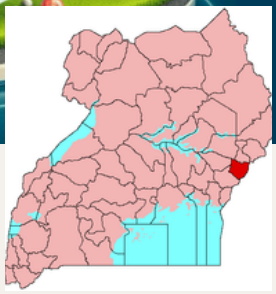
KEY FACTORS INFLUENCING ADOPTION OF HEALTH INSURANCE IN MBALE DISTRICT IN EASTERN UGANDA

Stephen Nambwira and Tobias Onweng



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Abstract

The research investigated key factors that influence the adoption of health insurance in Mbale district. A survey research design was employed in which data was collected from randomly sampled respondents and a mixed method approach employed including qualitative and quantitative methods of data collection and analysis. A sample of 110 elements drawn for company employed and self-employed persons enrolled in five insurance companies was determined by using Krejcie and Morgan Table of Sample Size Determination (Krejcie and Morgan, 1970).

Clients of five insurance companies using health insurance were selected. Five key informants comprising managers of insurance companies were purposively selected. Data was collected from key informants using key informants' interviews and from clients using semi-structured interviews. Quantitative data was analyzed using frequencies and percentages. Content analysis technique was used to analyze qualitative data from key informants. Results show that key factors that motivate clients to enroll for health insurance included requirements from their companies that they enroll, the desire to get treated easily when they are sick and the fear of spending out of pocket when they get sick.

Factors that made it easy or facilitated clients to enroll for health insurance included employment status, awareness of health insurance, educational status and income availability. The research concluded that key factors that influence adoption of health insurance included requirement by companies and desire to be benefit from easy treated when sick. According to key informants' motivation to enroll in health insurance included awareness of the benefits of insurance, affordability of insurance premium and quality of health services.

The research recommended that the public should be sensitized about the benefits and importance of insurance to increase enrollment of uptake, and health insurance should be made affordable to increase access of low-income communities to health insurance service.

Chapter I: Introduction

1.1 INTERNATIONAL CONTEXT

In most developed countries, good health is considered a basic right for all, as pronounced by the World Health Organization (1978) and the health sectors are allocated considerable financial resources by governments, in addition to funds from health insurance schemes. This, however, is not the situation in developing countries, where health services are under-financed and resources are inadequate, not equitably allocated and inefficiently utilized. Previously, finance for the health sectors of these countries came from tax revenues, donor funding and private out-of-pocket household expenditure (user fees). Funding from these sources, however, is not adequate to provide the basic right of good health for everyone in these countries, and many people do not have access to a minimum health care package.

Increasing health costs, insufficient tax revenues and the unsustainable character of donor funds have reminded developing countries' governments that their health sectors require money from sources other than conventional funding sources. The single largest source of funding for health care is out-of-pocket payments, which is more than a quarter of total health care expenditure in more than three quarters countries of sub-Saharan Africa (McIntyre et al, 2005). Out-of-pocket payments are unequitable means for health sector funding because they usually place a huge burden on households and present an obstacle to poor people who require access to health services.

The result of out-of-pocket payments for health care can be disastrous because the timing of such payments cannot be ascertained in advance and can threaten the livelihood of households (WHO, 2000).

The use of out-of-pocket payments as a funding mechanism has stimulated increased interest in health insurance, as shown by the resolution of 2005 World Health Assembly on sustainable health funding and universal coverage and social health insurance. Health insurance is one of the sources of funds for financing the health sector apart from direct government budget expenditure, out of pocket expenditure and donor support (Mathauer and Kutzin, 2018; Panda et al., 2016; Pettigrew and Mathauer, 2016). In low- and middle-income countries, voluntary health insurance exists typically in the form of employer-based and community-based health insurance schemes, which often cover user charges only.

However, the coverage of health insurance is still very low in many developing countries (Pettigrew & Mathauer, 2016). In examining voluntary health insurance expenditures trends (1995-2012), Pettigrew and Mathauer (2016) found that 49 out of 138 low- and middle-income countries had voluntary health insurance (VHI) contribution of less than 1% of the total health expenditure, 39 countries had VHI of between 1% and 5% while only 23 countries had a VHI of above 5% of the total health expenditure.

1.2 UGANDA CONTEXT

In Uganda, the government provides free health services at the point of consumption in all government health facilities except in the private wings of the general, referral and the national referral hospitals. Where the required services are not available in the government health facilities, Ugandans must resort to private health facilities where the health care services are expensive. As a result, Ugandans experience a very high out of pocket health expenditure, equivalent to 41% of the total spending on health (Republic of Uganda, 2018a). In addition, the 2015/16 National Health Accounts report showed that voluntary health insurance contributed 2.3% of the current health expenditure, which included employer-based insurance and community-based health insurance schemes (Republic of Uganda, 2018a).

The 2016/17 Uganda National Household Survey (UNHS) findings showed that health insurance coverage is still very low in Uganda and only 5% of the population aged 15 years and above had health insurance cover (Republic of Uganda, 2018b). In addition, only 11% of the population aged 15 years and above were aware of the health insurance services, out of which 42% would consider joining a health insurance scheme. More men (34%) had heard of health insurance than women at 24%. The uptake of health insurance services was higher in urban areas at 8% compared to 3% in rural areas (Republic of Uganda, 2018b).

Also, the Uganda Demographic Health Survey (UDHS) indicated that only 6% of the population aged 15-49 years have health insurance (Republic of Uganda, 2017).

