Critical Analysis of Regulatory Mechanisms for Governance of Community Health Insurance Schemes in Uganda

Hizaamu Ramadhan[1], Basaza Robert[2], Rose B. Namara[1]
Uganda Management Institute, Uganda
St. Augustine International University, Kampala, Uganda

Abstract

Regulating operational modalities of community health insurance schemes is important for protection of consumers and providers of healthcare services against exploitation. This study on governance of community health insurance schemes interrogated the current policies and legislation and the extent to which they addressed governance and sustainability issues of community health insurance schemes.

The investigation adopted a case study research design underpinned by the interpretivist philosophical orientation. The study site was Kampala Capital City, Nakasongola, Nakaseke, Kanungu and Luwero districts targeting policy and decision makers as well as program implementers. These were purposively selected for their unique exposure to community health insurance schemes. 16 key informants were interviewed. The variables of interest were enrolment and sustainability of community health insurance schemes. Key informant interviews and document review guides were used to generate the required data, subjected to thematic and content analysis.

This study established that the current policies and legislation do not adequately address governance and sustainability of community health insurance schemes despite the cultural diversity in communities. The governance structure of the schemes requires serious attention to the diverse social networks in the different communities in Uganda. The drive by Government of Uganda towards universal health coverage will continue to meet constraints especially with respect to integrating community health insurance governance and sustainability in the management of healthcare service delivery.

Provisions for social networks underpinned by diversity and homogeneity of communities be reflected in the law. The study exposes social cultural disparities inherent in the study population and recommends adoption of the Bull's Eye Community Health Insurance Governance Model which facilitates integration of communities in management of community health insurance.

Introduction

This study provides luminance to the legislative and knowledge gaps whose redress will be instrumental in facilitating the Government's drive towards universal health coverage. Community health insurance is one of the strategies for mitigating catastrophic health expenditures incurred by poor communities under the universal health coverage program (Chen *et al.* 2012). The stakeholder theory which has been widely used in health related studies to explain the roles of service users, service providers and policy makers in improving quality of healthcare was used in this study (Murdock, 2004). This study attempts to critically examine the existing regulatory mechanisms on community health insurance schemes governance in Uganda. The specific objectives of the study were; 1) to analyze the provisions of the Insurance

Act (2017) and how they facilitate or hinder sustainability of the schemes; 2) to examine the Draft National Health Insurance Bill (2017) and how its provisions were likely to hinder or support sustainability of community health insurance schemes.

Literature review

While the health insurance schemes provide different options to address gaps in healthcare financing, they have not spread out to all districts of Uganda, due to lack of supportive legislation and policies. As such, Basaza et al. (2013) noted that beneficiaries' premiums are insecure with community health insurance schemes in absence of a government regulated body for professional accreditation to ensure quality assurance and set standards for contract management systems across community health insurance schemes. Measures for community participation and ownership, equity in access, efficiency in operation of the schemes and the social objectives are currently not streamlined. This limits the ability to mobilize, enroll and retain beneficiaries which also affects the resource base, quality of healthcare services and sustainability of the schemes.

The Draft National Health Insurance Bill, (2017) is an attempt by the Government of Uganda to guide governance of the National Health Insurance schemes. However, it is deficient on governance of the community health insurance schemes yet they are expected to cover the informal sector which has majority of the population (UCBHFA, 2014). Studies have shown that enhancing accountability in health systems is progressively emphasized as vital for uplifting the type and quality of health services especially in developing economies (Cornwall et al. 2000; Atela et al. 2015). This position is echoed by several scholars (Alatinga and Fielmua, 2011; Basaza et al. 2007; De Allegri et al. 2005) who argue that unregulated community health insurance schemes suffer limited enrolment. This is partly contributed to by the minimal community involvement in decision making, governance of the schemes, adverse selection which progressively results into reduced repeat-enrolment and subsequently smaller risk pools and higher insurance costs. These combine to adversely impact on sustainability of the schemes.

Government regulatory mechanisms are essential in defining the power relations and as such help in creating and strengthening trust between the governance (Basaza et al. 2007; De Allegri et al. 2005; Alatinga and Fielmua, 2011) and communities to increase enrolment. As argued by different scholars (Atela, 2009; George, 2009; Atela et al. 2015), regulatory frameworks for community health insurance schemes would have the overall impact of increasing efficiency, sensitivity and responsiveness of health services. This is especially so in less developed nations where healthcare delivery structures and systems are under pressure to address the challenges of high disease burden amidst dwindling resource envelopes. The absence of clear policy and regulatory governance mechanisms leaves a lacuna for standards and affects quality of community health insurance services. This study will provide a critical perspective of the existing legal and policy frameworks and outline areas of improvement and remedies for strengthening operation of community health insurance schemes. This is in the perspective of fostering local accountability mechanisms which, as argued by George (2009) facilitate communities to meaningfully engage with health service providers.

