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**Providing for Health (P4H) is an initiative established and mandated to implement decisions taken by the G8 Summit 2007 in support of strengthening social health protection. ILO is a core partner of the P4H Initiative.**

**The following report was developed by a team of representatives of P4H partners upon request of the Government of Uganda. The report is currently formally tabled to Interministerial Committee (Ministers of State for Health, Labour, Finance and Planning and Public Service) for adoption.**

# Republic of Uganda



## **The proposed National Health Insurance Scheme and promotion of Social Health Protection in Uganda**

### **Final Report of a visit<sup>1</sup> of P4H Partners 4 to 14 August 2009**

March 2010

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## **List of abbreviations**

ACT	Artemisinin based combination therapy
AIDS	Acquired Immune Deficiency Syndrome
ARI	Acute Respiratory Infection
ARV	Anti Retro-Viral drugs
CHAI	Community led HIV AIDS Initiative
CHI	Community Health Insurance
CMI	Community Medical Insurance
DAH	Development Assistance for Health
DFID	Department for International Development
DRC	Democratic Republic of Congo
DRG	Diagnosis Related Group
FFS	Fee for service
GAVI	Global Alliance Vaccine Initiative
GDP	Gross Domestic Product
GFATM	Global Fund for AIDS, TB & Malaria
GOU	Government of The Republic of Uganda
HIV	Human Immunodeficiency Virus
HMO	Health Maintenance Organization
HSSP	Health Sector Strategic Plan
ICT	Information & Communication Technology
IEC	Information & Education Campaign
IHP+	International Health Partnership and related initiatives
ILO	International Labour Organisation
IMR	Infant Mortality Rate
ITN	Insecticide-treated bed nets
LIC	Low Income Country
LRA	Lord's Resistance Army
LTFQ	Less than fully qualified practitioner
MDGs	Millennium Development Goals
MIC	Middle Income Country
MOFPED	Ministry of Finance, Planning and Economic Development
MOGLSD	Ministry of Gender, Labor and Social Development
MOH	Ministry of Health
NDP	National Development Plan
NHIS	National Health Insurance Scheme
NUSAF	Northern Uganda Social Action Fund
OOP	Out-Of-Pocket Payment
OVC	Orphans and Vulnerable Children
P4H	Providing for Health Initiative
PEAP	Poverty Eradication Action Plan
PHC	Primary Health Care
PPA	Participatory Poverty Assessment
PWD	People With Disabilities
SHI	Social Health Insurance
SHP	Social Health Protection
SP	Social Protection
SWAp	Sector Wide Approach
TA	Technical Assistance
TCMP	Traditional and complementary medicine practitioners
TF or TFHI	Task Force on Health Insurance
THE	Total Health Expenditure
TOR	Terms of reference

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UC	Universal coverage
UCBHFA	Uganda Community Based Health Financing Association
UDHS	Uganda Demographic and Health Survey
UGX	Uganda Shilling
UJAS	Uganda Joint Assistance Strategy
UNDP	United Nations Development Program
UNHS	Uganda National Household Survey
UPE	Universal public education
USAID	United States Agency for International Development
USD	United States Dollar
WHO	World Health Organization

## **Executive Summary**

The Government of Uganda (GOU) wants to extend access to good quality, accessible, equitable and affordable health care to all Ugandan citizens and residents by mobilizing additional resources through a contribution-based national health insurance scheme (NHIS) as a complementary mechanism of health care financing.

To achieve this objective, the Ministry of Health of Uganda has requested the technical support of the Providing for Health (P4H) initiative. A team of representatives of P4H partners and their consultants has therefore visited Uganda from 4 to 14 August 2009 and has reviewed and discussed the current proposals and developments to date vis-à-vis the NHIS.

This report provides the observations of the review team and its recommendations and proposals for next steps. The team has based its observations on principles of social health protection (SHP) and universal coverage, which are to a great extent similar to the objectives of the GOU, especially as regards to equity in access to care for all, including the poor, preventing impoverishment due to high costs for necessary health services and fairness in financing of the health sector.

Comments of the task Force on Health Insurance were received shortly before a P4H team has made a follow up visit in February 2010 to discuss further actions as well as to explore the presented options more in-depth. The comments of the Task Force and a reply of the P4H team are annexed to this report and they are also taken into account in the revision of the draft of 7 October 2009. The February 2010 visit has led to a separate report, submitted to the Uganda Ministry of Health.

