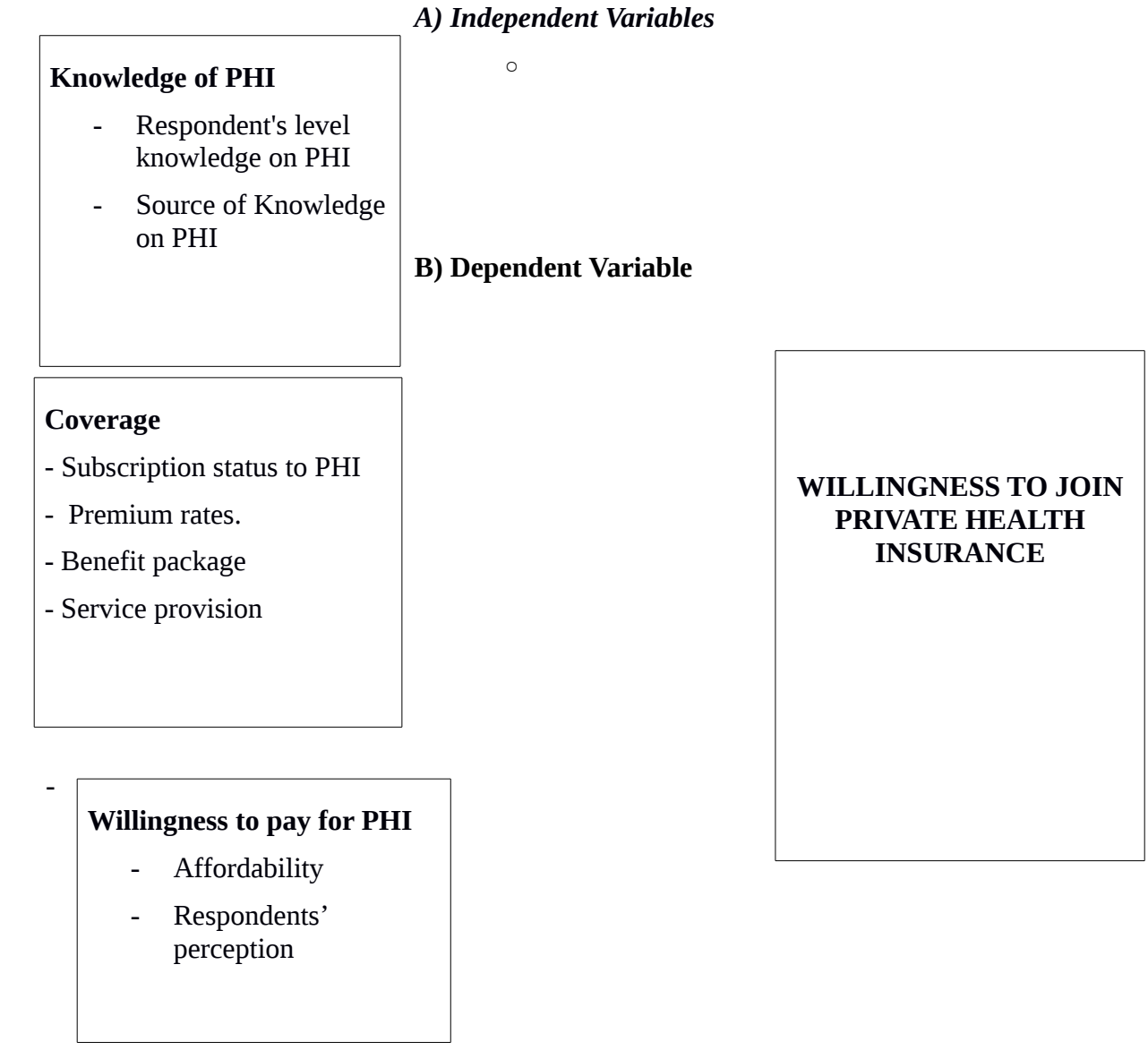
1.6 Significance of the study

Out-of pocket health care payment is still a major form of financing in the health sector. It amounted to about 9% of total household consumption expenditure and makes 37.9% of the total health spending in 2006 with about 28% of the sampled households facing health expenditures that could be deemed catastrophic (Okwero et al., 2010). OOP expenditure on health is also highly inequitable and predisposes households to incurring catastrophic expenditures and poverty (Orem and Zikuzooka, 2010).

Private Health Insurance (PHI) is one of the most effective ways of risk pooling to avoid the kind of shocks brought by illnesses because payment is done when one is healthy and working. Since there is still a very low uptake of PHI in Uganda, this study will clearly bring out information on whether the respondents know about PHI or if they are willing to join private health insurance services as well as the extent of PHI coverage in the study area. The results will then be used by Mukwaya General Hospital's prepaid health care department to improve on enrolment of clients to its Nsambya Health Network system as well as inform the policy agenda as Uganda prepares to launch the National Health Insurance Scheme so that clear strategies is put in place for the sustainability of the programme basing on evidence from this and other studies

1.7 Conceptual Framework

Figure 1



The conceptual framework in figure 1 shows the relationship between (A) independent variables; (level of knowledge on PHI, extent of coverage by PHI and respondents' willingness to join PHI) to the Dependent variable (B); (Factors influencing willingness to join Private Health Insurance). Any change in the behaviour of independent variables is expected to have a direct effect, either negative or positive on the willingness to join PHI which is the dependent variable. For example, we are going to assume that a person with a high level of knowledge on PHI would be able to buy PHI policies unless he/she has other constraints like lack of interest in PHI, unwilling to pay for PHI or is both willing to pay and interested in PHI but cannot afford the premiums charged. Another issue may be lack of knowledge and awareness, where it may be assumed that a person may afford the PHI premium but he may lack knowledge or awareness of its presence making him/her unable to join. There may also be some other reasons that make them unwilling to purchase PHI policies which will be established during the research data analysis.

CHAPTER TWO

LITERATURE REVIEW

Introduction

Private Health Insurance plays a large and increasing role around the world in handling financial crisis of increased OOP expenditures in healthcare services. This has led to a number of studies and discussions on why many people do not subscribe or subscribe for PHI and how people can be encouraged to increase uptake of this form of healthcare financing. This chapter is in 3 sub-sections. Sub-section 1 is the studies which shows how knowledge Influences willingness to join PHI. Sub-section 2 is addresses studies that are done to find out how the extent of coverage influences willingness to join PHI, while sub-section 3 is on how willingness and ability to pay for PHI influences willingness to join PHI.

2.0 Knowledge of private health insurance

Bolhaar et al (2007) in a study done in Ireland found that the educated individuals and individuals living in one of the big cities are more inclined to take supplementary private health insurance. They further pointed out that probably because of exposure and availability of private health insurance services in urban areas, but the study could not make a conclusion out of the findings. However, Kaur-Bawa and Ruchita (2011) on the other hand found that although health insurance is not a new concept and a section of the people in an Indian community in Punjab were also getting familiar with it, knowledge and awareness has not yet reached to the level of

subscription to PHI products meaning the level of knowledge may be high but other factors could be a barrier to uptake of PHI in this community.

Dercon et al., (2012) described the main findings of a field experiment offering PHI to tea farmers in Kenya and stated that demand for PHI increased substantially when price discount was offered, but contrary to expectations, the educational campaign done in this population did not have any significant effect on PHI demand despite the evidence of improved insurance literacy among participants.

2.1 Extent of Coverage by private health insurance.

Coverage usually shows the number of people covered by insurance policies in a particular population, the range of services covered by these policies and the costs to which [specified] services are covered by prepaid funds (Gottret & Schieber, 2006). They further noted that the criteria for [benefits] to coverage differ greatly among social health insurance countries, tax-financed countries and countries where a large part of health care services is funded by PHI and medical savings accounts.

A few studies that were done in both developed and developing countries showed that there is a significant accessibility gap existing between the most and least socio-economically advantaged in the society. Socio economic status is linked to disparities in access to primary health care, and this may impact on the health of an individual (Sakhri & savedoff, 2004). Banks et al., (2009) compared the insured and the uninsured populations in Australia and found that those covered by PHI are richer, better educated, more health conscious, in better health condition and are more likely to use discretionary health services. The study concluded that PHI coverage is generally

highest among those with least need for health care and that PHI coverage is strongly associated with demographic and life styles factors than with health status.

Premium rates

Long and Marquis (2002), found that the price of insurance or premium is another factor influencing the demand for private health insurance. However, no documented studies have attempted to estimate the price elasticity of demand for Private health insurance. In the individual market, Blumberg and Nichols (2001) points out that prices are in most cases based on individual characteristics; hence the premium paid by an insured individual is endogenous. Cream skimming usually occurs in non competitive regulated insurance markets. This may also occur in competitive unregulated markets because premiums will adjust to reflect insurers' perception of risk where it will be reduced to attract lower profitable risks or increased until higher risks become profitable (Preker, et al 2007).

The Irish health care system offers a tax financed universal entitlement to public care at a nominal user fee. However, despite the government´s policy of universal entitlement, about 50% of the Irish population still purchased Private Health Insurance which shows that there could be some kind of benefits the Irish population get in PHI but could not find in the public tax financed care (Finn & Harmon, 2006). Spending on PHI as a proportion of total expenditure on health care is low in the European Union, i.e. less than 10% of total expenditure in all the member states except France (12.2%) and the Netherlands (17.7%) and in Belgium, Denmark, Finland, Greece, Italy, Luxembourg, Portugal, Spain, Sweden and the United Kingdom it is below 5% of total expenditure (Mossialos and Thomson, 2004). PHI has a much larger share of private expenditure on health care in member states offering substitutive private health insurance

particularly in the Netherlands (70%), where about 30% of the population is excluded from statutory coverage.