Methodology

The research paradigm was underpinned by the interpretivistic philosophical orientation that sought to use qualitative data as the source of knowledge. The reason for using qualitative approach was based on the notion that community health insurance schemes' operations are context specific and cannot be generalized to the entire population (Basaza, O'Connell and Chapčáková, 2013; Schneider, 2005; De Allegri, Sanon and Sauerborn, 2006). The research adopted a cross-sectional explanatory case study design. The study sites were Kampala Capital City, Kanungu and Luwero districts. The choice of the study areas was informed by the existence of provider managed and community owned community health insurance schemes. These schemes have been operating in the two districts for over five years (Save for Health Uganda, 2016), thus providing sufficient ground for exploring the variables under study. Kampala Capital City was chosen because it is hosts head offices of the policy and decision makers. The target population included policy and decision makers as well as program implementers who were purposively sampled on the basis of their expert knowledge of legislation and operations of community health insurance schemes. A total of 16 key informants were interviewed. Data quality control involved ensuring acceptable levels of reliability and validity of the study. These two concepts are rooted in positivist perspective but have been redefined for application in the naturalistic (interpretive) paradigm (Golafshani, 2003) under which this study was premised. The study tools were field pre-tested and reviewed for flow of content so that they generate the desired information (Johnson, Onwuegbuzie and Turner, 2007). Analysis of data entailed assignment of data codes to emerging themes as they unfolded (Golafshani, 2003). Themes and sub themes were identified and built upon during analysis and discussion. The universal ethical standards were adhered to throughout the entire research process. Informed consent procedures and standards for confidential data management were complied with.

Findings and discussions

This section presents and discusses the findings simultaneously considering that the study collected qualitative data that enables seamlessly flow in prose.

Uganda's policy and legislative frameworks on Community Health Insurance Schemes

A number of legal, policy and program documents provide for the establishment of universal health coverage under which community health insurance schemes fall. The 1995 Constitution of the Republic of Uganda under part XIV on general social and economic objectives provides for the State to fulfill the fundamental rights of all Ugandans to social justice and economic development. In particular, it states the Government's obligation to ensure that all Ugandans enjoy their right to access health services. The 1995 Constitution of the Republic of Uganda provides for the State to take all practical measures to ensure the provision of basic medical services to the population in section XX on Medical services under Social and Economic Objectives in the National Objectives and Directive Principles of State Policy. This is operationalized under the Second National Health Policy (2010) where one of the Policy strategies states that Government shall "establish overall adjusted health financing mechanisms

based on pre-payment and financial risk pooling aiming at universal coverage and social health protection. These shall include national health insurance and other community health financing mechanisms". This provision addresses national health insurance and other community health financing mechanisms. Community Health Insurance schemes fall under the latter.

The Uganda Vision 2040 highlights the importance of co-financing for health by adopting the universal health insurance system through public-private partnerships. The Second National Development (2015) further states that the health sector will work towards achieving Universal Health Coverage through establishing a national health insurance scheme. In the absence of the National Health Insurance Act as the governance and regulatory framework (The Draft National Health Insurance Bill has been gazetted), the Insurance Regulatory Authority of Uganda regulates all health insurance activities in the country. The Authority was established under the Insurance Act, Cap 213 with the main objective of ensuring effective administration, supervision, regulation and control of the business of insurance in Uganda. This was consequent to Government's adoption of the liberalization and privatization policies which ended its role of directly engaging in the provision of goods and services and taking on the role of supervisor or regulator. Against this background, we analyze the specific legislation that regulates the operations of health insurance with the view of identifying gaps related to governance of community health insurance schemes in Uganda.

The Ministry of Health derives its mandate from the Constitution of the Republic of Uganda (1995) and is responsible for implementing healthcare interventions in the country. Investment in the promotion of people's health ensures that they remain productive and contribute to national development. The Uganda Health Accounts, National Health Expenditure Financial Years 2014/15 and 2015/16 indicate that health services are provided by the public and private sub-sectdor with the latter contributing about 43.4%. The Ministry of Health established a formal mutually supportive partnership with Uganda Protestant Medical Bureau towards realizing the Health Sector Development Plan goal of accelerating movement towards Universal Health Coverage with essential health and related services needed for promotion of a healthy and productive life (MoH, 2015). It is through this partnership and the desire to realize Universal Health Coverage that the community health insurance scheme under Bwindi Community Hospital was premised.