The review team noted that MOH has already made substantial progress in preparing for the NHIS, including technical arrangements, the drafting of a National Health Insurance Bill and establishing a process of involving selected stakeholders and in sensitizing the population about its NHIS plans and their significance. The P4H team would like to commend MOH for its tremendous efforts in this difficult endeavor.

### ***Main observations with regards to the NHIS***

The proposals and the draft Bill aim at achieving social health protection in Uganda. However, a further analysis of their implementation plans and trajectory has left the P4H team with the impression that the proposed NHIS in its current form may unintentionally introduce some serious risks in the process of attaining social health protection/universal coverage if the GOU/MOH plans go ahead unchanged, due to the following reasons:

- The poor may be worse off after the implementation of the current proposal because of the relative shift in financial and limited human resources to the insured population, while the inclusion of the poor in the NHIS is not secured, despite good intentions of the MOH.
- At the same time, the proposed package of benefits may not be sustainable without additional funds if the NHIS is extended to the whole population.
- The already limited efficiency of the health sector may be further lowered due to the creation of a parallel funds flow, the absence of increased pooling of funds and the increase in administration costs.

- A chance is missed to create a unified scheme to act as a strong purchaser, which could use its clout for selective contracting of efficient quality health care services of public and private providers.

The report of the P4H team provides detailed observations on the proposal, taking into account the existing health care system and the country's fiscal space. It highlights some alternative options for achieving social health protection, proposes to improve the process of consultation with the Ministry of Gender, Labour and Social Protection, the Ministry of Finance and other stakeholders, besides offering detailed comments on the draft NHI Bill and on the organizational aspects of the proposed NHIS.

After an introduction, the report continues with a broad assessment of issues related to the status of SHP in Uganda. Subsequently, attention is given to the development of social health protection in Uganda, followed by comments on the technical and organizational aspect of the proposed NHIS, the financial, quality assurance and legal aspects. Then alternative options are provided with their pros and cons, and implementation items and constraints are highlighted, ending the report with conclusions and recommendations. In the annexes, extensive comments and advice are provided on the draft NHI Bill. A separate annex is available with comments on the draft bill the margins and with textual revision in track changes mode.

### ***Alternative options***

The options to be considered are:

- Multiple options under a single insurer
- Beginning SHI with the Informal Sector and the Poor, using the increased budget
- Free care in different format
- Expanding the budget funded scheme and over time moving to NHIS
- Big bang, transferring all budgetary resources for curative care to the NHIS and add the revenues from contribution

These options need to be further discussed with the MOH and GOU.

### ***Recommendations***

The main recommendations of the P4H team are:

1. To include social **health** protection in the overall government strategy on social protection. To reconsider the current proposal and the draft NHI bill and to engage in further discussion and review of alternative options as suggested in this report in order to advance social health protection.
2. To strengthen the process of engagement and dialogue with stakeholders, including improved inter-ministerial coordination within the Government itself.
3. To organize guided public debates on advantages and disadvantages of various financing options outlined in this report.
4. To revise the draft Health Insurance Bill, taking into account the comments and revisions proposed by the P4H team.
5. To align and harmonize the NHI Bill revision process with ongoing policy and strategy development in the health sector, as well as the social protection framework process.



6. To separate the development of an accreditation system from health financing reform and create an independent accreditation system as part of a systemic quality assurance system/framework for the health sector applicable to all health facilities irrespective of the way they are being paid, i.e. via health insurance.
7. To start capacity building for health financing reform implementation at national and sub-national levels as soon as the directions of the reform are clear.
8. To consider the introduction of a purchaser-provider split, create greater autonomy of public health care institutions and develop capacity for effective purchasing of health services, including the development of a system of contracting of providers.
9. To clearly formulate the role, if any, of a community based health financing system under the NHIS after carefully assessing its potential (resource mobilization, risk pooling and purchasing).
10. To carefully choose the systems of provider payments that allow for cost-containment and quality assurance even while staying within the overall available budget envelope.
11. To coordinate via the Cabinet of Ministers that MOH and NSSF plans for health/medical insurance are well aligned, coordinated and unified, i.e. to prevent further fragmentation of the health care funding system, while NSSF could play a useful role in the collection of contributions.