In France, (51.7%) where 85% of the population is covered by complementary PHI to cover the cost of co-payments imposed by the statutory health care system. The relatively small proportion of private spending on PHI can be attributed to the fact that governments in the European Union have tended to rely on other methods of shifting health care costs onto consumers, such as user charges (co-payments and direct payments), rather than promoting and subsidizing PHI. As a result, out-of-pocket payments make up the bulk of private expenditure on health care in all European Union member states except France and the Netherlands (Mossialos & Thomson, 2004).

In the United States of America, the health financing mechanism is categorized as a mixed system because it has a large free market of PHI system as a primary source of financing, which operates side by side with tax-funded public health financing programs for specified groups as noted by Odeyemi and Nixon (2013). They continued to state that although PHI plays a major role, it accounts for less than half, that is, 35% of the total health care expenditure, while public expenditure accounts for about 44.9%. OOP payments are second highest at about 13.5%. It has further been noted that although the US has the highest health expenditure in the world, the public insurance and PHI coverage is highly fragmented, with various private and public sources and gaps in coverage rates across the United States population. Despite several arrangements by the different states to reduce the number of the uninsured and increase coverage, a significant number of the United States population have none, or inadequate, health insurance. In 2010, it was noted that 81 million people about 44% of US adults were uninsured or under-insured that

is, having high medical expenditures relative to their incomes. In an attempt to reduce this number of uninsured Americans, the Affordable Care Act (ACA) was introduced in 2010 by the Obama Administration. The aim is to expand Medicaid coverage to include individuals with incomes below 133% of the federal poverty level, and provide assistance to limit premiums for those with incomes of up to 400% of the federal poverty level. A recent study suggests that full implementation of the ACA could reduce the number of underinsured by up to 70% (Odeyemi and Nixon, 2013).

A study done by Bolhaar et al (2007) in Ireland to analyse the demand for health insurance and health care utilization, established that more than sixty- seven percent (67%) of the households in Ireland were privately insured and that the privately insured were less often unemployed and have on average a higher income. Furthermore, the study continued to note that getting an offer for buying supplementary Private Health Insurance from the employer increased the likelihood that an individual took supplementary private health insurance. Preker et al., (2010) concurs with these findings in a study focussing on PHI and its determinant to enrolment using a CASEN 2000 household data. They established that enrolment in PHI is positively correlated with income, health risk and education. This shows that income can be an important factor in joining PHI irrespective of other status.

Gustafsson-Wright et al, (2009) confirmed the above notion with a study done in Namibia which independently found out that the factors which were strongly associated with having PHI were; higher income, higher educational level, high levels of self-rated health and functional capacity and low levels of psychological distress. Gustafsson-Wright et al, (2009) further points out that

there is a large discrepancy in PHI enrolment across socio-economic categories in Namibia. Only five percent (5%) of individuals in the poorest consumption quintile were enrolled in medical aid while 70 percent of individuals in the richest quintile have medical aid benefits. In addition to income differences in insurance enrolment, they also noted that there existed a difference by industry of employment. Those most likely to be insured, they noted, were individuals whose head of household works in government or defence. Household members with household heads who worked in education and health followed close behind and the least insured industries they found in their study were the manufacturing, retail/accommodation and construction industries.

In a study done in Egypt to assess the determinants to enrolment in PHI, it was found that the choice to whether to enrol for PHI or not is influenced by two main determinants: individual´s decision weighting costs and benefits, as well as household´s and community´s characteristics (Nassar & El-Saharty, 2004) cited by (Preker et al., 2010). The same editors (Preker et al., 2010) looked at studies done in South Africa on determinant of utilization of PHI and noted that wealth and educational level of household´s head plays a major role in that the wealthier and highly educated the household head is, the higher the chance of having PHI coverage.

Osei-Akoto and Adamba (2011), in a study in Ghana hypothesized that religiosity was then known to reduce people's perception of health risk and a strong reliance on God and prayers for preventive health. They stated that if religious diversity is a good proxy for religiosity then a religiously diverse community should have low demand for health insurance. They then established that ethnic and religious diversity determine uptake of private health insurance and also that the health status and the presence of children and aged in a household also significantly influence the decision to purchase health insurance.

Dercon et al, 2012 in an experimental study done in Kenya found that referral incentives had a negative influence on private health insurance demand. This suggested that trust is an important element to promote private health insurance coverage. Additionally, the study continues to show that reduction in price impacts significantly on insurance demand, a lesson they concluded should be considered when pricing PHI products. Thus more consideration should be put on other factors like income, which may act as barriers to willingness to join and not necessarily the level of knowledge on PHI.

Bolhaar et al, (2008) in a study about age and gender influence on coverage of PHI, found that women, older individuals, high educated individuals and individuals living in big cities are more inclined to take supplementary Private Health Insurance. This probably is due to exposure and availability of Private Health Insurance services.

Benefit Package

Kutzin, (2001) pointed out that benefit package includes a set of services covered by health insurance under specified conditions and sets the risk limits as well as standards for adequate financial protection. Experiences from Costa Rica and some countries in South- East Asia show that it is important to develop an explicit benefit package regardless of the insurance model (Gottret & Schieber, 2006). Usually the more comprehensive the benefit package, the more health insurers are predicted to invest in risk selection but a very limited benefit package makes no difference in the expected contribution margins of the high-risk and low risk insured (Preker et al 2007).

Service provision

Preker et al, 2007 reports that in an effort to minimize costs, some schemes have adopted managed care initiative like chronic care medicine management, hospital pre- authorization and case management but are yet to work with network of contracted providers. They continued to state that, to remain [effective], the PHI schemes should avoid service for fee reimbursement but continue with risk-sharing arrangements with net providers. In some countries, antiretroviral therapies have become a prescribed minimum benefit and its costs have fallen greatly, therefore, access to HIV/AIDS services should not be limited by service providers. The service delivery systems are performing poorly in most developing countries due to shortage of skilled medical staffs, lack of critical resources for hospital services leading to low productivity. In order to provide incentives for improved quality and productivity, managed care provider payment mechanism should be introduced, where a fee for service payment or capitation- based payment systems that reward performance. In other countries per diem and discounted fees are used for procedures and specialists' care. These payment systems however, should have checks and balances to avoid abuse and control inflation (Preker et al 2007).

2.2 Willingness to pay for private health insurance

Asgary et al. 2004 examined willingness-to-pay for health insurance in rural Iran finding that households are willing to pay on average US$2.77 per month for health insurance. While levels are not necessarily comparable across countries and differing products, this evidence demonstrates that individuals in a variety of low-income countries would be willing to pay for low-cost health insurance schemes.

The findings of a study by Asfaw et al., (2008) in Namibia demonstrates that 87% of the uninsured respondents are willing to join the proposed health insurance scheme and more than half of them are willing to pay. Those respondents who are not willing to pay the more expensive premium were willing to pay a lower premium per month. This implies that most people will be willing to pay if the premium are categorised in such a way that people of different income levels can choose to pay the premium that suits them. The study further examined the factors that affect the willingness of respondents to join the proposed insurance product established that more educated and young respondents show more interest in joining the scheme. However, they also noted that contrary to common believe, income and health status indicator variables do not affect the decision of respondents to join the scheme. This means that if both the poor and the rich are more likely to join PHI plans, then there would be no serious adverse selection problem. However, in another study done in Ghana by Osei-Akoto and Adamba (2011), they noticed that in Private Health Insurance, the low demand and low willingness to pay pose a problem. They explained that the low participation or penetration of Private Health Insurance focused largely on the financial reasons in particular; poverty and low incomes have been advanced as valid explanation of much of the variation in insurance coverage. This study indicated that poor health outcomes in families/ households can act as a motivating factor that can influence families to buy Private Health Insurance policies in order to reduce the risk of catastrophic out of pocket spending on health care. The opposite is possible; De Meza and Webb, (2001) as cited by Bolhaar et al 2007, pointed that the healthy may insure more in some instances. This is called advantageous selection where more risk averse individuals are more inclined to buy insurance and they are also more prone to undertake precautionary efforts. This combination yields a

positive correlation between health and insurance status; therefore, risk aversion is one factor that can increase uptake of PHI.

CHAPTER THREE

METHODOLOGY

3.0 Study design

A cross sectional non-interventionist exploratory study design was used. The study involved both qualitative and quantitative data collection methods. The design was to establish the willingness of out- patients in Mukwaya General Hospital to join private health insurance. Key informant interviews from the health insurance companies, Insurance Regulatory Authority of Uganda and Health Maintenance organisations were also carried out.

3.1 Study population

The target population was all patients 18years and above, who sought healthcare services from Mukwaya General Hospital and key informants from AAR-Health, IAA Resolution, Jubilee Insurance, Kadic Health and Insurance Regulatory Authority of Uganda.

3.1.0 Eligibility criteria

3.1.1 Inclusion criteria

All patients who sought healthcare services from Mukwaya General Hospital and were above 18years of age as well as all patients who consented to participate in the research.