As a stakeholder, Ministry of Health is responsible for among others, policy formulation, regulation, advising, setting standards and quality assurance, capacity development and technical support, and evaluation of the overall sector performance. These responsibilities directly relate to the power and influence exerted on the community health insurance schemes with respect to health service quality and quantity provided to communities. Attention is now focused on the specific legislation related to community health insurance schemes.

The Insurance Act, (2017)

The Insurance Act, (Uganda, 2017) established the Insurance Regulatory Authority of Uganda whose objectives are (a) to promote and facilitate the maintenance of a sound, efficient, fair, transparent and stable insurance sector; (b) to promote and uphold public confidence in the insurance sector; (c) to protect the interests of persons who are, or who may become, policy

holders of insurers or customers of other licensees; (d) to regulate and supervise licensees on a risk-sensitive basis; (e) to promote effective competition in the insurance sector in the interests of consumers, the growth and development of the insurance sector and the development of an inclusive insurance sector. Indeed these objectives provide a strong basis for operationalizing the community health insurance schemes in general sense. It is however, notable that the thrust of the Insurance Regulatory Authority is on Social Health Insurance Scheme that covers public servants and formal employees in the private sector as well as the Private Commercial Insurance scheme. This omission has hitherto left community health insurance schemes to operate with minimal regulation and without streamlined governance and management standards as elaborated by one of the key informants:

> The Insurance Regulatory Authority tends to focus on Social Health Insurance Scheme where public servants and the private sector formal employees plus the Private Commercial Insurance scheme which are more vibrant. Community Health Insurance schemes by nature of their focus on rural populations present as very challenging to regulate given the big number of informal community groups (MoH official).

The limited legislative focus on community health insurance schemes by the Insurance Act (2017) lends credence to our earlier assertion (Basaza, O'Connell and Chapčáková, 2013) that beneficiaries' premiums are not protected in absence of clear legal frameworks. The multiplicity of community health insurance schemes without clear governance and leadership structures have adversely impacted on their performance. Some schemes had closed out while the functional ones continue to experience low enrolment. It is our contention that in the absence of Government regulated professional accreditation body to ensure quality services under community health insurance schemes, it will be a tall order to sustain them. In addition, the weak regulatory mechanisms have left the schemes without universal legal redress mechanism and contract management systems, prompting each scheme to devise its own. The example of the stakeholder relations and power play in the Save for Health Uganda supported schemes in Luwero and eQuality health insurance schemes run by Bwindi Community Hospital in Kanungu district which are not streamlined provides further insight into the regulatory dilemma. Another key informant stated thus;

> Regulating community health insurance schemes is actually the function of Insurance Regulatory Authority. Although we are mandated to work together with Ministry of Health in regulating these schemes, our hands are tied with respect to resources, technical expertise and the diversely spread community groups. A more specific law is necessary to further streamline the management and leadership structures of the schemes. I am hopeful that the Draft National Health Insurance Scheme Bill and its regulations thereof if passed will make good these gaps. (Official from Insurance Regulatory Authority)

The lack of sufficient research literature on regulatory frameworks for community health insurance schemes has created a gap in streamlining them. Given their informal operational modalities, the social dynamics involved and the context specific environment in the communities where they exist, there has been more focus on the other more organized schemes.

The Insurance Regulatory Authority is supposed to work in partnership with the Ministry of Health to regulate these schemes but lack the requisite resources in terms of finances and human resources skilled in this area. But this requires a specific legislation to back their mandate. Its absence has further constrained resource allocation to facilitate effective monitoring of performance of community health insurance schemes.

In fact, community health insurance schemes are supported by social networks (Lovell, 2002). In the Ugandan context, Health Insurance a social factor that transcends the Ministry of Health and the Insurance Regulatory Authority to include the Ministry of Gender, Labour and Social Development considering that the continuity of community health insurance schemes is based on trust and social networks in addition to finance. The voluntary nature of joining community health insurance schemes gives the community lee way not to join yet this is one of the key strategies to address the financing gaps in heath care service provision. The limited enrolment in community health insurance schemes is attributable to lack of supportive legislation that would enable enforcement of mandatory registration.

