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Health Insurance and Other Risk-Coping Strategies in Uganda: The Case of Microcare Insurance Ltd.

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Summary. — To reduce the burden of health expenditures in developing countries, health-insurance schemes have become popular and now feature prominently in poverty-reduction strategies. There is, however, limited empirical evidence on the effect of such schemes on the livelihoods of clients, especially regarding household strategies to finance medical expenditures. This paper explores the relationship between health insurance and other risk-coping strategies used to finance medical expenditures in Uganda. Insurance is associated with a lower frequency of asset sales but not with lower incidences of borrowing. The amount of money borrowed or generated through the sales of assets is lower for insured households.

Key words — Uganda, Sub-Sahara Africa, health insurance, micro-insurance, poverty, risk-coping strategies

1. INTRODUCTION

Achieving the Millennium Development Goals (MDGs) remains an important global challenge. Better protection for the poor against health risks is crucial in this endeavor and micro or community-based health-insurance schemes are being advanced as a means to reduce and stabilize the costs of treatment, increase access to health care and to reduce the use of costly risk-coping strategies (IFC, 2009; ILO, 2008; WHO, 2006). Previous studies have shown how insurance increases health-seeking behavior and reduces out-of-pocket (OOP) expenditures for medical treatment. Possible reductions in the use of other coping strategies, as an indirect effect of health insurance, have not been addressed in much detail. Based on data from specific areas in Uganda, this paper explores the relationship between health insurance and the use of other strategies to finance health care.

Illness is a significant risk for people in developing countries (see, e.g., Dekker, 2004; Dercon, Hoddinott, & Woldehanna, 2005; Leliveld, 2006) and can have considerable short-term financial effects on the household affected. Illness is likely to reduce a household's income if people are not able to work and may also result in additional expenditures to cover costs of treatment. As it is not uncommon for people to lack the cash to pay for medical fees (Asenso-Okyere, Anum, Osei-Akoto, & Adukonu, 1998), people may forego treatment, with potentially detrimental effects for their long-term health. Alternatively, households use costly risk-coping strategies to pay for medical care: they reduce spending on basic needs, sell household or productive assets or borrow money. In a study of coping strategies in Uganda, Leliveld (2006) reported how households sold land, cattle, or goats or used their savings to respond to (long-term) illness. Such strategies are expensive and may endanger the future economic status of the household by depleting its finances through indebtedness and its future income-generating capacity by selling productive assets (Scheil-Adlung, Carrin, Jütting, & Xu, 2006). This, in return, will increase the risk of ending up or being trapped in poverty. Bogale, Mariamand, and Ali (2005) and Krishna *et al.* (2006) demonstrate how the costs of illness contribute significantly to the impoverishment of households in rural Ethiopia and Uganda, respectively.

In this context, reducing the financial burden of health care, for example, by having health insurance, allows earlier medical treatment and enhances a household's long-term welfare as it may well shorten the duration of an illness, reduce the number of workdays lost, and improve productivity at work through having better health (Jutting, 2004; Young, Mukwana, & Kiyaga, 2006). More indirectly, when households are better protected against high medical costs, they are less likely to have to rely on other risk-coping strategies and may be able to accumulate savings and assets, thus improving their general welfare.

In line with these arguments, policy debates have placed a great deal of emphasis on the development of health-insurance products for the poor. In the past two decades, hundreds of small schemes have been implemented across the globe (Bennett, Creese, & Monash, 1998) but, to date, profound

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empirical evidence of the effects of health insurance is still limited (Ekman, 2004; Jutting, 2005; Scheil-Adlung *et al.*, 2006; Young *et al.*, 2006). Many studies describe the institutional underpinnings and the performance of the provider (see, e.g., Atim & Sock, 2000; McCord, 2000) or discuss the potential contribution of micro insurance for financing health systems (Dror *et al.,* 2005).[1] Some have documented the impact of insurance schemes on health expenditure and treatment-seeking behavior and have found that health insurance increases health-care utilization (Ekman, 2004; Preker, Carrin, Dror, & Jakab, 2001; Schneider & Hanson, 2006). Jutting (2004), Jowett, Contoyannis, and Vinh (2003) and Ranson (2002) have all reported reduced levels of OOP payments for medical treatment as a result of insurance.

Information on the relationship between insurance and the use of other coping strategies is scantier. Apart from a descriptive comparison of the incidence of risk-coping strategies in the context of three different health-insurance schemes (Scheil-Adlung *et al.*, 2006), the relationship between health insurance and the sale of assets or borrowing money to pay for medical expenses has not been tested statistically and remains unsubstantiated.[2] Based on household-level data collected in five rural and two urban communities in Uganda where the private health-insurance provider Microcare Insurance Ltd. (Microcare) operates, this paper considers the relationship between insurance and OOP expenditures, and then addresses the correlation of insurance and the incidences and value of asset sales and loans.