3.1.2. Exclusion criteria

Those who came for a review or for the second or more times during the research period and children below 18years

3.2 Sample size determination

The sample size was estimated using the Kish and Leslie formula, (Kish 1965:75). The uptake rate of private health insurance at Mukwaya General Hospital is eleven percent (11%). This is the estimated rate that was used in the formula below because the National rate of private health insurance coverage is very small at less than one percent (1%).

$$\mathbf{n} = \frac{\mathbf{Z}^2 \boldsymbol{p}\,\boldsymbol{q}}{\mathbf{d}^2}$$

Where**;**

n is the sample size

$\mathbf{Z}^2$ is the abscissa of the normal curve that cuts off an area α at the tails (1 - α equals the desired confidence level at 95% in this case we are going to use 1.96). The value for **Z** is found in statistical tables which contain the area under the normal curve.

p is the estimated proportion of patients at Mukwaya General Hospital who are enrolled in private health insurance which stands at eleven percent (11%).

q is 1-p; the difference of **p** from 100% which will be 1**00-p = 100-11 = 89% or 0.89**

d is the desired level of precision. The maximum error that will be allowed between the estimate and the true value in the population for this study is d = 5% or (d = 0.05).

Substituting in the formula below

$$n = \frac{Z^2 p\,q}{d^2}$

$$n = \frac{1.96 \times 1.96 \times 0.11 \times 0.89}{0.05 \times 0.05} = 150.4372$$ which can be rounded off to 150.

Therefore, the total sample size (n) was = 150 respondents in total.

3.3 Sampling technique/ procedure

This study employed a probability sampling technique to select respondents using systematic random sampling method. The respondents were selected according to their order of arrival at the reception where every second patient was selected (skip one patient and interview the next) but following the inclusion and exclusion criteria as stated in the previous pages of this dissertation. An informed consent document was first read to the respondents to request his/her permission to participate in the study and then the questionnaire was filled by the researcher/research assistants after the respondent had agreed. The respondents were allowed to withdraw consent during the interview if they chose to. The researcher and the research assistants enrolled every second respondent as they arrived at the reception until the required sample size was obtained. For clients who declined to participate, the researcher and assistants waited for the next client and followed the same steps for every participant.

3.4 Data collection and management

The data collection tool was interviewer- administered questionnaires. All respondents understood English; therefore, there was no need for the questionnaire to be translated in the local language. At the end of each day during the data collection period, the answered or filled questionnaires were looked at to see whether some questions were unanswered or if all questions were answered correctly. Those which were answered correctly were coded and subsequently entered into the data analysis system.

3.5 Plan for data analysis

Data was entered in the computer system at the end of each day of the data collection in the SPSS data editor and at the end of the data collection period the analysis was done by the use of SPSS 15 windows evaluation version using mainly univariate and bivariate methods. Chi square test of association was used in order to get the true interpretation of the results of the study because the majority of the variables were categorical.

3.6 Quality control

The questionnaires were pre tested before the actual study began among the residents in the neighbouring areas with similar demographic characteristics and any required changes to the tool was made to improve the precision of the data collection tool. The research assistants were picked from among the staffs of Mukwaya General Hospital and trained in the techniques of data collection. They were also given basic understanding of what the research was all about so that they could be able to answer simple questions that the respondents might ask before they consent to participate in the study.

3.7 Plan for dissemination of the results

The results is disseminated by giving copies to IHPM faculty at International Health Sciences University, Administration of Mukwaya General Hospital, the Supervisor, organisations where key informants were interviewed, friends of the researcher and head of planning, MOH.

3.8 Ethical consideration

Letters of approval was got from the Institute of Health Policy and Management (IHPM) faculty office which was then used to get permission from the management of Mukwaya General Hospital. Participation in this study was completely voluntary. An informed consent form was read to the respondents who were interviewed and/or was given to those who could read to do so by themselves. Those who voluntarily accepted to participate in the study were interviewed by the researcher and/or research assistants. Participants were free to withdraw from the study at any time they wished to.

3.9 Limitation of the study

This study was not able to identify the health system factors such as medicine availability, presence of human resources for health, distance from health facilities and presence of health infrastructures that could be an influence to patients' willingness to join PHI. Also in this study, the study population were patients attending OPD at Mukwaya General Hospital and not population based. Patients were in need of healthcare and these might not be a true reflection of the entire community.

CHAPTER FOUR

RESULTS

Introduction

This chapter includes data presentation, analysis and interpretation which have been arranged according to the order of the specific study objectives. There were 150 respondents who consented to participate in the study and interviewer administered questionnaires was the tool used to gather information from the respondents and key informants. The presentation, analysis and interpretation were done at both the univariate and bivariate level. At the univariate level, frequencies and percentages were got and results presented in tables, bar and pie charts. At the bivariate level, tests of association were between the dependent (willingness to join PHI) and individual categorical explanatory variable using the Chi-square test of association at 95% confidence interval.

4.0 The demographic characteristics of respondents

All the 150 respondents were interviewed. Of these, 91(60.7%) were women and 59(39.3%) were men, (table 1). The median age of the respondents was 28 years. Those whose age were below the median age were 68 (45.3%) and those whose age were equal or more than the median age were 82 (54.7). Most of the respondents were educated up to tertiary (post secondary) level of education 100 (66.7%), were Catholics 79 (52.7%) and formally employed 95 (63.3%) with

half of them being single 75 (50%). Within the respondents' household, a higher proportion 67/150 (44.7%) had 5 -7 total number of people living in their household and 44/150 (29.3%) had seven and more number of children in the household. Of those interviewed, 29/150 (19.3%) had no children living in their household while the rest had less than 3 children 41/150 (27.3) and 3 - 6 children 36/150 (24%) respectively.

Table 1: Demographic characteristics of respondents (n = 150)

Characteristic	Frequency	Percentage (%)
1. **Sex of respondents**		
Male	59	39.3
Female	91	60.7
2. **Age (Median age = 28)**		
< Median age	68	45.3
≥ Median age	82	54.7
3. **Age groups**		
Below 25	52	34.7
25 – 35	65	43.3
36 – 45	19	12.7
Above 45	14	09.3
4. **Marital status**		
Single	75	50.0
Married/cohabiting	68	45.3
Divorced	06	04.0
Widowed	01	00.7
5. **Educational level**		
Primary	29	19.3
Secondary	21	14.0
Post secondary	100	66.7
6. **Religion**		
Catholic	79	52.7
Protestant	33	22.0
Muslim	07	04.7
Born again	31	20.6
7. **Occupational status**		
Unemployed	13	08.0
Formally employed	95	63.3
Self employed	24	16.0
Student	18	12.0
8. **No. of people in household**		
1-4	30	20.7
5-7	67	44.7
More than 7	52	34.6

9. **No. of children in a household**		
None	29	19.3
Less than 3	41	27.3
3 – 6	36	24.0
7 and above	44	29.3

4.1 The knowledge of respondents on Private Health Insurance is presented in table 2.

About half of the respondents 77/150 (51.3%) said they did not know PHI and only 73/150 (48.7%) said they had some idea on PHI. When the respondents were asked whether they had seen or heard messages on PHI, 78/150 (52%) had seen or heard messages on PHI. The respondents were further asked if they were aware of the hospitals/clinics which offers PHI services, majority 92/150 (61.3%) did not know and only 58/150 (38.7%) knew. This proportion is less than the proportion of those who had earlier said they knew PHI. This means there were respondents who knew about PHI but did not know where to find the services. To further probe the respondents' knowledge and understanding on PHI, they were asked whether they knew what kind of people were eligible to subscribe/enroll/join PHI, more than half 86 (57.3%) of them did not know who is eligible to join PHI.

Table 2: Knowledge of respondents on private health insurance

Variable	Frequency (150)	Percentage (%)
1. **Knowledge**		
Know about PHI	73	48.7
Do not know PHI	77	51.3
2. **Heard/seen messages on PHI**		
Heard/seen messages	78	52.0
Did not hear/see messages	72	48.0
3. **Aware of Hosp/clinics with PHI services**		
Aware	58	38.7

	Not aware	92	61.3
4.	**Knowledge of who is eligible to access PHI**		
	Know who is eligible for PHI services	64	42.7
	Don't know who's eligible for PHI services	86	57.3

4.1.1 The respondents' source of knowledge on PHI is presented in figure 2.

There were several sources of information from which the respondents learnt about PHI. Most of the respondents had more than one source of information. The commonest source of information was employers 56/108 (51.9%). Other sources of information were; mass media 21.3% 23/108 (which included, television, newspapers, billboards, radio and brochures), insurance brokers 13.9% (15/108), friends/relatives 10.2% (11/108) and the internet 2.8% (3/108

Figure 2: Respondents' sources of knowledge on private health insurance.

4.1.2 The factors associated with knowledge of PHI are presented in table 3.

Knowledge of private health insurance was more likely to be present among respondents who were men (X^2 =7.679; p = 0.003), had formal employment (X^2 = 9.903; p = 0.031), and were Catholics (X^2 = 10.897; p = 0.040). There were no association between knowledge of private health insurance and marital status, education level, age groups and annual income level of the respondents.