Gaps in the Insurance Act

The Insurance Act (Uganda, 2017) provides for the functions of the Authority under section 12 which specifically aim to: (Sub section a) to regulate, supervise, monitor and control the insurance sector; (Sub section O); promote awareness of, and undertake public education concerning, the insurance sector; and (Sub section b) to establish standards for the conduct of business in the insurance sector and to issue such guidance as it considers appropriate. However, there is an apparent void on how these provisions are applied to community health insurance schemes. It is our thesis that the schemes' governance and management have been left in the hands of those whose epistemic influence to drive the agenda is minimal, to the disadvantage of the target beneficiaries at community level.

We further contend that the existence of multiple and complex configurations of social network arithmetics under which the different schemes operate take precedence over formal governance procedures to which the laws and regulations must conform. In Uganda, few if any of the community health insurance schemes would resonate with the provisions of the Insurance Act (2017) considering the high standards set in terms of qualifications of the scheme governing boards. The Law provides for a governance framework under section (58) which requires that every insurer and Health Membership Organization shall establish and maintain an appropriate governance and management framework. Subsection (3) states that the governance and management framework shall provide for the apportionment of roles between shareholders, directors, senior management and key persons in control functions. We thus contend that these legal frameworks notwithstanding, the current governance practices in both the provider, and community initiated and managed schemes falls short of these provisions. This is on account of the voluntary nature of operations and the fact that the governance committee members do not have the requisite educational levels necessary to comprehend the complexities inherent with the insurance business. The gaps in the legal frameworks debunk the weak local accountability mechanisms and epistemic influence that would enable beneficiary communities to meaningfully engage other stakeholders in managing the schemes

(Smudde and Jeffrey, 2011). It is our considered opinion that even with the provisions of the legal frameworks, the concept of social networks should be an integral part of the community health insurance scheme leadership to sustain the ground on which the organically formed health insurance groups are premised.

Setting premiums

The Insurance Regulatory Authority under section 64 of the Insurance Act (2017) is supposed to approve premium and commission rates. It prohibits the insurer or Health Membership Organisation to issue any policy of insurance if the premium rates and commission rates contravene any regulations made by the Authority under subsection (2). Furthermore, the Authority may prescribe minimum premium or maximum commission rates for any class or type of insurance business. In fact, applying these provisions will definitely undermine the spirit under which communities come together to form community health insurance schemes. The high poverty levels and catastrophic health expenditure that the schemes are supposed to mitigate cannot facilitate issuance of regulated premiums. This is on account of the different poverty indices in the regions of the country. For example, the Eastern region of Uganda has high levels of poverty estimated at 42% compared to 19.1% in the west (Uganda Bureau of Statistics, 2014) and as such the premium levied for this region cannot be comparable to the western region with lower poverty indices.

It is our contention that setting minimum premium for community health insurance schemes across the country would require considering regions with the highest poverty levels as bench marks. This would address health equity issues which have been defined as the lack of logical disparities in health between social groups with divergent social economic dispositions (Kotoh, Aryeetey and Van der Geest, 2017). We further aver that the need for Government to set up the minimum and maximum ranges of premiums cannot be overemphasized. This will provide for some level of elasticity within which premiums can be fixed to integrate all levels of social economic variations in the different communities across the country. This position is underpinned by our earlier understanding that community health insurance schemes generate much of their premiums from enroled members and to some extent from external funding by development partners (UCBHFA, 2014). The latter is usually not very reliable hence the need to focus on the more sustainable community sources of funding.

The Draft National Health Insurance Bill, (2017)

Government of Uganda is in the process of enacting a law for National Health Insurance Scheme. This Law provides for pre-payment and financial risk pooling aimed at universal coverage and social health protection (MoH, 2015; MoH, 2013). While it may not be appropriate to discuss the provisions of the draft Bill before it comes into law, it is important to highlight some salient gaps which might contribute to low enrolment. The purpose of pooling resources for health financing is to make funding available, as well as to set the right financial incentives for healthcare service providers. This would ensure that all individuals have access to effective public health and personal healthcare irrespective of their social economic differentials (Orem and Zikusooka, 2010). The draft Bill does not provide for compulsory

enrolment yet it is evident that without additional funding through health insurance, it will remain a tall order for Government to equitably address the healthcare access disparities in the country as noted infra;

> Joining community health insurance schemes is voluntary in nature; there are no legal provisions for forced enrolment where the provisions of the law on insurance can be effectively applied. It is important that the proposed Draft National Health Insurance Bill includes provisions for mandatory enrolment for all adults. (Program Officer of an IO)