Regarding the health insurance type, about 50% of the women's insurance was provided by the employer, 36% were insured by mutual or community organizations, and 14% had privately or commercially purchased the insurance. To improve health insurance coverage, the government has proposed the introduction of a contributory national health insurance scheme (Republic of Uganda, 2020; The National Health Insurance Bill, 2019). The Bill envisages integrating the existing private and community-based health schemes into one national risk pooling scheme. This is aimed at achieving universal health coverage through financial protection, equitable access to health care services, capital development and enhance health care utilization by all. It is against this background that the study investigated the factors that influence adoption of health insurance in Uganda. This serves to guide the implementation of health insurance schemes and inform policy formulation (Turyamureba M.et al.,2022).

Chapter II: Literature Review

2.1 THEORETICAL REVIEW

Two theories have been advanced and applied to explain adoption of health insurance. They include the expected utility theory and state dependent utility theory as explained below.

A. EXPECTED UTILITY THEORY

According to the Expected Utility Theory by Von Neumann and Morgenstern (Moscati Ivan, 2018)) individuals are risk-averse and choose between taking risks with different implications on wealth. At the time of purchasing health insurance, individuals are not only uncertain about whether they will be ill or not but also of the financial implications should they become ill, for instance, the cost of treatment. Individuals purchase health insurance to protect themselves from catastrophic health expenditures in the event of ill health. In most cases, the cost of care is higher or more than the premium paid.

The decision to demand health insurance is based on the expected utility with health insurance compared to the expected utility without health insurance. It is a choice between an uncertain loss that occurs with a probability when insured and a specific loss such as payment of premium. Risk-averse individuals prefer to pay a certain known amount as the insurance premium to an uncertain amount of the same expected utility in the event of illness. According to the theory, purchasing health insurance depends on the individual's reaction to risk.
The demand for health insurance by risk-averse individuals to avoid the possibility of wealth loss is higher than among risk-neutral and risk-loving individuals. The theory is applicable to the study because it guided the assessment of the extent to which client's enrollment is motivated by fear of income loss by spending out of pocket when not enrolled in health insurance. (Moscati Ivan, 2018).

B.STATE DEPENDENT UTILITY THEORY

The state-dependent theory asserts that a consumer's utility level and taste are influenced by the state of his/her health or social-economic status. Thus, individuals have different degrees of risk aversion, which influences their insurance demand decision. For instance, individuals who perceive their health status as good are less likely to purchase insurance than individuals who perceive their health status as poor. Also, individuals in households with higher socioeconomic status are more likely to demand health insurance because they can either afford (paying the premium) or have a better understanding of the benefits of being issued. The poor have liquidity constraints that cause them to remain uninsured even when they may be better off with insurance (Brown J. R., Goda S. G., McGarry K., 2013). The theory is applicable to the study because it points out that socioeconomic status are likely to influence the demand for health insurance. The study applied the theory and investigated the influence of socioeconomic factors such as income, employment, educational status, knowledge and gender on enrollment in health insurance.

2.2 LITERATURE REVIEW

Several studies have investigated factors that influence adoption of health insurance in Uganda. A study on health insurance in Uganda revealed that access to information, wealth, level of education, and area of residence are significantly associated with adoption of health insurance (Sempala, 2018). Another study found that awareness was a very important factor in determining adoption of health insurance (Mpuuga D., Yahwe B., L., Mwanga, J., 2020). The study further found that although many people were willing to pay for health insurance, very few had health insurance. This meant that mere willingness alone does not translate into actual health insurance. In a study on factors affecting women's demand for health insurance, education and wealth were found to be the demographic factors that affected the demand for community and employer health insurance, while age, marital status, age, and education were the demographic factors that affected the demand for community, employer, and private health insurance respectively. Watching television, reading newspaper, and listening to radio were the media factors that affected the demand for employer provided health insurance, while listening to radio was the only media factor that affected the demand for community health insurance (Musoke E, Sekiyivu B., Ashaba C., 2022). Literature search has not yielded any study that specifically investigated factors affecting the adoption for health insurance by men in Uganda.

A study by Turyamureba M. et al (2022) examined the factors that influence uptake of private voluntary health insurance in Uganda. The results showed that wealth index, level of education, age of the individual, marital status, residence, and access to information were significant factors affecting uptake of health insurance in Uganda. Individuals from well off households were more likely to have health insurance cover compared to individuals from the poor ones. Also, individuals who had access to information through listening to radio, reading newspapers, and watching television were more likely to demand health insurance compared to those without access. A study in Kenya found demographic factors, level of education, socio-economic factors (income) and awareness influence the uptake of National Health Insurance in the informal sector (Ndungu T., T, printed in 2015 Unpublished). It recommended research on factors influencing retention and dropout from the insurance scheme. Studies found that reducing the price of health insurance premiums for public or private insurance increased coverage (Assuming, Patrick Opoku et al 2020; Banerjee, Abhijit et al., 2021; Fischer, Torben et al, 2018; Levine, David, et al, 2016; Thornton, Rebecca L. et al, 2010; Wagstaff, Adam et al, 2016.). Evidence from other studies indicated that hassles associated with enrollment or reimbursement can deter enrollment (Banerjee, Abhijit, et al, 2021; Thornton, Rebecca L., 2010). In addition, exposure to low-quality care under health insurance led to dropout in Burkina Faso (Fink, Günther et al, 2013; Robyn, Paul Jacob, et al., 2012).

Furthermore, Ayiteyet al. (2013) studied the determinants of insurance enrolment among Ghanaian Adults and found that income, age, religion, and access to information through televisions and media were significant determinants.