***The P4H partners are very much looking forward to engage in further dialogue with the GOU and offer their support to achieve social health protection and would welcome a reaction of GOU/MOH as to further such dialogue.***

## **I. Introduction**

### **1. General**

From 4 to 14 August, 2009, a delegation of partners of the P4H Initiative and selected consultants visited Kampala on the invitation of the Uganda Ministry of Health (MOH) to work together with officials and staff of the Ministry on the promotion of Social Health Protection. The visit was excellently organized by the MOH with support from the Uganda Country Office of the World Health Organization (WHO) and the P4H coordination team at WHO Geneva. The visiting team has greatly appreciated the hospitality of MOH and the WHO Uganda Office.

The visit has been well timed with a health financing review mission of a WHO health financing team with which the P4H delegation has cooperated. The information from this health financing review will provide valuable information in a timely way to feed into the upcoming development of a health care financing strategy and the creation of a social health protection system and will help in setting the baseline for the evaluation of health policies.

Meetings were held with officials and staff of the MOH, the Ministry of Finance (MOF), the Ministry of Gender, Labor and Social Protection (MOGLSP), social partners, members of the Task Force on Health Insurance (TFHI) and with stakeholders and national health insurance and health financing experts. The list of persons met is attached as Annex 1. The team visited the District Referral Hospital in Jinja Town and

the private ward of Mulago Hospital in Kampala. The Schedule of Meetings is attached as Annex 2.

The main observations and recommendations of the team and the proposed next steps are summarized hereafter. They were briefly presented as observations and questions raised during a debriefing meeting with the leadership and management of the Ministry of Health and the Task Force on Health Insurance.

## **2. Background and reasons for cooperation**

Uganda's draft national health policy (2010-2020) acknowledges the existence of significant gaps in health care provision and financing and calls for the delivery of a minimum health care package, optimum provision and allocation of health resources, strengthening public and private partnerships for health and strengthening of district health systems. Accordingly, the government of the Republic of Uganda is in the process of reviewing its health financing policy and designing a National Health Insurance Scheme (NHIS).

### **P4H invited**

P4H was contacted by the Ugandan Director General of Health Services to assist the Ugandan health sector to carry out further preparatory work in designing of the NHIS. Subsequently, a P4H team visited Uganda during 15-18 June 2009 and held discussions on the draft National Health Policy (2010-2020). The concepts of Universal Coverage and Social Health Protection (SHP) were taken up in the policy document and suggestions for corresponding policy statements have been discussed and included. It was also agreed to organize a comprehensive P4H mission in August 2009 to review the proposed NHI Bill and to contribute to the development of the new health sector strategy. This report is the result of the August 2009 mission. Following the P4H quest for harmonization of various activities related to SHP, it was proposed that a previously planned health financing review by WHO would be time wise and conceptually linked to the upcoming P4H mission, which actually happened.

## **3. Objectives**

The overall objective of the visit was to assist the Government of the Republic of Uganda in the process of developing a social health protection framework to suit the Ugandan context.

In collaboration with the Government, the specific objectives of the proposed mission were formulated as follows:

- To discuss a possible revision of the proposed National Health Insurance Bill and propose an adaptation, in particular by considering the concerns raised by the Ugandan public and various stakeholders.
- To discuss the implications and potential relevance of the recent health financing study tour to east Asia (Thailand, Vietnam, China).
- To design options for the proposed National Health Insurance System (NHIS), in particular concerning the lack of social health protection of the poor, considering the current high out-of-pocket spending and associated impoverishment due to seeking health care.
- To explore:
  - ways of linking the proposed NHIS to broader social protection and social health protection issues.

- the possibility of mobilizing additional funds for social health protection (SHP), e.g. through the health systems component of GFATM support (link to German BACKUP Initiative, example from Rwanda).

#### **4. Terms of reference**

The terms of reference (TOR) were agreed with the Ministry of health and included to

- (i) Getting an overview of the status of social health protection (SHP) in Uganda
- (ii) Explore possible options for linkage and integration of National Health Insurance Scheme (NHIS) in the Social Protection (SP) framework and SHP agenda
- (iii) Explore the institutional set up for the NHIS, in particular as integral part of SHP and broader Social Protection
- (iv) Explore the possibility of mobilizing additional funds for SHP

The full text of the TOR is included in Annex 3.

## **II. Social health protection: context**

This section takes – guided by the questions developed in the P4H social health protection framework – the health, the social, the development perspective and the broader political and economic context into account to assess the current status of social health protection in Uganda.