Table 3: Factors associated with knowledge of private health insurance (n = 150)

Variables	Know PHI		Don't know PHI		Degree of freedom (df)	X^2 / Fisher's exact	P-value
	Frequency	Percentage	Frequency	Percentage			
1. **Sex**							
Male	37	50.7	22	28.6	1	7.679	0.003*
Female	36	49.3	55	71.4			
2. **Age groups**							
Below 25	26	35.6	26	33.8	3	1.511	0.070
26 -35	32	43.8	33	42.9			
36 – 45	07	09.6	12	15.6			
Above 45	08	11.0	06	07.8			
3. **Marital status**							
Single	33	45.2	42	54.5	3	3.493	0.097
Married/cohabiting	38	52.1	30	39.0			
Divorced/separated	02	02.7	04	05.2			
Widowed	00	00.0	01	01.3			
4. **Educational level**							
Primary	15	20.5	14	18.2	2	0.136	0.077
Secondary	10	13.7	11	14.3			
Post secondary	48	65.5	52	67.5			
5. **Religion**							
Catholic	31	42.5	48	62.3	3	10.897	0.040*
Protestant	24	32.9	09	11.7			
Muslim	04	05.5	03	03.9			
Born again	14	19.2	17	22.1			
6. **Occupational status**							
Unemployed	10	13.7	03	03.9	3	9.903	0.031*
Formally employed	47	64.4	48	62.3			
Self employed	06	08.2	18	23.4			
Student	10	13.7	08	10.4			
7. **Annual income**							
Less than 5million	27	37.0	24	31.2	3	2.088	0.086
5 – 15million	35	47.9	45	58.4			
16 – 20 million	08	11.0	05	06.5			
More than 20 million	03	04.0	03	03.9			

**Statistically significant*

4.2 The level of coverage by private health insurance

Of the 150 respondents, majority 117/150 (78%) were uninsured with only 33/150 (22%) enrolled for PHI. Most of the insured respondents 23/33 (69.7%) were primary policy holders and their premium were being paid by their employer 25/33 (75.8%). About half of insured respondents 18/33 (54.5%) were the principal and only insured persons among members of their households. Premium payment among the insured were either monthly 9/33 (27.3%) or annually 16/33 (48.5%), **(Table 4).**

Table 4: Extent of coverage of private health insurance among respondents

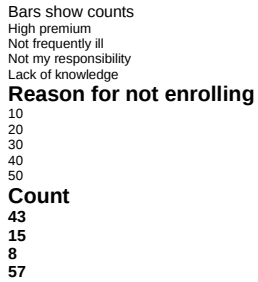
Questions	Detail	Frequency (150)	Percentage (%)
Are you currently enrolled/subscribed to PHI?	Yes No	33 117	22.0 78.0
How many people are covered by PHI in your household?	Only the insured person Insured + spouse Upto 4 other persons	18 11 04	54.5 33.3 12.3
The insurance status of the respondents	Primary Dependent	23 10	69.7 30.3
What type of policy are you holding?	Corporate Gold Gold Silver Basic	02 05 12 14	06.1 15.2 36.4 42.4
Who pays your premium?	Self/spouse OOP Employer Deducted from salary 50%employer/50%employee	05 25 02 02	15.2 75.8 06.0 03.0
How often is the premium paid?	Monthly Annually	09 16	27.3 48.5

	I don’t know	08	24.2

4.2.1 Reasons for not enrolling for private health insurance

Seventy eight percent (117/150) of respondents were not enrolled for private health insurance and several responses were given as reason for not enrolling. The most frequent response among respondents was lack of knowledge 57/123 (46.3%) on private health insurance, high premium 43/123 (35%) was the second highest reason and others as seen in figure 4 below.

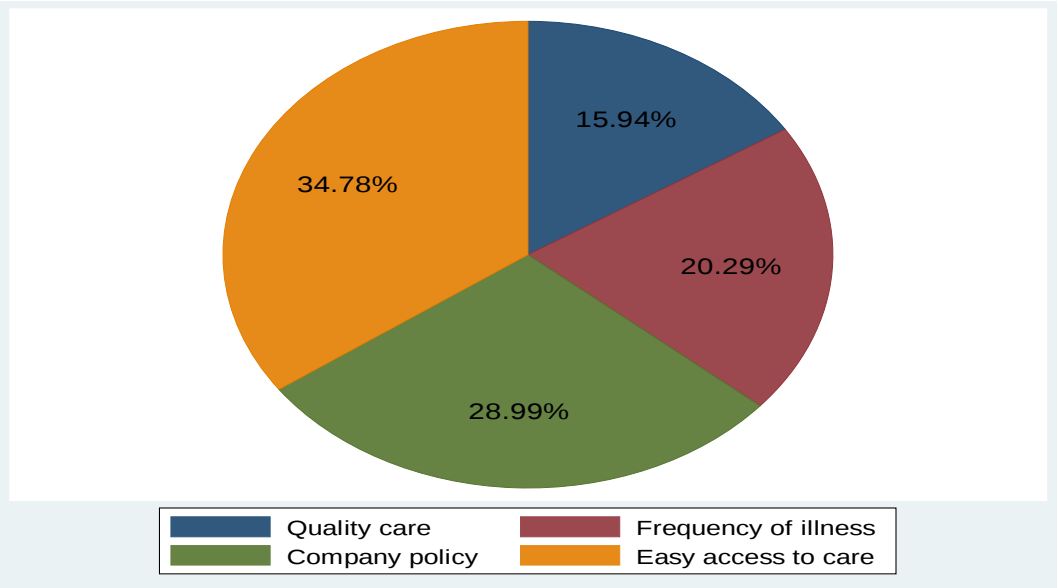
Figure 3: Reasons for not enrolling for private health insurance



4.2.2 The respondents gave one or more reasons for enrolling for PHI.

Several responses were given as reasons for enrollment for PHI with some respondents having more than one reason. Most people enrolled for PHI because of; easy access to healthcare services 24/69 (34.8%), company policies 20/69 (30%), frequent episodes of illness in their household 14/69 (20.3%) and the opportunity to access quality health care services 11/69 (15.9%).

Figure 4: Reasons for enrolling for private



4.2.3 Premium payment

Of the 33 respondents who were currently enrolled for PHI, 15/33 (45.3%) of them did not know the amount of money paid as annual health insurance premiums to cover them and/or their dependants. Basing on the fact that most of the enrolled members 23/33 (69.7%) were formally employed and the employers pay the whole insurance premium for them, it is not surprising that a significant number of the insured did not know how much the premiums were. Looking at the responses of the 10 respondents who knew the amount of premiums paid for them or by them, the yearly premiums ranged from Ugshs 200,000 (i.e. US$76.9) to Ugshs 6,000,000 (i.e. US$2307.7

4.2.4 Benefit package and excluded services for the insured respondents

Benefit packages for the insured varied and many of the respondents had more than one set of package. The one which was common among all the respondents was general outpatient services (OPD) which accounted for 48.5% of the responses, 42.4% of the responses had both inpatient

and outpatient packages while only 8.8% of the responses were in-house doctor or clinic where the insured get services from the insurers' own doctors/clinics. When asked services are excluded from their benefit packages 40.7% of the responses which is 66.7% of the respondents didn't know what services were excluded. The rest of the respondents had more than one excluded services from the benefit packages as seen in the table below.

A HMO key informant interviewed on issue of benefit said;

'Our benefit package depends on the option an individual or a group have selected. However, most of our benefit packages come with maternity cover, HIV/AIDS & pre-existing conditions, congenital condition for new born (from the mother's cover), annual check-ups, emergency evacuation or ambulance services in all our covers"(Health insurer, September 2013).

Table 5: Benefit package and excluded services for the insured

Questions	**Item detail**	**Frequency**	**Percentages (% age)**
How do you get the service benefit and who pays the service provider?	- In house Clinic/ doctor	06	08.8
	- OPD/insurer pays provider	33	48.5
	- OPD/IPD/ insurer pays provider	29	42.6
What are the excluded services?	- I don't know	22	40.7
	- Dental/Eye care	10	18.5
	- General medical exams	05	09.3
	- Cosmetic surgery	08	14.8
	- Supplements/multivitamins	09	16.7

4.2.5 Service providers

Several responses were given by the insured respondents when asked where they get their health care services from. A higher proportion 42.4% of the responses were private clinics/hospitals and the least proportion 6.8% of the responses were private wings of government hospitals. Others responses are summarized in figure below.

However, one key informant from the HMOs and PHI companies interviewed said;

"*We have varieties of service providers throughout the country through networks created with hospitals and clinics where our subscribers can access healthcare services at all time they need them"* (Health insurer, August 2013).

Three of these companies have their network throughout the region. Access to services outside Uganda depends on the bouquet individuals or groups have chosen. Another key informant from one these companies with links throughout the region said;

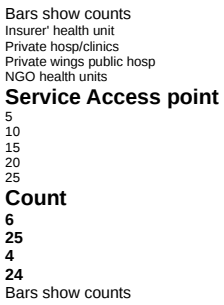
"The company has Uganda only bouquet, Uganda, Kenya and Tanzania bouquet, Uganda and South Sudan bouquet and quality budget providers bouquet for each country"(Health insurance manager, August 2013).

There are several service providers within Makindye division who provides services on behalf of various health insurance companies. One such service providers said;

"We have an arrangement with the insurance companies. They provide us with a list of the insured persons covered by their insurance policies and the kind of services/benefits they can receive from us. At the end of every treatment process, each insured person signs a form with all the treatments and investigations done. The form will then be attached to the invoice we send to

the insurance company for payment at the end of every month" (Service provider September, 2013).

Figure 5: Service providers for the insured respondents



4.3 Willingness of respondents to join PHI schemes

Respondents were given a brief information on what private health insurance is and were then asked if they were willing to join the scheme in organisations/hospitals where it exist and these were the findings. Willingness to join private health insurance was more likely to be among younger respondents of age groups below 25 years (53.1%) 52/98 ($X^2 = 46.23$, $p = 0.000$). Catholics (49%) 48/98 ($X^2 = 1.511$, $p = 0.044$) and those with annual income between 5 to 15 million Ugshs (53.1%) 52/98 ($X^2 = 7.824$, $p = 0.016$) were having higher likelihood of willingness to join PHI. On the other hand, there was no significant association between willingness to join PHI and occupational status ($X^2 = 2.158$, $p = 0.111$), educational level ($X^2 = 1.723$, $p = 0.080$) marital status ($X^2 = 0.754$, $p = 0.137$) and sex ($X^2 = 0.006$, $p = 0.204$) of the respondents.