Nketiah-Amposah (2009) found that women in Ghana were more likely to demand for health insurance than males. The study findings further indicated that the Ghanaian national health insurance scheme only served a few poor individuals. Another study by Owusu-Sekyere and Chiaraah (2014) found that income, level of education, sex, marital status, cost of curative care, and poor health status influenced Ghanaians' decision to join insurance schemes. In addition, Mhlanga and Dunga (2020) investigated the determinants of demand for health insurance in South Africa. The study revealed that that health insurance coverage in South Africa was still low, and that gender, marital status, race, and education level were significant determinants, and males had a higher probability of demand for health insurance than their female counterparts.

Dror et al. (2016) and Panda et al. (2016) investigated the factors that affect uptake of voluntary and community-based health insurance in low- and middle-income countries. The results showed that household income, education, age of the household head, gender of the household head, and marital status were significantly associated with enrolment in community health insurance schemes. Similarly Adebayo et al (2015) conducted quantitative and qualitative studies low-income and middle-income countries including African countries and revealed that the major factors affecting enrolment included low levels of income and lack of financial resources, poor healthcare quality (including stock-outs of drugs and medical supplies, poor healthcare worker attitudes, and long waiting times),trust in both the CBHI scheme and healthcare providers, educational attainment (less educated are willing to pay less than highly educated), sex (men are willing to pay more than women), age (younger are willing to pay more than older individuals), and household size (larger households are willing to pay more than households with fewer members).

Income was consistently found to influence adoption of health insurance in several countries including Australia, Malaysia and Ghana, Senegal and Kenya. Cameroon et al. (1988) established that income and price significantly influenced demand for health insurance. Similar findings were found by Abu Bakar et al. (2012) in Malaysia; and Owusu-Sekyere and Chiaraah (2014) in Ghana who found that income had a positive influence on demand for health insurance. Also, Hopkins and Kidd (1996) estimated a logit model and found that income, age, health status, and location was significant in determining demand for health insurance in Australia. Abu-Baker et al. (2012) found that income level, age, gender, religion, education level and risk attitude significantly affected purchase of private health insurance in Malaysia. Similarly, Yamada, Yamada, Chen, and Zeng (2014) found that household income positively influenced purchasing of health insurance.

Similarly, Nkatha et al. (2020) analyzed macro-economic determinants of demand for health insurance in Kenya using macro data. The results showed that income levels, education level, inflation and unemployment affected demand for health insurance in Kenya. The results further indicated that income levels and education levels had a positive effect on demand for health insurance in the long run. In contrast, the inflation rate and unemployment had a negative effect on demand for health insurance.

Jutting (2003) analyzed factors explaining people's participation in insurance schemes in rural Senegal. The results showed that household income and religion were significant in influencing demand for health insurance. The results further revealed that the schemes had not reached the poorest of the poor, especially in villages that have difficulties accessing health care. Similar findings were also found by Nsiah-Boateng & Aikins (2018) in Ghana. A similar result was found in a study by Finn and Harmon (2006) who employed panel data to examine demand for private health insurance in Ireland. The results showed that education, income, and health status were significant determinants of demand for private health insurance in Ireland.

Takudzwa, Thabani, and Smartson (2020) investigated the factors that influence demand for a health insurance cover by the public service employees in Zimbabwe. The findings showed that premium, employment type, place of residence, education level and access to information were significant predictors of participation in health insurance schemes. A unique factor was revealed by Tavares (2020) who in his study that health status and being risky takers significantly influenced the decision to buy voluntary private health insurance in universal coverage health systems in Europe.

Chapter III: Problem Statement

Health insurance coverage is still very low in developing countries and Uganda despite its capacity to increase access of the poor population to health care. A key factor in health insurance's ability to increase access to medical care, protect individuals from financial hardship, and be financially sustainable insurance schemes is adoption. Adoption of the scheme is still low in many developing countries including Uganda. Studies identified several factors associated with or influenced enrollment or adoption of health insurance. The study investigated the degree to which easy access to health service, fear of payment of out of pocket, income, education, awareness, employment and gender influenced adoption of health insurance. The factors that drive adoption and the ones that make adoption easy or facilitates adoption of health insurance were investigated.

Chapter IV: Conceptual Framework

Independent variables included easy access to health service, fear of payment of out of pocket, income availability, knowledge or awareness of health insurance, education status and gender status. Dependent variable was adoption of health insurance. A person adopts health insurance if he registers or enrolls for the services. Independent variables positively influence dependent variables.

Chapter V: Objectives

5.1 MAIN OBJECTIVE:

The main objective of the study was to assess key factors that influence the adoption of health insurance in Mbale district in eastern Uganda.

5.2 SPECIFIC OBJECTIVES:

Specifically, the study:

1. Assessed the influence of easy access to health service and adoption of health insurance
2. Assessed the influence of fear of spending out of pocket on adoption of health insurance
3. Assessed the degree to which income influenced adoption of health insurance.
4. Assessed the extent to which knowledge of health insurance influenced its adoption.
5. Examined the effect of education attainment on adoption of health insurance.
6. Assessed the influence of gender on adoption of health insurance.

5.3 RESEARCH QUESTIONS:

The research answered the following questions:

1. To what extent does easy access to health insurance influence adoption of health insurance?
2. To what extent does fear of spending out of pocket influence adoption of health insurance?
3. To what extent does income influence adoption of health insurance?
4. To what extent does knowledge of health insurance influence its adoption?
5. What is the effect of education status on adoption of health insurance?
6. What is the influence of gender status on adoption of health insurance?

5.4 STUDY SIGNIFICANCY

The study revealed the distinction between key drivers of adoption and key facilitators of adoption. Drivers of adoption are the requirements by companies (involuntary driver) that their employees register for insurance and voluntary drivers are factors that push a person to adopt health insurance, while facilitators make it easy for a person to adopt health insurance. While key drivers included the desire for easy access to health service and the fear of payment out of out of pocket, facilitators of adoption included income, employment, knowledge/awareness of insurance and gender status.