### **1. Health Care Financing**

#### **a. Financial Protection and Equitable Distribution of Burden**

Financial health protection is inadequate in Uganda with over half of the estimated health spending coming from household out-of-pocket spending (OOPs); the estimated per capita funding of the health sector in Uganda was US\$ 27 in 2007.<sup>6</sup>

For the period between 1995-96 and 2006-07, per capita public expenditure on health ranged between US\$ 4 and US\$ 7, which falls below the estimated cost (US\$ 28) of delivering the minimum package in Uganda (excluding the cost of expensive interventions such as ACTs, ARVs, ITNs and Pentavalent vaccine)<sup>7</sup>. The estimated target of the *Commission for Macroeconomics for Health* is \$34.<sup>8</sup> Money available for the purchase of non-salary inputs particularly remained constant from 2003-04 to 2007-08.<sup>3</sup> Current per capita expenditure on essential medicines is only US\$ 0.87 against an estimated requirement of US\$ 2.4 per capita (excluding ARV's, ACT's ITNs and the pentavalent vaccine). Due to this, only 35% of the health facilities have six tracer medicines and supplies in stock.<sup>2</sup> When medicines are not available in public facilities, patients must buy from private facilities or pharmacies where prices of drugs are much higher than in public facilities and, as a result, OOPs on health remains high.

Global Initiatives provide the bulk of resources needed for malaria, HIV/AIDS, tuberculosis, vaccines and reproductive health commodities.

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<sup>2</sup> The tracer medicines and supplies are: (Coartem; Fansidar, Depo Provera (injectable contraceptive), ORS, measles vaccine, co-trimoxazole).

The sector is under-funded partly due to an increased cost of service delivery owing to the pressures of global human resources for health market that has driven up salaries, more costly service delivery standards, and adoption of new technologies and less-than-optimal efficiency levels.

The percentage of households incurring catastrophic health expenditure is over 25%, with the majority coming from poor households.<sup>3</sup> The % of households that became impoverished due to health expenditure is 2.3%.<sup>4</sup>

Household out-of-pocket spending is the most unorganized, inefficient and inequitable form of health spending, as it occurs at the time of delivery of service. The impact of this form of health spending on the household economy is generally felt longer since households pursue some hard options such as high-interest borrowing and selling of assets, if any, so as to finance the OOPs. In Uganda, however, the estimated share of OOPs in total health expenditure came down from 78.9% in 1995 to 51% in 2007.<sup>5</sup> This is mainly due to an increase in the share of external resources from 14% in 1995 to 31.2% in 2006 because the share of government funding remained more or less the same about 25-30%. While OOPs signifies the level of (un)organization of health care finance and the level of social health protection, it masks the level and spread of inaccessibility to health care.

The poor tend to use government health centers and the better off use (both government and private not-for-profit) hospitals.<sup>6</sup> Incidence of catastrophic health expenditure among the poor has been steadily increasing in 1996-2006 even after the abolition of user fees in the public facilities, probably because of the greater use of private health facilities by the poor and/or because of the lack of medicines in public facilities due to frequent stock-outs<sup>7</sup>, leading to the use of the much more expensive drugs of private pharmacies.

#### ***b. Resource Generation***

The amount of resources generated and spent on health care is low. Per capita health spending is US\$ 27, although total health expenditure (THE) as a percentage of GDP is 7.2 % (in 2006).<sup>8</sup>

Different sources give different figures on the mix of financial resources for health. According to the MOH, OOPs accounts for 49.7%, donors 34.9%, and central government 14.9%.<sup>9</sup> But the World Bank shows that OOPs accounts for 37.9%, external sources 28.5%, and government 30%, indicating that OOPs in Uganda is lower than the average of sub-Saharan African countries and other low-income countries although it amounts to 9% of total household consumption expenditure<sup>10</sup>. Lower OOPs may also indicate that access to health care is generally low or the estimation of OOPs is inaccurate. Development Assistance for Health (DAH) has steadily increased recently with on-budget DAH being stable while off-budget DAH is increasing.