Table 6: Factors associated with willingness to join and pay for private health insurance

Variables	Willing to join PHI	Unwilling to join PHI	Degree of	X^2 /	P.value

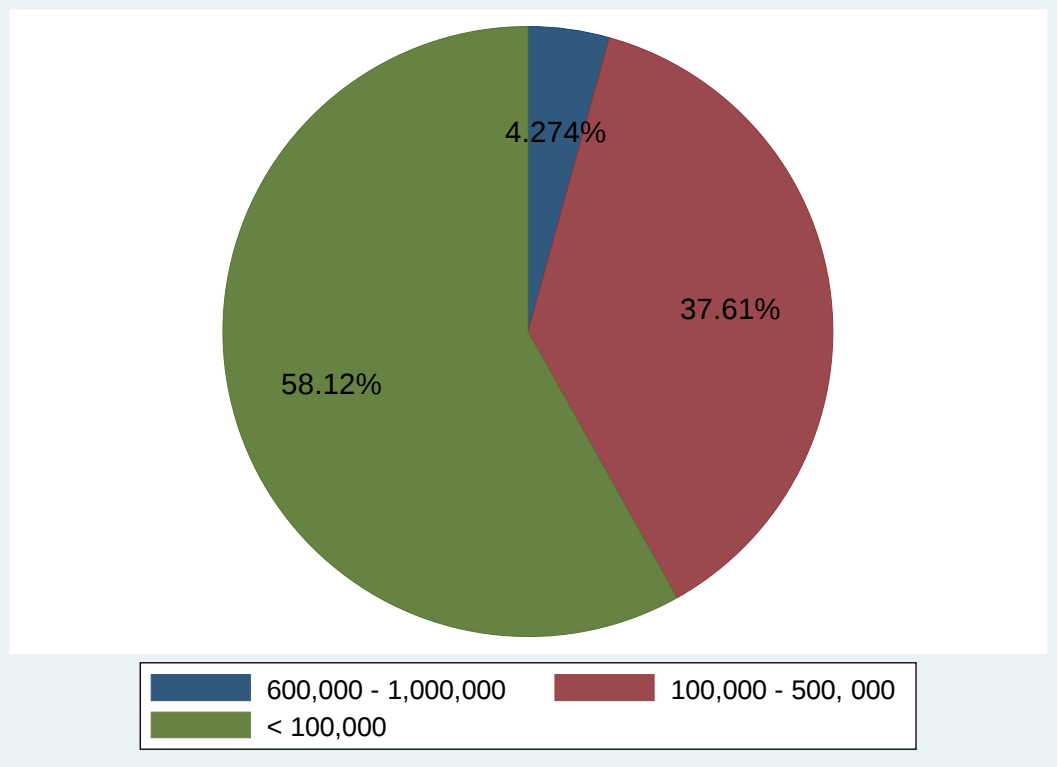
					freedom (df)	Fisher's exact	
	Frequency	**Percentage**	**Frequency**	**Percentage**			
1. **Sex**					1	0.006	0.204
Male	37	37.8	07	36.8			
Female	61	62.2	12	63.2			
2. **Age groups**							
Below 25	52	53.1	00	00.0	3	46.23	**0.000***
26 -35	42	42.9	07	36.8			
36 – 45	00	00.0	07	36.8			
Above 45	04	04.1	05	26.3			
3. **Marital status**							
Single	57	58.2	04	47.4			
Married/cohabiting	41	41.8	10	52.6	1	0.754	0.137
Divorced/separated	00	00.0	00	00.0			
Widowed	00	00.0	00	00.0			
4. **Educational level**							
Primary	15	15.2	02	10.5	2	1.723	0.080
Secondary	16	16.3	01	05.3			
Post secondary	67	68.4	16	84.2			
5. **Religion**							
Catholic	48	49.0	12	63.2			
Protestant	21	21.4	04	21.1	3	1.511	**0.044***
Muslim	06	06.1	00	00.0			
Born again	23	23.5	03	15.8			
6. **Occupational status**							
Unemployed	09	09.2	01	05.3	3	2.159	0.111
Formally employed	60	61.2	11	57.9			
Self employed	13	13.3	05	26.3			
Student	16	16.3	02	10.5			
7. **Annual income**							
Less than 5million	36	36.7	05	26.3	3	7.824	**0.016***
5 – 15million	52	53.1	09	47.4			
16 – 20 million	10	10.2	03	15.8			
More than 20 million	00	00.0	02	10.5			

**Statistically significant*

4.3.1 **Premium amount respondents are willing to pay**

Respondents were asked to select from the listed options how much money they were willing to pay per person in their homes to joins to join PHI scheme. A higher proportion 68/117 (58.1%) were willing to pay only 100,000 Ugshs per person per year as premium for each individual in their household and only 5/117 (4.3%) willing to pay 600,000 – 1,000,000 Ugshs per person in a year for them to join PHI. Figure 6 shows the summary of the amount of money respondents were willing to pay in order to join PHI.

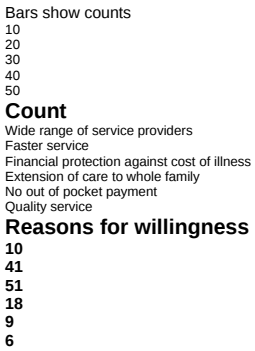
Figure 6: Amount of money respondents were willing to pay to join PHI scheme



4.3.2 Reasons for willingness to join PHI

Financial protection against costs of illness was the most common reason given making 51% of the responses by respondents for their willingness to join PHI. This was followed by faster access to services 41% of the responses and extension to health care services to whole family 18%. The responses given by respondents for their willingness to join PHI schemes are presented in figure 6.

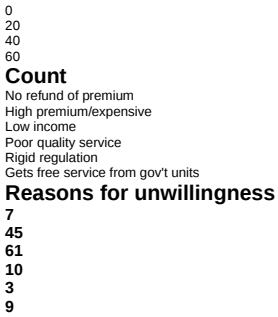
Figure 7: Reasons for willingness to join PHI



4.3.3 Reasons for unwillingness to join PHI

The respondents gave several reasons for their unwillingness to join PHI with a higher proportion of the responses being low income 61/135 (45.2%). Other reasons for unwillingness were high premium rate 45/135 (33.3%) and rigid regulation 3/135 (2.2%). However, during the interview with further prompting from the interviewer, some respondents mentioned that there is no refund for unused premium in situations where none of the insured felt sick or sought health care services within the covered period meaning they wasted money on the premium.

Figure 8: Reasons for unwillingness to join PHI



4.3.4 Preferred service providers

When asked where they would prefer to get health services after they have joined the scheme, most of the respondents 68/117 (58.1%) expressed preference for private hospitals and clinics and the least proportion 5/117 (4.3%) referred private wings in government hospital (table 6). Some of the reason the respondents gave for their preference were: better quality services, faster services without delay since there are usually fewer people waiting on the line, better equipments especially in private hospitals and PNFP hospitals, easy access to specialists and kind/caring health workers which they say are lacking in government facilities.

Table 7: Respondents' preferred service providers under the PH policy plans

Facilities	Frequency	Percentage (%)
Gov't hosp. (Private wings)	05	04.3
NGO/PNFP hospitals	44	37.6
Private hosp/clinics	68	58.1

CHAPTER FIVE

DISCUSSION

Introduction

This study was done on outpatients in Mukwaya General Hospital to assess their willingness to join private health insurance scheme. Pearson's Chi square (X^2) test of association was performed to find relationship between sets of categorical variables. This is because the variables are categorical and chi square test is the best test of independence between two categorical variables. In this study, the level of significance used was the conventional value of $p = 0.05$.

5.0 Level of patients' knowledge on private health insurance

This study shows that the level of knowledge on private health insurance among outpatients in Mukwaya General Hospital (MGH) is low with more than half of the respondents having no idea. There was a statistically significant difference in the level of knowledge between men and women, with women less knowledgeable (71.4%) ($p = 0.003$*). Looking at religion as a determinant of knowledge on PHI, a significant association was noted with Catholics less knowledgeable 62.3% ($p = 0.040$*). This could be explained by the fact that more than half of the Catholics are women and women constitute 71.4% of the less knowledgeable respondents. This finding on religion is also consistent with results found by Reshmi et al (2007), which noted religion as a significant determinant of health insurance awareness. Furthermore, those in formal employment were significantly (64.4%; $p = 0.031$) more knowledgeable than the rest within the listed occupational status. The low level of knowledge could be because there has never been clear information disseminated to educate the public on PHI both by the PHI companies, HMOs and MOH. The few available insurance brokers only move in offices of formal employers. For this reason Reshmi et al (2007), in their study on awareness on health insurance in a South Indian population found that it is important for those concerned especially [PHI companies and HMOs] to work harder to ensure the target population access more information on PHI. This is also

consistent with what was stated by Donfouet et al (2011) in their study on economic value of the willingness to pay for community based prepayment scheme in rural Cameroon that awareness campaigns should be increased to inform the community better on community health care prepayment scheme. This study further shows that the workplace had been one place used for selling and/or disseminating information on private health insurance. Looking further at the results, there is need to find ways to let the whole population in Kampala and beyond know about how PHI works. More especially to the population in the informal sector so that they get access to health insurance information in order to improve their level of knowledge and awareness on health insurance in general. This study also found that more than half of the respondents lacked basic knowledge in many aspects of PHI schemes like: How frequent the premium is paid, the benefit packages, the excluded services, and where to find PHI services yet all these are essential information for all subscribers and potential subscribers. This concurred with a study done in rural Gujarat which found that respondents` knowledge on health insurance is still low and was yet to reach its optimum level (Mohd and Suthar, 2011).