Chapter VI: Methodology

6.1 RESEARCH DESIGN:

The research employed a survey research design in which data was collected from randomly sampled respondents. A mixed method approach was used to facilitate a comprehensive examination of all research variables. Use of mixed methods included qualitative and quantitative methods of data collection and analysis.

6.2 SAMPLE SIZE DETERMINATION

The sample size was determined by using Krejcie and Morgan Table of Sample Size Determination (Krejcie and Morgan, 1970). The population of health insurance clients was estimated to be five hundred (500). According to Krejcie and Morgan Table the sample for a population of 500 was 217 respondents. However due to limited financial resources and time, the sample was reduced to 100 respondents. The actual sample interviewed was 110 respondents.

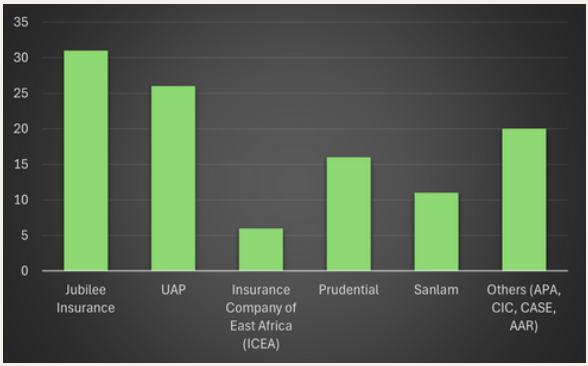
6.3 SAMPLING PROCEDURE:

a) Clients of Insurance Companies

Companies using health insurance in Mbale City were selected and visited and the staff enrolled in health insurance were listed and interviewed. Respondents were enrolled in five (5) main insurance companies as indicated in the graph 1 below:

Graph 1

Insurance Companies



Note: Others include self-employed and unemployed clients.

b) Key informants

Key informants were managers of insurance companies who were purposively selected. The purposive sampling method was used to ensure that only officers with the knowledge and experience in managing health insurance were targeted and selected.

6.4 DATA COLLECTION:

6.4.1 Reliability and Validity of Research Instruments:

Instruments for collecting included key informants guides and semi-structured interview schedules. Reliability and validity of instruments were ensured. Reliability concerns the extent to which a measurement of a phenomenon provides stable and consistent results (Carmines and Zeller, 1979). A scale or test is said to be reliable if repeat measurement made by it under constant conditions will give the same result (Moser and Kalton, 1989) To ensure reliability of instruments, they were tested and retested and results compared.

Validity of instruments it measures what it is supposed to measure, relevant literature was reviewed and all the essential elements of the instrument were included. Secondly, research instruments were sent to consultants in health insurance for comments.

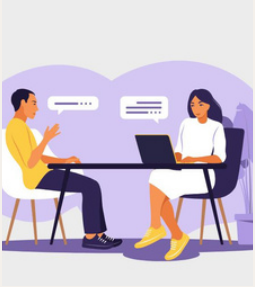
6.4.2.Data Management.

Data was managed by appropriately labeling, storing, and ensuring easy access.

6.4.3 Key informants and semi-structured interviews

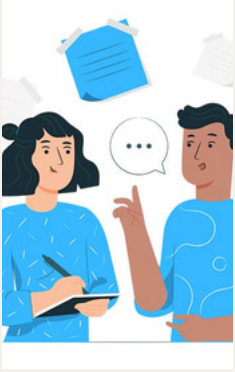
Data collection Key informants' interviews and semi-structured interviews were conducted with key informants and selected health insurance clients as described below.

a) Key Informant Interviews



Key informants' interviews were conducted using key informants interview guide to obtain data from managers responsible for health insurance. Key informants' interviews were conducted with five (5) insurance managers including four (4) branch managers and 1 compliance officer. The justification for the use of key informants' interview method was to enable accurate information on the performance of health insurance to be captured as they have experience with the scheme.

b) Personal interviews



Personal interviews were conducted with clients of health insurance using a semi structured interview schedule. The instrument was developed and used to collect data from 110clients of insurance companies. The team leader and the researcher trained three (3) data collectors in data collection. Data collectors were trained through discussion of the research proposal, going through the interview schedule to familiarize themselves with the data collection tools, data collectors practiced by role playing, each of them acting as interviewer and interviewee. Through this method, they were able to make comments on the process and make improvement in their interviewing skills.

6.5 DATA ANALYSIS:

6.5.1 Analysis of Quantitative Data:

IFilled-in semi structured interview schedules were first checked for their completeness. Complete checks were conducted to establish whether both the structured and unstructured sections of the instruments have been properly filled. Data was entered into Excel data entry format and analysis. The data set was transformed into descriptive statistics namely frequencies and percentages. Data was disaggregated by gender, age, educational status, and employment status. The unit of analysis was individual respondents.

6.5.2 Analysis of Qualitative Data:

Information collected from key informants was qualitatively analyzed. After key informants' interviews, field notes were rewritten in a well-organized set of notes. The notes were cleaned by removing information considered not relevant to study objectives. Data was reduced into small chunks by use of research questions.

Content analysis was used to analyze transcripts and extract information from responses guided by research questions. Responses were compared to determine similarities and differences to facilitate conclusions based on study objectives. The unit of analysis was health insurance companies as managers provided information for their companies.