In terms of government commitment to health care, health expenditure accounts for 9.6% of government's discretionary expenditure, showing a stable trend. Per capita public health expenditure is below US\$10, and government health budget as a percentage of GDP is 2.4%.<sup>11</sup> There is no official user fee in public health facilities, except for private wards. While utilization of public facilities increased after the abolition of user fees, there has also been a marked increase in informal OOPs and catastrophic

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<sup>3</sup> World Bank (2009)

<sup>4</sup> Xu, et al. (2007)

<sup>5</sup> WHO (2009b)

<sup>6</sup> World Bank (2009)

<sup>7</sup> World Bank (2009)

<sup>8</sup> WHO, cited from World Bank (2009)

<sup>9</sup> GoU MoH (2009)

<sup>10</sup> World Bank (2009)

<sup>11</sup> World Bank (2009)

expenditures due to limitations in service provision, e.g. drug shortages in the public system forcing patients to buy their medication on the private market.

***c. Fiscal space***

There is significant pressure to increase government spending on health. A number of factors are responsible for this pressure, including the Abuja Declaration target; high fertility and population growth rates; the HIV/AIDS epidemic; adoption of more costly service delivery standards and new health technologies; and unregulated expansion of health infrastructure, which leads to escalating unit costs of health service delivery.

Despite fairly steady economic growth in the past, the overall level of funding for health remains inadequate for Uganda to meet its sector and national targets. Balancing economic and social objectives and rethinking the low priority given to the health sector may open up new opportunities to increase its share of health spending beyond the present level. However, evidence suggests that limited opportunities exist to mobilize new substantial financing. It therefore looks improbable that Uganda can dramatically increase its share of health spending beyond the present level. Alternatively, the NHIS is under consideration. Its success will depend on the level of additional resources it generates, the credibility of the scheme and the extent to which informal subsector employees can be brought on board as well as how concerns about the size of the premiums and perceived quality of health care are tackled.

***d. Resource Pooling***

Pooling of resources is fragmented. Pooling of financial resources through social health insurance is not yet in place and pooling through private or community health insurance so far is minimal. The Budget funds are only pooled to a certain extent, at the MOH, but districts are also mandated to add their own revenues to the district budget pool. The MOH has increased the percentage of the GOU Health budget allocation channeled to districts from 38% in 2000/01 to 54% in 2006/07, contributing to pro-poor allocation of resources<sup>12</sup>. Mortality indices are incorporated in the resource allocation formula to take into account health needs of population, although morbidity trends and figures would be better parameters as these better reflect the burden for the health care system.

***e. Purchasing, Payment and Financial Resource Allocation***

No purchasing mechanism exists in the public sector, i.e. there is no active purchaser who can independently contract public providers and buy their services and review the performance of the contracted provider. No split exists between the payer and the provider, it's the government who owns, pays and provides health care services. Only some managed care organizations (HMO-type) and private insurance companies use contracting with providers. In terms of payment mechanism, public health institutions are financed on a budget basis. Physicians are salaried in public facilities. There is little results-based budgeting for public hospitals. Overall, there is not much fiscal space but a recent World Bank study suggests a (not quantified) potential for fiscal space by improving efficiency, e.g., improving health workforce management and performance, strengthening procurement and logistics management for medicines and supplies, and aligning sector performance to defined results.<sup>13</sup>

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<sup>12</sup> GoU MoH (2009)

<sup>13</sup> World Bank (2009)

## **2. Health Care System and Outcomes**

### **a. Health Care System and Policy**

The Health System Brief in Annex 4 describes Uganda's health care system in detail. In essence the health care system can be described as a mix of public and private (for profit and not for profit) providers with decentralized stewardship functions. Public providers are mainly financed from the budget and to a limited extent through private contributions for private wings or eventually as informal copayments. Private providers funded from private pockets although not-for-profit private provided are subsidized to keep their user charges low.

The health care system is organized at several levels, the National Referral, Regional Referral, HSD level (headed by a hospitals or a HC IV), HC III, HC II. At the community level, The Village Health Team is responsible for sensitization on health issues and mobilizing the community to utilize health services in addition to providing health commodities for a few health ailments.

Uganda's serious shortages of human resources for health are a result of the problems in training, recruitment, and motivation, further aggravated by the brain drain and by allowing dual practice for the doctors in the public sector, which causes many problems like absenteeism of staff and therewith leakage of public monies.