On trying to find out how many respondents has heard/seen information on PHI, a substantial proportion of respondents 52% have heard or seen messages on PHI but do not have much information about it with many having several unfounded myths and inaccurate facts about PHI. For example, over 60% of the respondents were not aware of which hospitals, clinics and companies provide health insurance services and more than half of these did not know who is eligible or not to subscribe for private health insurance. This suggests that improving access to information on health insurance would benefit this groups greatly and the insurers would benefit too as it will widen their clientele base. With improved access to knowledge on PHI, more people

would buy insurance policies leading to reduced catastrophic out-of-pocket expenditure on health care.

On sources of information, the study found that more than half of the respondents have heard or seen messages on private health insurance and many of them had more than one source of knowledge. The most common source of knowledge which made over fifty percent of their responses was employers. This could suggest that employers have understood the importance of health insurance and are taking it upon themselves to inform their employees on the same. The other responses on sources of knowledge which also showed some important sources were; mass media (23%) that is (television, newspapers, radios, billboards and brochures), insurance brokers (15%), friends/ relatives (11%) and the internet (3%). This contrast a bit with findings of Priyadarsini and Ethirajan (2008) which noticed that television alone played a major role in dissemination of information to both rural and urban respondents in their study on knowledge, attitude and practices on health insurance among selected urban and rural population of Chidambaram, Tamil Nadu. However, in Uganda television may not be the best option for dissemination of PHI information as its coverage is generally low in both rural (4.9%) and urban (45%) settings. The most appropriate means to disseminate information could be the radios which have fair coverage both in rural (64%) and urban (71.8%) areas. (UDHS, 2011)

5.1. Level of coverage by private health insurance

There has been a slight general growth in the number of PHI and HMO companies in the country but this has not yet translated into increased level of subscription since coverage is still low. This study found that less than a quarter of the respondents were enrolled for PHI. The result is

consistent with findings of Orem and Zikusooka (2010) in their study on Health financing reform in Uganda: 'How equitable is the proposed National Health Insurance scheme?' found that private health insurance coverage is low at only 0.2% of the population and is largely subsidized by employers on behalf of employees. A similar finding was noted by Kaur-Bawa & Ruchita (2011) who found that only 19.4% of a study group in Punjab India was being covered by some form of health insurance with a large proportion of the population still without health insurance. This finding in a way could indicate low level of risk aversion, affordability and accessibility of PHI. It should also be noted that low level of coverage could lead to difficulty in sustainability of PHI scheme incase expensive risks occur as seen by Preker & Carrin, (2004). However, the good news is that most of the PHI companies in Uganda are re-insured to protect them from this type of loses. For example one KI from a PHI company said,

Our company has a sound financial basis to take care of any occurrences like expensive risks. Our company protects customers by spreading the risk across a wide base, managing members' healthcare budget through structures that control delivery costs and having suitable reinsurance to minimize our exposure to unmitigated risks. We are reinsured by one re-insurance company and underwritten by three well known underwriters in East Africa", (KI from a health insurance company, August 2013).

This study also provided some future hope for the PHI companies. Internal two year records from two different health insurance companies showed a 5% and a 1.3% increase in the number of policy holders despite the low coverage. This increase was attributed to individuals becoming more aware of the risk associated with out-of-pocket payments. The insured respondents also gave several reasons for enrolment for PHI (figure 3). These are: easy access to care, company

policy, frequency of illness and quality care. As seen in the result, one hundred percent of the insured were in formal employment and more than half of them mention company policy as one of the reasons why they enrolled for PHI. This could indicate that employers have already seen the importance of health insurance coverage on the productivity of their employees and the profitability of their companies. This benefits could be inform of less absenteeism from work since most insured persons tend to seek care earlier before the disease progresses into serious condition. Ng et al (2011) found that employers and employees in China are beginning to attach health insurance benefit packages as an important component of job offers and that employers improved health insurance benefit packages in order to attract and retain the most talented employees in the country. On the other hand, Ocen et al (2010) in their study on an analysis of the competitiveness of local construction contractors in Uganda noted that most companies in Uganda lack [health insurance], simple health and safety kits and that workers treat themselves when they fall sick or get injuries at work. The study continued to state that these issues surrounding health and safety of workers have led to high turnover of staffs to other companies that would provide health insurance and/or some kind of medical benefits to its workers. This , the study concluded, could lead to low competitiveness and in some cases collapse of the company as they could not retail their skill manpower.

Looking further at the study results, less than a quarter of the insured respondents were from the informal sector. They gave several reasons for not subscribing for PHI and some of which were: high premium, not frequently ill, not my responsibility and lack of knowledge. It can clearly be seen that the work have been cut out for the PHI companies and HMOs to find ways to tap in the market in the informal sector by using the findings of this research if they want to widen the

clientele base. These could be a multi-sectoral approach which should include the ministries of finance and health as well as the politicians who are involved in setting the policy agenda. On a positive note though, the study noted a general increase in the trend of enrolment. This however small, provides the much needed hope for private health insurance companies to put in more effort to improve coverage. Further encouragement was provided by Ng et al (2011) who pointed out that the ground is ripe for PHI insurers to step up and fill the gap created by absence of social health insurance.

5.1.1 Premium payment and rates

This study found that premium ceiling is set by IRAU for all insurance Companies including health insurance under its regulation. However, individual PHI companies have their own ways of rating their premium. A KI at the IRAU could not clarify on the issue of hospitals who receive money from clients and acts as HMOs. This requires serious attention as these can bring serious legal implication since large sum of money is involved here. During the study it was noted that most of PHI companies do some form of risk rating (actuarial or experience) and adjusted community rating but none of the companies visited did income rating. However, at the end of the day, the premium paid should be within the ceiling set by the IRAU. Blumberg and Nichols (2001), in their study on ‘why are so many Americans uninsured’, noted that premium prices are in most cases based on individual characteristics. Further, this study found that the premium was paid per person or group and depended on the benefit packages and presence of pre-existing conditions in some cases.

Furthermore, most of the insurers accept policy paid in lump sum, but some HMOs also accept premium payment in installment except that it should be paid in a given number of installments and within a specified period of time. It was also noted that this installment payments attract a certain amount of interest which is calculated at a certain percentage depending on the policy chosen. The HMOs with only in-house service access point however provided services depending on the amount deposited and any extra services provided will be either post paid or paid out-of-pocket depending on the agreement between the two parties. The findings also noted that more than half of the insured respondents did not know the amount of premium paid to the insurer because it was paid by their employers as part of the employment benefit. There was no report of co-payment among the respondents and none of the key informant mentioned it. The commonest amount of known premium paid ranges between Ugshs 200,000 – 6,000,000 (about $76.9 – $2307.7) for both individual and group policies. Most of the premiums are paid annually with some few monthly payments especially for those HMOs who have only in-house clinics/hospitals.

5.1.2 Benefit packages and excluded services for the insured respondents

All the interviewed KIs and respondents said that the benefit packages included both outpatient services with the exceptions of some specific services like eye and dental care. Inpatient services depended on the policy one is holding and how long one has been a policy holder. For example, the study found that one PHI Company and HMO policy holders were unable to access maternity, HIV/AIDS and non communicable diseases like hypertension and diabetes treatment in the first year of buying the insurance policy. Preker et al (2007) in his work stated that the more comprehensive the benefit package, the more health insurers are predicted to invest in risk

selection. Another HMO on the other hand had maternity cover, HIV/AIDS and treatment of congenital diseases in children born to mothers who are their insurance policy holders as soon as the insurance policy becomes effective. This agrees with Gottret & Schieber, (2006) in their study on health financing revisited which stated that it is important to develop an explicit benefit package regardless of the insurance model.

5.1.3 Services provision

MGH acts mostly as a service provider for other bigger HMOs and PHI companies who cover more expensive risk. For its own clients, the arrangement is that the hospital makes claims for services provided at the end of each month. There is also an internal arrangement MGH has with its private clients through Nsambya Health Network where any amount of money is prepaid to the hospital account. These clients and their list of beneficiaries can then access services at the hospital without making an out-of-pocket payment whenever they need the services. When the paid money is used up, they just deposit more. In some cases services are provided before payment and invoices sent at the end of the month after which payment is made. This particular option also applies to the PHI companies and HMOs which have contracted MGH to provide services for its policy holders. Those insurers who have contracted MGH as a service provider have cards with the status of policy for each client. The client presents this card before being treated. There are some excluded services (table 5) which are not to be provided by MGH especially for the clients of Kadic Health insurance. Those who really needed to access these excluded services have to go to Kadic Hospital in order to access them. Another interesting finding noted was that more half of the insured respondents did not know the excluded services. This could suggest that the insurers are either not giving enough explanation on their policies or

they are giving it to the employers who in turn are not passing the information to their employees. According to Gottret & Schieber (2006), private hospitals are expensive because of their for-profit nature and health care providers are paid on the basis of a fee-for-services leading to provision of unnecessary services or price inflation. However, KIs from 3 HMOs stated that they are frequently in touch with their service providers and always harmonise prices. Any change from the agreed prices by the providers is communicated immediately to the insurer before services can be provided. This, they say has worked well and has helped them control costs as well as provider and consumer induced moral hazards. For example one of them said,

"We are in constant contact with our services providers. We update each other monthly and in situations of emergencies, the service providers call us before they provide any service which is outside the agreed packages. Besides we have standby ambulances and a helicopter, so these situations rarely happen", (KI from a HMO, September 2013).