Chapter VII: Results

This section presents findings on demographic characteristics of respondents, insurance companies in which interviewed clients enrolled for health insurance, factors that motivated clients to enroll in health insurance service, factors that made it easy for clients to enroll in health insurance, health insurance benefits, quality of health service, challenges experienced in health insurance and suggestions to address them, conclusions, and recommendations.

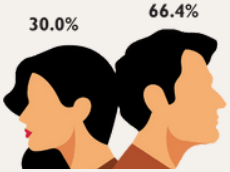
7.1 DEMOGRAPHIC CHARACTERISTICS:

Demographic characteristics included gender, age, educational level, marital status and employment status as presented below.

a) Gender:

66.4% of the respondents were male, 30% female and 3.6% of the respondents did not indicate their gender.

Figure 1
Gender Disaggregation



b) Age:

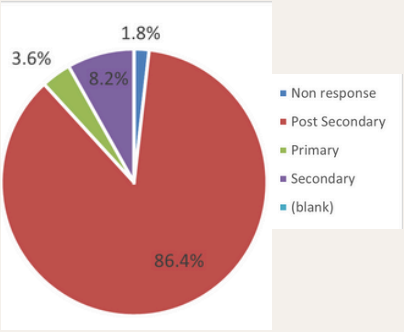
Half of the clients were aged between 31 and 40 years followed by 27.2 % who were between 21 and 30 years. Clients aged 50 and above were only 4.5% as depicted in figure 2. 2.7% of the participants did not indicate their ages.

Figure 2
Age Disaggregation

c) Education Status:

An overwhelming majority of respondents (86.4%) had attained post-secondary education, compared to a small percentage of 8.2% who had attained secondary level. A tiny percentage of 3.6% had reached primary school level. This is shown in graph 2.

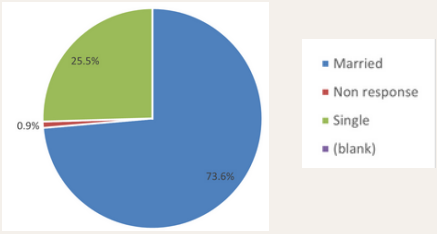
Graph 2
Education Status



d) *Marital Status:*

More respondents were married (73.6%) compared to single represented by 25.5%. 0.9% did not indicate their marital status as shown in graph 3.

Graph 3
Marital Status



e) *Employment Status:*

Most clients (82%) interviewed were employed compared to a small percentage (14.4%) who were self-employed. Only a small percentage (3.6%) of clients interviewed were unemployed. This is shown in figure 3.

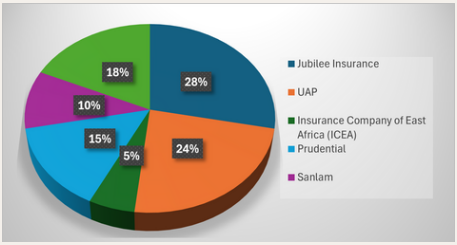
Figure 3
Employment Status

7.2 INSURANCE COMPANIES IN WHICH CLIENTS WERE ENROLLED.

Respondents were enrolled insurance companies as shown in graph 4.

About a third of clients (28.2%) interviewed were enrolled in Jubilee Insurance Company, followed by UAP (23.6%) and Prudential (14.5%). ICEA had the least percentage of clients interviewed (5.5%).

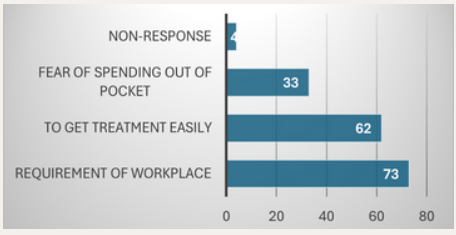
Graph 4
Enrollment in Insurance Companies



7.3 MOTIVATION TO ENROLL IN HEALTH INSURANCE

A relative majority of respondents (42.4%) were motivated to enroll in health insurance by requirement of their companies followed by more than a third (36.1%) who were motivated to register to get treatment easily. About one fifth of respondents (19.2) were motivated by fear of spending out of pocket when they get sick as shown in graph 5.

Graph 5
Motivators



Results from Key informants' interviews show that factors that influence a person's decision to buy health insurance included awareness of the benefits of health insurance, affordability of health insurance and quality of services. They suggested that to attract people to enroll for health insurance, insurance companies should sensitize the public in partnership with the government on the importance and benefits of insurance. They further suggested that premiums should be made affordable to increase uptake of health insurance. For instance, banks could provide loans to low-income segment of the public for health insurance and allow them to pay by instalment.

7.4 FACTORS FACILITATING ENROLLMENT IN HEALTH INSURANCE.

A relative majority of respondents (42%) reported that their employment status made it easy for them to register for health insurance. This was because being a requirement of their company to enroll for health insurance, registration was processed by their company, and they therefore did not struggle to enroll. Furthermore, employment also provided them with income to be able to register for health insurance. Slightly more than a third (32.6%) reported that knowledge or awareness of health insurance made it easy for them to adopt health insurance. Knowledge or awareness of the benefits of health insurance and the negative consequences of not getting health insurance propelled respondents to get insured. Other facilitating factors included educational status (12.7%) and income availability (9.9%). The responses are shown in table 6 below.