Mandatory enrolment into community health insurance schemes has been recommended by scholars as long as it is accompanied with quality health services. It has been noted that in some countries like Ghana where every citizen is enjoined to being to one form of health insurance, cases of out of pocket expenditures still occur because the quality of services in the designated health facilities are poor. This supports the observation that compulsory or voluntary informal payment is a barrier to healthcare access for poor families. For example, about 25% of healthcare users in Ghana pay illegal fees to public health providers (Kotoh, Aryeetey and Van der Geest, 2017). While this observation may be correct, we contend that the basic principle for compulsory enrolment boarders more on ensuring equity in access to healthcare and the failures in ensuring provision of quality healthcare services by Government agencies cannot independently negate the good intentions of compulsory enrolment.

Community health insurance schemes are mutual solidarity groups built around the concept of trust and reciprocity characterized by common social expectations (Katia et al. 2012; De Allegri, Sanon and Sauerborn, 2006). Given the diversities in the Uganda society, it is unlikely to have the same governance mechanisms for community insurance schemes. This means that the law should provide for alternative schemes that accommodate the social diversities as noted hereunder;

> The focus of the community health insurance scheme leadership is based on trust and social networks rather than the provision of the Law. In fact, if you go by the provisions of the Law, it is very likely that community trust will be undermined and this will affect the levels of enrolment which are already low" (Program Officer from an implementing organization)

If trust, as argued by different scholars is important for sustainability of community health insurance schemes (Katz, 2018; Chen et al. 2012), then it should resonate with the legal provisions. The implications are that the concepts of mutual reciprocity should have presence in the laws regulating community health insurance schemes in order to sustain the social fabric that binds communities. We thus present that this will promote community ownership of these schemes even in situations of compulsory enrolment.

Salient provisions of the National Health Insurance Bill

Uganda's Proposed National Health Insurance Scheme Clause 6(k) of the National Health Insurance Bill provides for the establishment of community health insurance schemes. These are intended to cover persons who do not qualify as members of the National Health Insurance

Scheme by virtue of not being either public servants or employees making National Social Security Fund contributions. The broad objective of the National Health Insurance Bill is to provide for the establishment of the National Health Insurance Scheme and its functions. Accordingly, it will enable among other things the establishment of the Scheme's Board, outlining its composition, functions and powers as well as provide for staffing and funding. The Bill will further provide for registration of contributors and their beneficiaries; the articulation of benefits available under the scheme; the creation of an accreditation committee to review prospective healthcare providers and their service and payment agreements. Other provisions include the regional health insurance offices and an Appeals tribunal to hear disputes arising from the implementation of the Bill.

One salient omission of the Bill is how community health insurance schemes will integrate the different perspectives of social networks in the leadership structures and regulatory mechanisms. It is our contention that the provisions for the National Health Insurance Scheme governance give more focus to the national, regional and district levels and do not in any way address the divergent social networks that impact on enrolment and sustainability of the schemes (Basaza, O'Connell and Chapčáková, 2013). Furthermore, the Bill is not very clear about communities in the informal sector who constitute 43 percent of gross domestic product and employs about 90% of the total non-farm private workers (Government of Uganda, 2015). It is therefore pertinent to make adequate provision for the informal sector as a significant proportion of Uganda's economy is dependent on this sector. The Bill presumes that the informal sector implies and includes all members who are not public servants, members of the National Social Security Fund or indigent persons. Clause 8 provides that whoever is not a beneficiary of the National Health Insurance Scheme under clause 5 shall be registered under the community health insurance. We thus note that Clause 8 of the Bill which provides for the informal-sector population is elaborated in the regulations. The regulations should be able to detail out how the community health insurance schemes will be organized, their mode of operation and generally how social networks mechanisms will be integrated.