5.3 Willingness to pay for and join private health insurance

More than three quarter of non private health insurance policy holders (83.8%) were willing to join and pay for PHI. Chi-square test was performed in order to find out the association between the variables associated with the individuals having impact on their ability and willingness to join and pay for private insurance. The tests showed that willingness to join and pay for private health insurance was positively associated with age groups (46.23; $p = 0.000^*$), where those in the age groups below 25 years were more likely to express willingness to join and pay for private health insurance than the rest of the age groups followed by those in the age groups of 26 – 35 years. This suggests that the younger generations were more willing to join and pay for private health insurance than the older generations contradicting Cantor et al (2001) in their study on

willingness to purchase health insurance among the uninsured in New Jersey, where they found that older respondents were willing to pay more than the younger respondents. This can further be explained by the fact that MGH being in an urban setting, the population is comprised mostly of young people; seventy eight (78%) of the respondents were 35 years and below. This could be partly explained by the presence of young workers who may be risk averse. This in turn could influence their decisions to secure their health through health insurance in order to avoid the uncertainty that comes with out-of-pocket health expenditure due lack of health insurance. Contrasting this as well is Banwat et al (2011) in their study on community based health insurance knowledge and willingness to pay, which found that willingness to pay for CBHI in rural North Central Zone of Nigeria increases as the age group gets older with the age group of 40 – 49 years having 100% willingness to pay for CBHI and then it declined steadily to the over 60 age groups. However another study by Aamir and Qureshi (2013) on awareness and willingness to buy PHI and a look into its future in Pakistan found no significant association between age and willingness to join and pay for private health insurance.

Another factor that showed statistically significant association with willingness to join and pay for private health insurance was religion ($X^2 = 1.511$; $p = 0.040$*). This study found that although there was generally a high (83.8%) level of willingness to join private health insurance, religion was significantly associated with willingness to join and pay for PHI.

It was realized that Catholics leads on both sides; that is, a higher proportion (63.2%) unwilling to join and pay for PHI while on the willing side they were the majority who were willing to join and pay for PHI with a 49%. This could be explained by the fact that most Catholics were less knowledgeable on PHI. It is therefore, not easy for someone to join or pay for something they

have little knowledge. On the other hand, the willingness to join PHI could stem from the fact that most of the Catholics were formally employed and most of the employed had higher level of knowledge than the rest of the group. Donfouet et al (2009) confirmed this notion in the study where they found that religion had a positive and statistically significant results which implied that Catholic household heads were more willing to pay for community based health insurance scheme than those in other religions in rural Cameroon. The negative association of religion and unwillingness to join and pay for PHI could be reasons given by respondents: low income, high premium and rigid regulation. Some of the respondents said they need time to learn more about PHI before they could decide while others out rightly said they won't be willing to pay money for something they might not use. Basing on the fact that if they fail to use any services within the year they held the policy, their money will not be refunded. This group will need more information on the importance of health insurance and how resources work (pooling) in order to change their attitude towards PHI. Without that, it is going to be very hard to convince them to join the scheme. However, the positive association could be because of: quality services, no out of pocket payment at point of service, faster services and others as pointed out by respondents as reasons for willingness to join PHI. On the other hand, Osei-Akoto and Adamba (2011), in a study in Ghana hypothesized that religiosity was then known to reduce people's perception of health risk and a strong reliance on God and prayers for preventive measures. They stated that if religious diversity is a good proxy for religiosity then a religiously diverse community should have low demand for health insurance.

Another variable that showed positive significant association with willingness to join PHI was annual income ($X^2 = 7.824$; $p = 0.016$*). Those with annual income between Ugshs 5-15 million were more likely to express willingness to join and pay for private health insurance. This

can be explained by the fact that in this study majority of the young population, who were also in this income group were more willing to join and pay for PHI. In relation to this, Dror et al (2006) in their study on why "one size fits it all" health insurance products are unsuitable for low-income in the informal economy in India, argued that households income affects willingness to join and to pay for PHI with more affluent households willing to pay a higher nominal amount for health insurance. A critical look at those with higher income suggests that this group is motivated by financial protection against the cost of illness, no out of pocket payment faster and quality services as some of the reasons for their high level of willingness to join and pay for PHI. This study suggests that respondents recognize the challenges of direct out-of-pocket payments and are looking for alternative ways to finance their healthcare.

The general high level of willingness to join and pay for PHI could presents an opportunity to find means to attract and retain them once they have subscribed. Willingness to pay arises from life experiences which they faced with OOP and would want to avoid in the future with the help of the alternative health financing mechanism like PHI. The respondents are also aware of their needs for health care and the kind of services they would wish to receive once they have joined PHI with many of them preferring to access services from private hospitals and NGO/PNFP hospitals. This suggests that the respondents want the best for themselves because they believe that private hospitals offer best services than the government health facilities.

CHAPTER SIX

CONCLUSIONS AND RECOMMENDATION

Introduction

This study has provided key factors on willingness to join PHI in MGH and pointed out that 83.8% of the respondents were willing to join PHI and only 16.2% were unwilling to join. The respondents were willing to pay on average less than Ugshs 100,000 per year which is very small compared to the current market premium prices. MOH, PHI companies and HMOs should find means to get additional funding which could be used to subsidize the premium for the clients to get quality services at affordable premiums.

6.0 Conclusions

Private health insurance schemes is increasingly being seen as a potentially powerful means for granting the urban well off and the poor access to health services in a way that is less stressful in terms of catastrophic expenditure that comes with OOP. Hence, the overall objective of the study was to assess patients' willingness to join private health insurance scheme in Mukwaya General Hospital, Makindye Division, Kampala City. **T**he level of knowledge on PHI among outpatients in MGH is still low which may be due to lack of information through campaigns or mass media. This means awareness campaigns should be increased to inform the community better on PHI. The level of coverage by PHI is still low among outpatients of MGH. Although there has been a slight general growth in the number of PHI and HMO companies in the country, it has not yet translated into increased level of subscription among the population since coverage is still low. Most respondents among the outpatients in MGH expressed willingness to join and pay less than 100,000 Ugshs ($38.5) for PHI per person annually if introduced in the hospitals where they access health care services from. The study also revealed age groups, religion, annual income and lack of knowledge of the basic concept of private health insurance as key determinants of

willingness to join and pay for PHI. Respondents preferred to access their health care from private hospitals if they joined and paid for PHI, this is against pooling effects of risks in health insurance as it affects the roles in health insurance.

This research finding could be useful to PHI companies, Government of Uganda especially MOH which is planning to set up NHIS and the IRAU. It could also be useful to health insurance practitioners in similar settings.

6.1 Recommendations

Insurance companies and HMOs need to increase the intensity of public awareness campaigns in order to better inform the population especially those in the informal sector about private health insurance. This may encourage them and increase uptake of the scheme and lead to reduced health care expenditure

Government could come out with favorable clear cut policies and roll out the National Health Insurance Scheme where the formally employed could be made to contribute compulsorily to a health insurance scheme to ensure no unnecessary out-of-pocket expenditures.

Explanation on benefits and exclusion services or treatments a health insurance plan will provide or not provide coverage for and a listing of all services that will be billed by a health care provider should be done in advance. This could involve explaining how service charges will be processed and patients' responsibilities for the claims if any should be clearly explained to the potential subscribers before they sign a policy contract with the health insurance company.

Awareness campaigns should be increased to inform the population better on PHI through mass media like radios, TVs and newspapers. These, especially radios can reach a wide range of the community since most of them have access to. This will improve the level of knowledge and awareness on health insurance among the population.

Allow varied forms of payments which are convenient to the potential subscriber as inflexible or rigid mode of payment discourages those who may be willing to subscribe but cannot manage to pay the premium at a particular time or at once in a lump sum. These types of people could be allowed to pay in installments without extra charges on the premium.

Health insurance companies and the government need to adopt where possible the sliding premium scale to cross subsidize the poor who cannot afford the high premium rate. This could also be state-subsidized where the subscribers and potential subscribers share in the cost of their insurance.

The health insurance companies and HMOs could exclude HIV/AIDS treatment especially the Anti-retro viral drug in the benefit package across the different levels of policy plans because the government provides free access to these drugs making it less expensive.

Insurance Regulatory Authority of Uganda (IRAU), PHI companies and HMOs could find alternative ways of increasing individual policy coverage by especially reaching the uninsured in the informal sector. This could be by increasing information dissemination among the population in the informal sector, doing more research to find their insurance needs and tailoring their insurance policy to meet these needs.

Health insurance companies and their service providers should ensure continuous improved quality services to the insured. This will help them retain the current health insurance policy holder leading to clients' satisfaction. The satisfied policy holders or clients will in turn spread the word to the uninsured and lure them to join and pay for PHI.

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APPENDICES

WORK PLAN 2012 to 2013

Months	**Activities**	**Responsible person(s)**
Late April 2013	Completion of proposal	Researcher
Early May 2013	Approval	Supervisor and IHSU research committee
Mid May 2013	Pre test	Researcher
Mid May 2013	Corrections and remodeling of questionnaires and other study tools.	Researcher and Supervisor
Mid May 2013	Research assistants training	Researcher
Late May – early June 2013	Data collection	Researcher and research assistants.