Graph 6
Facilitators of enrollment

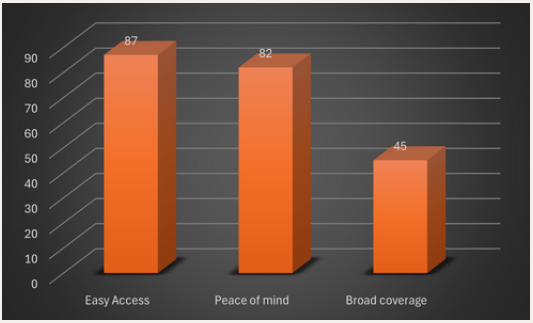
Key informants' interviews with insurance managers indicated that lack of affordability and lack of awareness of insurance of health insurance were responsible for the low coverage of health insurance. They further revealed that that lack of awareness was responsible for the negative attitudes of the public towards insurance companies. In the public perspectives insurance companies were not trusted to pay a client who incurred a loss. The officers suggested a campaign to educate the public on the benefits of insurance to encourage the public to buy health insurance. For the educated who were aware of health insurance benefits, the main reason for not enrolling is lack of money.

7.5 HEALTH INSURANCE BENEFITS

The results in the graph below show that a total of 214 participants responded to this section. One in four respondents (40.7%) reported the benefits of health insurance to be easy access to health service, while more than a third of respondents (38.3%) revealed that the benefit they obtain from health insurance was peace of mind. When they pay for health insurance, they feel at ease because they are sure that when they fall sick, they will get treatment. One fifth of respondents (21%) indicated that the benefit they obtain from health insurance was a broad coverage of health services as depicted in graph 3 below.

Graph 7

Insurance Benefits

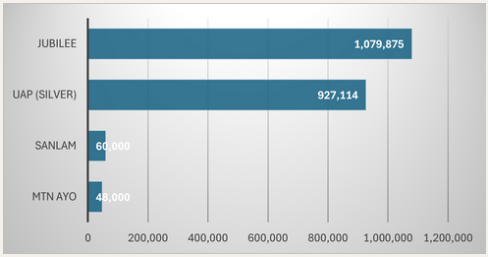


7.6 PREMIUM

Key informants' interviews with managers of insurance companies revealed that the insurance premium varied from company to another as indicated in table 8: The premium ranged from Uganda shillings 48,000 to over one million shillings as shown in the graph 4.

Graph 8

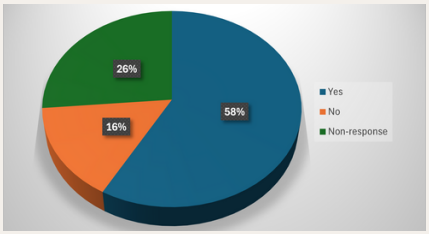
Premium



When asked whether the premium was fair, about two thirds (58.2%) reported that it was fair while 15.4% indicated that it was not fair as shown in graph 5.

Graph 9

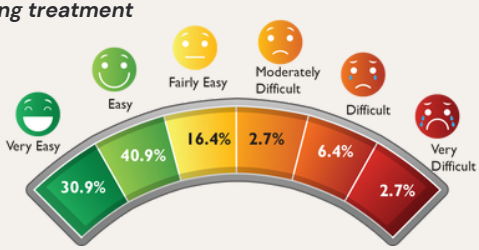
Fairness of Premium



7.7 EASE OF GETTING TREATMENT

When asked whether it was easy to get treatment, the responses were as follows. A relative majority of respondents (40.9%) revealed that obtaining treatment under the health insurance scheme was easy. This was followed by a third of respondents (30.9%) who reported that getting treatment was very easy. Only 2.7% reported that it was very difficult to get treatment under the scheme. The results are depicted in graph 4.

Figure 4
Ease of getting treatment



7.8 QUALITY OF HEALTH SERVICE

Satisfaction with quality of health service:
An overwhelming majority of respondents (80%) expressed satisfaction with the health service provided under health insurance scheme, while only one fifth (20%) indicated lack of satisfaction with health service as illustrated in figure 5.

Figure 5
Satisfaction with quality of health service

7.9 CHALLENGES OF HEALTH INSURANCE

Respondents reported many challenges they experience from health insurance schemes. These included a limited number of high-quality hospitals that provide services under insurance, most of which are in large urban centers leaving small towns and rural areas unserved. Sometimes clients must travel long distances looking for hospitals. Even the few hospitals that exist offer few ranges of services. Other areas of health such as dental and optical health among others is not covered in some hospitals. In a related manner, some medicines and tests are not covered. There are also inadequate health care services under health insurance compared to obtaining health service through direct cash.

In addition, some respondents reported that good customer service as expected is lacking. Furthermore, there is the limited-service providers resulting in long procedure to access medical care. Another related challenge includes exorbitant bills due to delayed payment by insurance companies and premium is high limiting dependents. Some hospitals are not involved in providing health service through health insurance because insurance companies take a long time to pay compared to payment of service in cash. When payment is delayed, treatment is delayed. Finally, clients are forced to make out of pocket due to lack of drugs.

Chapter VIII: Discussions

8.1 DEMOGRAPHIC CHARACTERISTICS

Demographic characteristics of respondents included gender, age, educational level, marital status and employment status and marital status.

Gender: More males than females were employed in companies selected. This provided male employees more opportunity to be enrolled in health insurance than female employees.

Age: Most clients of health insurance were relatively young.
Educational status: Most health insurance clients were relatively highly educated, a majority having attained post-secondary education. This shows that the more a person is educated, the higher the chances of getting enrolled in health insurance.
Marital status: Most clients were married. The results shows that marriage tends to make one decide to enroll in health insurance to ensure the health of the family as clients are allowed to insure family members.

Employment status: Most clients of health insurance were employed and a small proportion were self-employed. Only a small proportion client unemployed. Results show that more formally employed people were enrolled in health insurance compared to self-employed persons. Two factors explain this. Persons employed in companies are usually required to join health insurance by their companies or organizations Secondly, availability of stable income tends to make it easy for one to enroll in health insurance.