Regarding community interventions, only 30 out of 80 districts have trained village health teams. In an effort to increase physical access to health care, the number of health facilities in the public sector and the private not-for-profit sector was recently increased. Many existing government facilities, however, lacked basic infrastructure and other essential inputs. Less than 25% of facilities have all essential equipment and supplies for basic antenatal care (blood pressure meter, obstetric stethoscope, iron and folic acid tablets, and tetanus toxin vaccine) while basic equipment and supplies for conducting normal deliveries (such as scissors or blades, cord clamps or ties, and a disinfectant) are available in only 33% of facilities offering delivery services.

The health work force in the country is inadequate. There are 8 physicians, 55 nurses, and 16 midwives per 100,000 people<sup>14</sup>, 64% of nurses and 71% of physicians work in the central region, where 27% of the population live as of 2006. I.e. the workforce is unevenly distributed over the country and attracted towards greener opportunities provided by the private for-profit sector. As in November 2008, only 51% of the approved positions in government facilities at the national level were filled<sup>15</sup>. Vacancies in regional referral hospitals alone ranged between 13% for nurses and 54% for medical doctors<sup>16</sup>. Similarly, medicines are in short supply; 72% of government health units have monthly stock outs of any of the six tracer medicines<sup>17</sup>. This leads patients to buying much more expensive drugs at private pharmacies, if they can afford them. There are also efficiency and equity issues concerning the functioning of public and private facilities in the country.

41% of hospitals are private (not-for-profit). The expansion of private health providers has not been adequately regulated.<sup>18</sup> Not-for-profit hospitals are mainly based on religious denominations. Even though the private sector provides a significant proportion of health care services, it is not properly integrated with the public sector to fully take

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<sup>14</sup> WHO (2007)

<sup>15</sup> Government of Uganda (May 2009)

<sup>16</sup> Government of Uganda (October 2008)

<sup>17</sup> GoU MoH (2009)

<sup>18</sup> GoU MoH (2009)

advantage of each other; however, the government has established a public-private partnership whose functioning needs to be expedited. Health care facilities are more or less equitably distributed across regions in terms of population size.

The pharmaceutical sub-sector is better regulated. Most medicines are imported and distributed by the private sector; about 90% of all medicines are imported and close to 95% of them are generic products. The cost of medicines is 3-5 times higher in the private sector.

The emergence of new districts and the HIV and AIDS epidemic have put a big strain on management and on human and other health resources.

### ***b. Health Care utilization***

Seventy two per cent of the Ugandan households live within 5 km from health care facilities.<sup>19</sup> Approximately 60% of Uganda's population seek care from traditional and complementary medicine practitioners or TCMPs (e.g. herbalists, traditional bone setters, traditional birth attendants, hydro-therapists and traditional dentists) before visiting the formal sector. While 94% of women aged 15-49 years, who had a live birth during 2001-06, made at least one antenatal care visit, only 42% made a return visit and 40% of the live births took place in a health facility.

13% of sick people do not seek medical attention<sup>20</sup>, i.e. 1.4 million people, of which 32% (nearly 450,000 people) mentioned costs reasons. Access to health services is further limited by the problem of the long distances to health centers.<sup>21</sup>

In terms of health care utilization and access, the percentage of deliveries in health facilities is 32%, and pentavalent vaccine coverage is 87% (2006/07). Barriers to health care utilization exist due to poor infrastructure, lack of medicines and supplies, and shortage and low motivation of health care personnel<sup>22</sup>.

### ***c. Health outcomes***

Life expectancy increased from 45 years in 2003 to 52 years in 2008, with Malaria, HIV and AIDS and tuberculosis as leading causes of morbidity and mortality. Malaria is the most common cause of death in children under the age of five years. Malaria, ARIs, diarrhea, pneumonia and malnutrition account for 75% of child mortality. There is a close relationship between poverty and the incidence and prevalence of malaria, malnutrition, dysentery, and diarrhea<sup>23</sup>. HIV/AIDS and high population growth rate are the main drivers of health care spending<sup>24</sup>.

However, HIV prevalence has stabilized and is down to 7% in 2008<sup>25</sup>, but 350,000 infected persons already need antiretroviral therapy and more than 100,000 new infections occur annually. Cancer prevalence is increasing, while polio and guinea worm have nearly been eradicated but concerns exist about the re-emergence of polio cases due to cross border migration; and the prevalence of other vaccine preventable diseases has declined sharply.