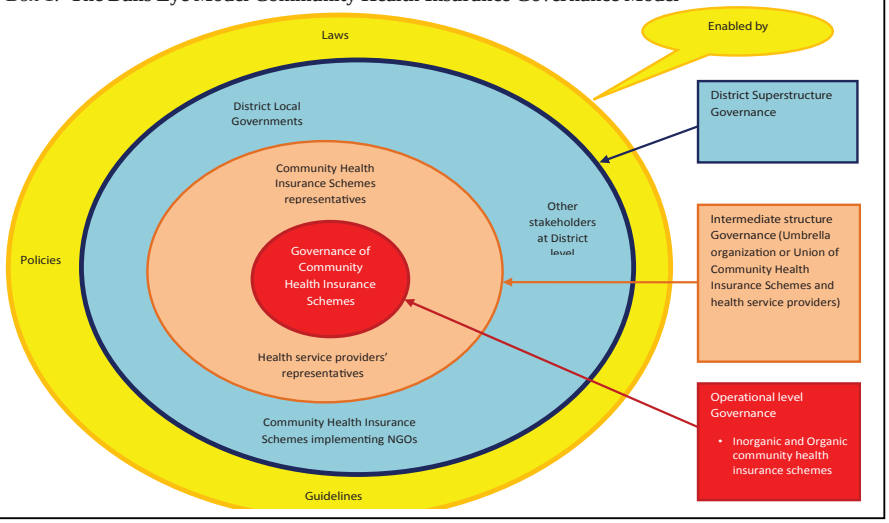
Governance of community health insurance schemes under the National Health Insurance Bill

The study findings showed that the current policies and legislation including the proposed National Health Insurance Bill (2017) do not adequately address governance of the schemes within the premises of diversity and homogeneity in various communities. The drive by Government of Uganda towards Universal Health Coverage will continue to meet constraints especially with respect to integrating community health insurance. The Bill lacks provisions that would facilitate addressing issues of social networks which are underpinned by diversity and homogeneity of communities. These would have a strong anchor upon which social networks are premised in operationalizing the law. It will also ensure that the poor and vulnerable populations who bear the brunt of disease burden and catastrophic healthcare expenditures are included in the drive towards Universal Health Coverage. Furthermore, a model that integrates community health insurance governance into the proposed National Health Insurance Bill will help in addressing the current legal gaps in the relationships among stakeholders involved in running the schemes. For example, the current health insurance legal regime does not define

the relationship between the formally registered nongovernmental organizations, healthcare service providers and the mainly unregistered community health insurance schemes. As such, the current information asymmetry in favour of the registered nongovernmental organizations and health service providers, and the effects of bounded rationality on the less knowledgeable community insurance schemes has continued to abound. Perhaps this partly explains why enrolment into community insurance schemes has remained low despite the benefits therein. This raises pertinent concerns on the processes of dispute resolution and definitely impacts on the levels trust within these stakeholders.

The Bull's Eye Community Health Insurance Governance Model

Box 1: **The Bulls Eye Model Community Health Insurance Governance Model**



In order to address the governance gaps identified in the proposed National Health Insurance Bill, we propose the Bull's Eye Model (Box 1). To elaborate on the model, the inner ring or what we shall term as the Bull's Eye represents the operational level governance structure for both organically and inorganically formed community health insurance groups. This is irrespective of whether the schemes are provider or community initiated and managed. As discussed before, the composition of governance structures for the different community health insurance schemes influences the cohesion mechanisms and levels of trust in view of enrolment levels and sustainability of operations (Ding and Liu, 2011; Katz, Lazer, Arrow and Noshir 2004). This model indicates that no uniform governance mechanism can be prescribed across the board. The need for guidelines that provide for integrating social networks in the governance modalities based on whether the schemes were organically of inorganically formed cannot be overemphasized.

The second ring is constituted by an intermediate governance structure of an umbrella organization or union of schemes and health service providers. This structure will bring together all community health insurance schemes and health service provider on a common platform through which negotiations on premiums and benefit packages will be held. Additionally, stakeholder power imbalances as well as epistemic influences shall be discussed (Gatsos, 2015). This governance structure will facilitate trust building between the healthcare

service providers and community health insurance groups. Trust building will be premised on meaningful representation and participation of different stakeholders as shall be regulated by supportive legal frameworks. Umbrella organizations will have their own secretariat of technical staff responsible for management of the health insurance schemes. Its composition will be constituted by the respective district local government councils to which it will be held accountable on behalf of communities. Its additional function will be community mobilization as well as building governance and management capacities of community health insurance schemes.

The third ring represents the district superstructure governance which will be composed of representatives of community health insurance schemes implementing Nongovernmental Organizations (NGO), district local governments and other stakeholders working on health insurance at district level. This forum will provide for higher level technical and political support to the intermediate governance structure. It will further provide legislative and advocacy support for the promotion of the schemes. This governance structure in collaboration with the other aforementioned will be instrumental in lending legitimacy and credibility to the schemes as well as being one of the trust building structures (Karlijn and Peter, 2011; Katia et al. 2012).