8.2 MOTIVATION TO ENROLL IN HEALTH INSURANCE

While a relative majority of clients were motivated to enroll in health insurance by requirement of their companies followed by more than a third who were motivated to register to get treatment easily. One fifth were motivated by fear of spending out of pocket when they get sick as shown in the table below. Results shows that it is easier to enroll for health insurance when one is employed that when one is unemployed. In addition, clients who enroll voluntarily are motivated by the desire to get easy access to treatment and fear of spending more money by out of pocket payment when they are not registered.

While literature revealed factors influencing adoption of health insurance to include income, knowledge or awareness of insurance, education status employment status gender status, this study revealed the key motivators to be requirement to enroll by the employing company (involuntary driver), easy access to health service and fear of payment of out of pocket. The contribution of the study is the distinction it made between key motivators or driver of adoption which included easy access to health care and fear of out of pocket payment; and facilitators which included income availability, education status, awareness or knowledge of health insurance, employment status and gender status.

These findings indicate that health insurance is mainly used by employed persons. The research revealed that it is a mandatory requirement of companies that their employees get insured to enable get prompt treatment when one falls sick. When workers become ill it is easier for companies to treat workers as responsibility is placed on insurance companies and the cost of treatment is cheaper as premiums are negotiated for workers as a group.

It should be noted that there were multiple responses where employed clients who mandatorily enrolled also reported that they were motivated to enroll to get treatment easily as well as fear of spending out of pocket when they become sick. Where one is required to spend out of pocket, the risk is that one may not have money at the time of falling ill. Self-employed respondents also indicated being motivated to enroll in health insurance by getting treated easily. If they were not insured, they would face the risk of not getting easy treatment due to the possibility of lack of money at the time when they fall ill.

The finding is consistent with Expected Utility Theory by Von Neumann and Morgenstern (Moscati I., 2018) which states that at the time of purchasing health insurance, individuals are not only uncertain about whether they will be ill or not but also of the financial implications should they become ill, for instance, the cost of treatment. Individuals purchase health insurance to protect themselves from catastrophic health expenditures in the event of ill health. In most cases, the cost of care is higher or more than the premium paid. The decision to demand health insurance is based on the expected utility with health insurance compared to the expected utility without health insurance. Risk-averse individuals prefer to pay a certain known amount as the insurance premium to an uncertain amount of the same expected utility in the event of illness.

According to key informants' factors that influence a person's decision to buy health insurance included awareness of the benefits of health insurance, affordability of health insurance and quality of services. Key informants suggested that to attract people to enroll for health insurance, insurance companies in partnership with the government, should sensitize the public on the importance of and benefits of insurance. They further suggested that premiums should be made affordable to increase uptake of health insurance. Banks could for instance provide loans to low-income segment of the public for health insurance and allow them to pay by instalment.

8.3 FACTORS FACILITATING ENROLLMENT IN HEALTH INSURANCE

For a relative majority of respondents employment status made it easy for them to register for health insurance. Employment status made it easy to enroll for health insurance because being a requirement of their company, registration was processed by their company, and they therefore did not struggle to enroll. Furthermore, employment provided them with income to be able to register for health insurance. Knowledge or awareness of the benefits of health insurance and the negative consequences of not getting health insurance propelled respondents to get insured. Other facilitating factors included educational status and income availability.

Educational status and income influence one's decision to enroll for health insurance. One may desire to insure and get treatment when insured, but lack of money may be a constraining factor. Availability of income therefore makes enrollment for health insurance easy.

Key informants who comprised insurance company managers confirmed this finding by indicating that lack of affordability and lack of awareness of insurance of health insurance were responsible for the low coverage of health insurance. They further revealed that that lack of awareness was responsible for the negative attitudes of the public towards insurance companies. In the public view, insurance companies were not trusted to pay a client who incurred a loss. The officers suggested a campaign to educate the public on the benefits of insurance to encourage the public to buy health insurance. For the educated who were aware of health insurance benefits, the main reason for not enrolling is lack of money.

The preceding findings are consistent with earlier researches which revealed factors that influenced adoption of health insurance to include income and level of education (Sempala, 2018, Turyamureba M. et al, 2022), and awareness of health insurance (Mpuuga D., Yahwe B., L., Mwanga, J., 2020), household income, education, age of the household head, gender of the household head, and marital status (Dror et al., 2016 and Panda et al., 2016). The results can also be explained by the State-dependent Theory which asserts that a consumer's utility level and taste are influenced by the state of his/her health or social-economic status. Individuals in households with higher socioeconomic status were more likely to demand health insurance because they can either afford (paying the premium) or have a better understanding of the benefits of being issued. The poor have liquidity constraints that cause them to remain uninsured even when they may be better off with insurance (Brown J. R., Goda S. G., McGarry K., 2013).

8.4 HEALTH INSURANCE BENEFITS

The results show that to one in four respondents benefits from health insurance comprised easy access to health service, while more than a third of clients the benefit from health insurance was peace of mind. When people pay for health insurance, they feel at ease because they are sure that when they fall sick, they will get treatment. For one fifth of respondents the benefit from health insurance was a broad coverage of health services.

8.5 PREMIUM

Health insurance premium was found to range from UGX 48,000 to over one million shillings. Health insurance premium was fair for a relative majority of clients This was only true for the employees who earn relatively high income by Uganda standards. In addition to the respondents who revealed that the premium was not affordable, to most Ugandans who live in rural areas, the amount may not be affordable.

8.6 EASE OF GETTING TREATMENT

For a relative majority of respondents, obtaining treatment under the health insurance scheme was easy, compared to a third of clients for whom getting treatment was very easy. Only a tiny number of client found very difficult to get treatment under the scheme. Obtaining treatment was easy for most clients.