Late June 2013	Data analysis	Researcher and Data analysts
July 2013	First Draft	Researcher and supervisor
Late July 2013	Second Draft	Researcher and supervisor
Late August 2013	Final report submission	Researcher and supervisor
September 2013	Distribution and dissemination	Researcher

BUDGET 2012 TO 2013

Activities	**Unit Cost (Ugshs)**	**Quantity**	**Total Amount in (Ugshs)**	**Source of Fund.**
Stationeries Reams of papers	17, 000 ==	4 Reams	68, 000 /=	Self
Pens	5, 000 /=	1 Dozen	5, 000 /=	Self
Pencils	2, 500 /=	1 Dozen	2, 500 /=	
Note books	5, 000/=	5	20,000 /=	Self
Training and allowance for research Assistants	150, 000 /=	2	300,000 /=	Self
Typing	40, 000 /=	1	40, 000 /=	Self
Data Analysis	300, 000 /=	1	300, 000 /=	Self
Binding				

Spiral Hard cover	10, 000/= 25, 000/=	3 5	30, 000 /= 125, 000 /=	Self
GRAND TOTAL			**890, 500 /=**	

THE CONSENT FORM

Dear Sir/Madam,

Greetings!

My name is Adyero Filder Claret, a final year student of Bachelor of Science in Public Health at International Health Sciences University carrying out a study on willingness to join private health insurance among out patients in Mukwaya General Hospital.

Your participation in this study is voluntary and you can decide to pull out at will without any loss of benefit or treatment you will get in this hospital. Your name will not appear anywhere or directly be associated with the report of this study and the interview will take about 10-15 minutes only.

For any information related to this study contact; 0751 55 77 55 and 0706 18 19 02

The Information obtained will be confidential and only be used for the purpose of this study.

If you agree to this study, kindly sign here below

Signature---------- or finger Print----------

Witness----------

THE QUESTIONNAIRE

Questionnaire Number----------

SECTION A: PERSONAL PROFILE OF THE RESPEONDENTS

1. How old are you? (Tick one)
   a) Below 25
   b) 25-35
   c) 36-45
   d) Above 45

2. Gender of respondent (Tick one)
   a) Female
   b) Male

3. What is your marital status? (Tick one)
   a) Married/cohabiting
   b) Divorced/separated
   c) Widowed
   d) Single

4. What is your highest level of education? (Tick one)
   a) Primary
   c) Secondary

d) Post secondary (Certificate, Diploma, degree, masters etc.)

5. What religion do you practice? (Tick one)
   a) Catholic
   b) Protestant
   c) Muslim
   d) Born Again

6. What is your current occupation status? (Tick one)
   a) Unemployed
   b) Formally employed
   c) Self employed
   d) Student

7) How many people live in your household?
   a) 1-4
   b) 5-7
   c) More than 7

8) How many children are there in your household?
   a) None
   b) Less than 3
   c) 3 – 6
   d) 7 and above

SECTION B: KNOWLEDGE AND EXTENT OF COVERAGE FOR PRIVATE HEALTH INSURANCE.

9) Do you know what private health insurance is? (Tick one).
   a) Yes
   b) No

10) Have you heard or seen messages on PHI?
   a) Yes
   b) No

11) Are you aware of which hospitals or clinics with PHI services?
   a) Yes
   b) No

12) Do you know who is eligible to access PHI?

a) Yes
b) No

13) If yes to questions 9-12, how did you come to know about it? What were your sources of information? (Tick all applicable).

a) Mass Media (TVs, Radios, Newspapers etc.)
b) Insurance Brokers
c) Employers
d) Friends/Relatives
e) Internet

14) Are you currently enrolled/subscribed for health Insurance scheme?
(IF NO, GO TO QUESTION NUMBER 34)

a) Yes
b) No

15) How many people are covered by PHI in your household?

a) Only the insured person
b) The insure person and the spouse
c) Upto 4 other persons

16) If insured, what is your insurance status?

a) Primary
b) Dependant

17) What type of policy are you holding?

a) Corporate gold
b) Gold
c) Silver
d) basic

18) Who pays your premium?

a) Self/spouse
b) Employer
c) Deducted from salary 50% and employer pays 50%.

19) How often is the premium paid?

a) Monthly

b) Annually
c) I don't know.

20) What was the most important reason for joining health insurance? (Tick all that apply).
a) Easy access to health care
b) High frequency of illness in the household
c) Better quality service

BENEFIT PACKAGE

21) Under the mentioned health insurance scheme, what health services are you eligible to receive? (Tick all that apply)
a) Outpatient
b) Dental
c) Antenatal
d) In patient hospitalization
e) Optical/eye facilities

22) How many other family members (apart from you) are insured under this scheme?
a) _____children (i.e. under 18 years)
b) _____adults (Above 18 years)

23) What kinds of health benefits are provided under the arrangement made by your insurer?
a) In house clinic/doctor
b) Out-patient care and the insurer pays provider
c) Out- patient and in-patient care and the insurer pays provider
d) Employees pay for care and get reimbursed for it by employer
e) Top up medical allowance
f) Other (Specify)

24) Under the health benefit arrangement, where do you go for health care services?
a) Insurer's health facilities
b) Other private clinics/hospitals
c) Public sector facilities (private wing)
d) NGO facilities

PREMIUMS

25) Who pays your health insurance premiums/money?
a) Myself or my spouse out-of-pocket
b) My employer
c) Whole amount is deducted from my salary
d) Part from my salary and the other part by my employer
e) I don't know

26) Is your health insurance premium paid monthly or annually?
a) Monthly
b) Annually

27) From the payment mode chosen above, how much money is paid as premium contributions for health insurance? Ugshs_____ or US $_____

28) Is this amount paid for the whole family or for each individual insured in the family?
a) Whole family
b) Each individual

29) Are all the members in the family enrolled/subscribed to PHI?
a) Yes
b) No

30) If no, what are the reasons for not enrolling all members in family?

31) Are you aware of any excluded services in the private health insurance policy you are holding?
a) Yes
b) No

32) If yes, state any excluded services in the Health Insurance Scheme.

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33) Do you believe that the premium rate is affordable?
a) Strongly agree
b) Agree
c) Disagree
d) Strongly disagree

34) If not subscribed/enrolled for Private Health Insurance, what are your reasons for not enrolling? (Why are you not insured?).

a) High cost of insurance
b) Not frequently ill
c) Not my responsibility

35) If not subscribed/enrolled for private health insurance, how do you often pay your medical bill when you or someone in the family falls sick?
a) Pay at the point of service (out of pocket)
b) Seek free care in public Hospitals
c) Use traditional medicines

36) If you are not subscribed /enrolled for private health insurance, are you willing to pay for private health insurance given the opportunity or if it is initiated in your preferred hospital/health unit?
a) Yes
b) No

37) If no, what are you reason?

-

38) If yes, what would attract you to the scheme? (Why would you be very much willing to join health insurance?)

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39) If yes, how much money will you be willing to contribute per person per year in order to join the scheme as a household/family?
a) Less than 50,000shs
b) 50,000- 100,000shs
c) 100,000-300,000shs
d) Above 300,000shs

40) If your household/family joins the scheme and you have paid your yearly contribution for everyone in the household, where would you choose to get treatment for you and your family members? (Choose one).
a) Government health units
b) NGO health units
c) Private hospitals/clinics

41) What is the reason for your choice?

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42) Do you think Health Insurance is of important to you and family?
a) Yes
b) No

43) If yes, in what way is it of importance to you and family?
a) Faster access to care
b) Financial protection against cost of illness
c) Extension of care to whole family/household

44) If no, why is it of no importance to you?
a) High premium/Expensive
b) Wide spread poverty
c) Poor quality service
d) Rigid regulation
e) It is not culturally or religiously accepted in my community

Key Informant Questionnaire for Insurance Regulatory Authority Uganda (IRAU)

1. What relationship model has been adopted between service provider, Private health insurance organizations and the policy holders?
2. Do all the PHI companies have an annual budget?
   a) Yes
   b) No
3. Is there a ceiling on bills for an individual beneficiary per year?
4. If yes, is the ceiling amount set by the authority?
5. Is there a way set in place for the policy holders to get involved in the decision making process of the PHI companies?
6. Is there a consumer representative within the authority?
7. What would you consider a key underlying factor than influences the performances of PHI market in Uganda?
   a) Individual
   b) Household
   c) Community level
   d) Organizational level

Key Informant Questionnaires for Private Health Insurance Companies

1. How many people are enrolled for health insurance in this organization?
2. Describe the procedures of;
    a) Determining benefit packages
    b) Recruitment of members (Individual, groups and households).
    c) Premium setting and mode of payment.
    d) Processing claims
    e) Accessing health care services
    f) Provider payment (how are the providers reimbursed for services offered).
3. What scheme design feature facilitates enrollment?
4. What hinders enrollment?
5. Is the scheme managed by any governing body?
    a) Yes
    b) No
6. If yes, which one?
7. Is the PHI currently being marketed?
8. What is the scheme's major success to date?
9. Comment on the economic potential of PHI in terms of;
    a) Efficiency (value for money)
    b) Sustainability (is PHI strategies sustainable)?
10. Please suggest recommendations for the successful adoption of PHI strategies
11. What are the major obstacles to sustainability?

12. What overall recommendation do you propose/suggest to improve the performance of this PH

Key Informant Questionnaires for Service Providers

1. What do you consider as key contribution of PHI in the catchment area?
2. How has PHI scheme impacted on the service delivery by the hospital in terms of percentages of total cost from the services offered for the insured?
3. What challenges is the hospital facing as a result of working with PHI schemes?
4. Please comment on the appropriateness of the scheme designs in terms of;
   a) Benefit packages (Are the exclusion justifiable)
   b) Premium rate against cost of care and patients' income
   c) Mode of payment
   d) Service provision
   e) Mode of enrolment
   f) Claims procedures
   g) Any other comment