The outer ring of the Bull's Eye contains the key factors that facilitate effective governance of community health insurance schemes. As posited by Michael, (2016), good governance requires backing by enabling legislation in order to promote accountability and transparency as well as legitimacy and support by citizens through meaning participation. It was earlier noted that the current legislative frameworks do not sufficiently support governance and functionality of community health insurance schemes which has hitherto curtailed their ability to increase on enrolment (Basaza et al. 2010). In this respect, operationalization of the "Bull's Eye Governance Model" will require the supportive legal frameworks in order to realize the role the schemes play in mitigating out of pocket expenditures for healthcare.

Conclusion

The study has significant health financing policy utility to the Government of Uganda, Development Partners, Researchers, Academicians and Managers of community health insurance schemes in informing policy review under the National Health Insurance program. This study has established that the current policies and legislation do not adequately address governance of community health insurance schemes. Against this background, it will be very challenging to sustainably run the schemes without sufficient provisions in legislation and policies. The provisions of the National Health Insurance Bill only serve to offer technocratic solutions to a more sophisticated societal issue with respect to social networks that drive group formation upon which community health insurance schemes are founded. In its current form, we posit that the proposed National Health Insurance Bill does not make sufficient provisions for sustainability of community health insurance governance mechanisms. Consequently, the overall effects will be felt at community level especially where trust building structures and social networks are weak. This will definitely affect the levels of enrolment which ultimately impacts on sustainability of the schemes. It is therefore imperative that a model that integrates components of community level governance and sustainability provisions be integrated in the

proposed Bill in order to make the schemes more viable. Equally, the leadership mechanisms adopted by the different community health insurance scheme structures further pose challenges of standardization across the country. The notion of prescriptive legislation based on standard leadership structures and mechanisms may not promote people's participation. It is our thesis that the manner in which the different stakeholders are regulated and how the schemes are governed determine institutional sustainability. Regulating these forces will definitely enhance the drive towards streamlining community health insurance schemes as viable entities for realization of universal health coverage in Uganda.

Recommendations

The study makes a proposition for review of supportive policies to community health insurance schemes to address significant lapses especially on the governance perspective. The process of policy reviews on the national Health Insurance Bill should integrate the societal diversities as a background variable for leadership of community health insurance. We further recommend legislation for establishing compulsory community insurance schemes but allowing for flexibility to integrate the social cultural disparities inherent in the different populations. This will ensure that every citizen is enroled under the different types of health insurance and also foster enrolment and sustainability. This study further proposes the "Bull's Eye Governance Model" for community health insurance as a practical framework for streamlining governance and enhancing trust building mechanisms within district local governments. However, the framework will require supportive legal backing to have optimal effects.

References

Alatinga, K., and Fielmua, N. (2011). The impact of mutual health insurance scheme on access and quality of healthcare in northern Ghana: The case of Kassena-Nankana east scheme'. *Journal of Sustainable Development,* 4(5), 125–138.

Atela, M. (2009). *Health System Accountability and Participation in Sub-Saharan Africa: a review of the Literature*. Amsterdam: KIT - Royal Tropical Institute, Development Policy and Practice.

Atela, M., Bakibinga, P., & Ettarh, R. (2015). Strengthening health system governance using health facility service charters: a mixed methods assessment of community experiences and perceptions in a district in Kenya. *BMC Health Serv Res 15*(539). https://doi.org/10.1186/s12913-015-1204-6

Basaza, R.K., O'Connell, T.S. & Chapčáková, I. (2013). Players and processes behind the national health insurance scheme: a case study of Uganda. *BMC Health Serv Res. 13*(357). https://doi.org/10.1186/1472-6963-13-357.

Basaza, R., Criel, B. & Van der Stuyft, P. (2007). Low enrolment in Ugandan Community Health Insurance Schemes: underlying causes and policy implications. *BMC Health Serv Res 79*(105). https://doi.org/10.1186/1472-6963-7-105

Basaza, RK., Criel, B., & Van der Stuyft, P. (2010). Community health insurance amidst abolition of user fees in Uganda: the view from policy makers and health service managers. *BMC Health Services Research 10*(33*)*. https://doi.org/10.1186/1472-6963-10-33

Chen, Y., Xiao-Ping, C., & Portnoy, R. (2009). To whom do positive norm and negative norm of reciprocity apply? Effects of inequitable offer, relationship, and relational-self orientation. *Journal of Experimental Social Psychology*, *45*(1), 24-34

Cornwall, A., Lucas, H., and Pasteur, K. (2000). Introduction: accountability through participation: developing workable partnership models in the health sector. *IDS Bulletin*, *31*(1), 1-13.