8.7 SATISFACTION WITH QUALITY OF HEALTH SERVICE

An overwhelming majority of clients were satisfied with the health service provided under health insurance scheme, while only one fifth expressed dissatisfaction with health service Most clients were satisfied with health service provided under health insurance.

Respondents who expressed satisfaction with health services explained that under the health insurance scheme, even families go for treatment when ill without struggle. In addition, there is a wide range of treatment, the right medication and good customer care and easy access to emergency treatment and it is affordable. In addition, prescriptions are made in time and there is good quality medical care, and the treatment meets the required standard. Furthermore, they can get quick treatment when one is broke.

In addition, there is professional treatment by staff, service covers multiple illnesses and patient congestion is limited. Furthermore, there are better facilities at private hospitals which provide comprehensive holistic management and one can go to hospital when sick anytime with a card. When one presents the insurance card, a form is filled in, and a doctor is booked. For some respondents the scheme helps them stay healthy and have peace of mind. Overall respondents revealed that it was easier to get treatment when sick and helps them save money when sick.

The small proportion of respondents who expressed lack of satisfaction with quality of service explained that service providers are few and even the few don't offer some services like optical and dental care and there is a problem of stock out of medication. In addition, service providers tend to administer drugs with the motive of money which may not cure their illness. Furthermore, some staff were still learning on the job. Other reasons for dissatisfaction with quality of service included lack of involvement of clients in selection of hospitals, distance of clients from health centers, delays in treatment characterized by long procedures and some health facilities are not in good condition. Finally, some services were lacking due to lack of good doctors and equipment, while some drugs were restricted like vitamins, and some effective brands of drugs were not covered by health insurance.

8.8 CHALLENGES OF HEALTH INSURANCE

Many challenges were experience from health insurance schemes. These included a limited number of high-quality hospitals that provide services under insurance, most of which were in large urban centers leaving small towns and rural areas unserved. Sometimes clients have to travel long distances to hospitals. Even the few hospitals that exist offer few ranges of services. Other areas of health such as dental and optical health among others were not covered in some hospitals. In a related manner, some medicines and tests were not covered. There were also inadequate health care services under health insurance compared to obtaining health service through direct cash.

In addition, good customer service as expected was lacking. Furthermore, there was limited-service providers resulting in long procedure to access medical care. Another related challenge included exorbitant bills due to delayed payment by insurance companies and premium was high limiting dependents. Some hospitals were not involved in providing health service through health insurance because insurance companies take a long time to pay compared to payment of service in cash. When payment is delayed, treatment is delayed. Finally, clients are forced to make out of pocket due to lack of drugs.

Chapter IX: Conclusions and Recommendations

9.1 CONCLUSIONS

The research concludes as follows:

1. The main motivators of enrolment in health insurance included requirement by companies and the desire to easily get treatment when one is sick by purchasing health insurance. In this way they reduce the risk of getting sick when they have no money to get health care service.
2. Key informants identified key motivators of enrollment in health insurance to include awareness of the benefits and importance of affordability of insurance and quality of health services.
3. Factors that enable easy enrollment in health insurance by clients included employment status, awareness of insurance and income availability. People employed are usually required to be enrolled for insurance, making it easy for clients as the process is undertaken by the company. When one is aware of the benefits of insurance, she or he would find it easy to decide to buy health insurance. When one has income, the decision to buy insurance can be easily implemented compared to a person without income.
4. Low coverage of health insurance is explained by key informants to include lack of awareness of health insurance, lack of affordability, public perception of insurance companies as fraudulent, the existence of few quality service providers and limited range of health service provided.
5. The main benefits of health insurance identified by respondents included easy access to health services and peace of mind. Peace of mind occurs when one is sure of being treated when ill.

9.2 RECOMMENDATIONS

The following recommendations are made in order of priority:

1. Sensitize the public about the benefits and importance of insurance to increase uptake or coverage of health insurance. Uganda Insurance Association (UIA) could sensitize the public in collaboration with relevant government authorities and Insurance Training College. For example, if the Ministry of Health is conducting Malaria prevention outreaches, UIA should encourage the public to enroll for health insurance. If the Ministry of Works is campaigning against road accidents, UIA could encourage the public to insure against road accidents.
2. Make health insurance premiums affordable to Ush. 430,000 to increase access of the low-income communities to health insurance service. The current premium charged by insurance companies is not affordable to the rural population as well as slum dwellers in urban centers. Organizations and individuals with low incomes should be encouraged to join health insurance schemes through their bankers where premiums can be paid by banks to insurance companies and repaid as a loan with a small interest.

3. Make medical insurance mandatory for everyone in the country to make the poor access health service.
4. Increase number of hospitals that offer high quality service on health insurance scheme.
5. Expand the range of health services provided to clients to include dental service and surgery among others.
6. Increase the number of service providers and provide more training in service delivery under health insurance.
7. Insurance companies should do detailed evaluation on the adequacy and quality of services before selecting a health service provider.
8. Engage more health institutions in health insurance by offering them attractive packages.
9. Get feedback from companies and clients on health services received to improve adequacy and quality of service.

Annex: Key Informants Interviewed

1. Denis Kasta, Branch Manager APA Insurance Company
2. Lina Akumu, Branch Manager, Sanlam Insurance Company
3. Stephen Omunyokole, Branch Manager, Jubilee Insurance Company
4. Mukwana Halid, Branch Manager, Insurance Company of East Africa (ICEA)
5. Irene Wanjala, Executive Claims Officer, Ayo MTN

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