We have found that health insurance is associated with lower OOP expenditure on health and with less use of other risk-coping strategies. This association between health insurance and other risk-coping strategies calls for additional empirical work on the relationship between insurance, risk-coping, and poverty. If reductions in other coping strategies can indeed be attributed to health-insurance schemes and this is found in a wider range of schemes, health insurance can be seen as relevant beyond its direct effects on health-seeking behavior and reduced health expenditures, and has important indirect effects on household well-being too.

This paper is organized as follows. Section 2 describes the operation of the health-insurance scheme and this is followed by a description of the data in Section 3. Section 4 discusses the empirical strategy, including the hypotheses, the methodology used, potential sources of bias, and some descriptive statistics. Section 5 presents the results of the analyses. Section 6 discusses the implications of our results, while Section 7 draws some conclusions.

2. MICROCARE'S HEALTH-INSURANCE SCHEME

Microcare is a regulated and licensed private insurance company that provides health insurance in Uganda to employees in the formal sector and to groups of households in the so-called informal sector, such as self-employed farmers. The communities in the informal sector are previously established groups, such as credit groups or farmers' associations, or groups that have organized themselves in order to access insurance. Microcare's health-insurance schemes are concentrated in the rural areas around Kisiizi and Kisoro and in the urban centers of Kampala and Entebbe. This study is restricted to Kisiizi and Kampala. Around Kisiizi there are 74 groups, with a total of 3,134 households (approximately 15,512 people) in the scheme. In Kampala and Entebbe, 18 groups of households (approximately 1,396 individuals) are part of the health-insurance scheme. Participation rates in Microcare's informal-sector health-insurance scheme are approximately 15% in Kisiizi and less than 1% in Kampala.

Microcare offers a health-insurance package covering outpatient and inpatient services but excluding medication for chronic illnesses such as HIV/AIDS, hypertension, and diabetes (McCord & Osinde, 2002). Microcare contracts public and private health-service providers to offer services to members insured in the schemes. Those in Kampala can choose between three health-service providers with user fees for Out Patient Department (OPD). In Kisiizi, only Kisiizi Hospital provides services to the insured and charges user fees for OPD and an admission fee for inpatient services. Premiums for informal-sector members have to be paid as an annual lump sum, are non-refundable, and vary according to a household's size and location. At the time of this study, the annual premium in Kampala and Entebbe was USh 149,000 (US$ 80.54) for a family of four in the scheme with additional premiums for extra members: USh 52,000 (US$ 28.11) for each extra adult and USh 26,000 (US$ 14.05) for an extra child. The Kisiizi scheme charged annual premiums starting at USh 24,000 (US$ 12.97) for a family of 4 while a family of 8 paid USh 32,000 (US$17.29) per annum and a family of up to 12 members paid USh 40,000 (US$ 21.62). On average, this amounts to between 1% and 2% of a household's annual expenditure (UBOS, 2006). The premiums paid by informal-sector clients are not sufficient to cover all Microcare's costs. These are cross-subsidized by the premiums paid by their clients in the formal sector.

In Kampala, the microfinance institution Foundation for International Community Assistance (FINCA) provides loans to clients to pay their health-insurance premiums. In Kisiizi, such services were planned by Uganda Microfinance Limited (UML) but were not yet available to the respondents at the time of our study.

3. DATA

The data for this study were collected in June/July 2006 and cover insured and uninsured households in and around Kisiizi and Kampala.[3] The sample for this study was a convenience sample; in both size and selection. It is not representative of the population in Kisiizi or Kampala and the uptake of insurance in our sample was higher than the true rates of insurance in these areas. Based on availability and group size, the researchers visited five community groups around Kisiizi that were part of Microcare's insurance scheme: Kyondo, Muhanga/Butale (a combined group for survey purposes), Rwababishisha, Kamakinda, and Kamoobwa. Not all the members of these groups were insured.

The data were collected using individual interviews with members during their weekly group meetings with Microcare. Such meetings, headed by a sales representative from Microcare, were used to discuss disease prevention and provide information about Microcare's insurance products. At the end of these group meetings, every member, usually the head of the household, was asked to participate in a private interview with the researchers and a Ugandan interpreter. The questionnaire included questions about their health-seeking behavior, and their use of health insurance and other strategies to finance health care. In addition to these community group members, the researchers randomly selected people at the market place in Kisiizi town and patients waiting for treatment at Kisiizi hospital to participate in the same survey.

In and around Kampala, the questionnaire was administered in the area where two microfinance institutions, UML