De Allegri, M., Sanon, M., Bridges, J., & Sauerborn, R. (2006). Understanding consumers' preferences and decision to enroll in community-based health insurance in rural West Africa. *Health Policy*, *76*(1):58–71.

De Allegri, M., Sanon. M., and Sauerborn, R. (2005). To enrol or not to enrol? A qualitative investigation of demand for health insurance in rural West Africa. *Social Science and Medicine*, 62(6), 1520–1527.

Ding, R., and Liu, F. (2011). A Social Network Theory of Stakeholders in China's Project Governance. *iBusiness*, *3*(2), 114-122. doi: 10.4236/ib.2011.32017.

Gatsos, D. D. (2015). *Exploring the Significance of Social Influences on Epistemic Beliefs.* (PhD Dissertation, University of Kentucky, USA). Retrieved from: https://uknowledge.uky.edu/epe_etds/30

George, A. (2009). By papers and pens, you can only do so much: views about accountability and human resource management from Indian Government health administrators and workers. *The International Journal of Health Planning and Management.* 24, 205-224.

Golafshani, N. (2003). Understanding Reliability and Validity in Qualitative Research. *The Qualitative Report*, 8(4), 597-606.

Government of Uganda. (2015). *The Second National Development Plan (NDPII) 2015/16 – 2019/2021*. Kampala. GoU

Government of Uganda. (2017). *The National Health Insurance Scheme Bill*. Kampala: GoU.

Johnson, R., & Onwuegbuzie, A. (2004). Mixed methods research: a research paradigm whose time has come. Educational Researcher, 33, *14 - 26.*

Karlijn, M., and Peter, G. (2011, November). *Informal trust building factors and the demand for micro insurance*. Paper presented to the 7th Annual International Micro insurance Conference, Rio de Janeiro.

Katia, C., Ramona, D., Przybyl, A., and Nicholas, F. (2012). *Trust, community-based health insurance and enrollment rates.* Geneva: World Health Statistics WHO.

Katz, N., Lazer, D., Arrow, H., and Noshir, C. (2004). Network theory and small groups. *Small group research*, 35 (3), 307-332. doi:10.1177/1046496404264941

Kotoh, A. M., Aryeetey, G. C., and Van der Geest, S. (2017). Factors that influence enrolment and retention in Ghana' National Health Insurance Scheme. *Int J Health Policy Manag*, 7(5), 443–454.

Lovell, A. M. (2002). Risking Risk: The influence of types of capital and social networks on the injection practices of drug users. *Social Science and Medicine, 55*(5), 803-821.

Michael, J. (2004). *Good Governance: Rule of Law, Transparency, and Accountability*. New York: Colgate University.

Retrieved from: http://unpan1.un.org/intradoc/groups/public/documents/un/unpan010193

Ministry of Health. (2013). *Uganda health accounts report* 2010/11-2011/12, Kampala, Uganda

Ministry of Health. (2015). *Health Sector Development Plan 2015/16 - 2019/20*. Kampala, Uganda, Ministry of Health.

Murdock, A. (2004). Stakeholder Theory, Partnerships and Alliances in the Healthcare Sector of the UK and Scotland. *Research in Public Policy Analysis and Management 5*(1), 85-104. DOI: 10.1016/S0723-1318(04)13004-1

Orem, J. N., & Zikusooka, C. M. (2010). Health financing reform in Uganda: How equitable is the proposed National Health Insurance scheme? *International Journal for Equity in Health*, 9 (23),1-8.

Save For Health Uganda. (2016). *The first Ugandan national community health financing conference.* Kampala: Save for Health Uganda.

Schneider, P. (2005). Trust in micro-health insurance: an exploratory study in Rwanda. *Social Science and Medicine, 61*(7), 1430–1438.

Smudde, P., and Jeffrey, C. (2011). A holistic approach to stakeholder management: a rhetorical foundation. *Fuel and Energy Abstracts,* 37: 137-144.

Uganda Bureau of Statistics, (UBOS) (2014). *National Population and Housing Census 2014.* Kampala, Uganda.

Uganda Community Based Health Financing Association (UCBHFA). (2014). *Community Health Insurance - a vital sub scheme of the National Health Insurance.* Position paper presented to the Ministry of Health, Kampala, Uganda