The maternal mortality ratio is still one of the highest in the world. Though it has been reduced from 527 to 435 per 100,000 live births, it is still far from the national target of 354 and international target of 60<sup>26</sup>. Other indicators read:

<sup>19</sup> Government of Uganda (May 2009)

<sup>20</sup> Uganda Bureau of Statistics (2006)

<sup>21</sup> Uganda Bureau of Statistics (2006)

<sup>22</sup> GoU MoH (2009)

<sup>23</sup> GoU MoH (2009)

<sup>24</sup> World Bank (2009)

<sup>25</sup> GoU MoH (2009)

<sup>26</sup> Government of Uganda (November 2008)

- Infant Mortality Rate (UDHS 2006): 75 per 1,000 Live births
- Under 5 (year-year-old) mortality: 156 (1995) to 137 per 1000 (2005)
- Infant mortality: 85 (1995) to 75 per 1000 (2005)

Inequality in health outcomes is a concern. Under-five and infant mortality rates in urban areas are much lower than those in rural areas. Wealth-related inequalities in under-five and infant mortality rates are persistent over time<sup>27</sup>.

### **3. Socio-demographic and Policy Perspective**

#### **a. Demographics and Population Characteristics**

- Total population (2009 midyear projected): 30.7 million persons<sup>28</sup>.
- Annual Population growth rate between 1991 and 2002 censuses: 3.2 percent
- The population of older persons in Uganda was estimated at 6.1 % of the total population and is expected to rise to 20% of the total population by 2025<sup>29</sup>
- Total Fertility Rate: 6.7 Births per woman, 6<sup>th</sup> highest in the world<sup>30</sup>
- Contraceptive prevalence rate: 24%<sup>31</sup>
- 49 percent of the population was below 15 years.
- Dependency (ratio of 15-64 years adults to non-working age population) is 1.12, which is higher than Tanzania (0.85), Kenya (0.84), average for Sub-Saharan Africa (0.87)

The expected greening of society will contribute to higher dependency ratios, making it more difficult to finance health care from contributions paid by the working population.

Rapid growth in population has contributed to the limited effect of high economic growth on household welfare.<sup>32</sup>

#### **b. Vulnerability and access to health services**

Despite the high economic growth and poverty reduction efforts by the government, a large part of the population is still living in poverty and inequality is on the rise.

The second participatory poverty assessment (PPA) conducted in Uganda during 2001/2002 revealed that poor health and diseases were the most important cause of poverty and vulnerability followed by limited access to land and land shortages especially due to large families, by the lack of markets, unemployment, illiteracy and the lack of income, among other factors.<sup>33</sup>

#### **c. National policy on social protection and social health protection**

Uganda is one of the 13 countries that participated in the Livingstone process hosted by the Republic of Zambia in 2006. African governments agreed to use social protection programs in response to poverty and to care for reliable long-term funding for social protection – using funding from national budgets and the development partners.<sup>34</sup> The Government of Uganda committed itself to implement the Livingstone Call for Action.

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<sup>27</sup> World Bank (2009)

<sup>28</sup> GoU MoH (2010)

<sup>29</sup> Uganda Bureau of Statistics (2006)

<sup>30</sup> UDHS (2006)

<sup>31</sup> GoU MoH (2010)

<sup>32</sup> World Bank (2009)

<sup>33</sup> MFPED (2002)

<sup>34</sup> The Livingstone Call for Action (2009)



However, in the national Uganda debate on social protection and social health protection little reference is made to the Livingstone commitments.

A coherent social protection framework or strategy for the country does not exist. The Ministry of Gender, Labor and Social Development (MoGLSD) is initiating the development of a common social protection agenda. Currently, only a concept note (September 2008) on social protection strategy is available. However, the health sector is not listed as a social health protection issue and the discussion on the introduction of a social health insurance is not linked to the broader debate on social protection. The MoGLSD has held two national level workshops so far to further discuss the concept.

***d. Programs supporting social protection objectives and their underlying concepts and values***

There are a great number of social protection programs run by the government and civil society organizations that are targeting the poor and/or vulnerable<sup>35</sup>:

DFID and MOGLSD are designing a cash transfer pilot, a new scheme next to already existing programs. The pilot is expected to contribute to improved human development outcomes via increased school attendance, improved nutrition and increased use of health facilities.

GTZ is implementing a vouchers program in Western Uganda and Makerere University School of Public Health in Busoga (Iganga and Mayuge Districts).

However, no comprehensive review or evaluation for these various programs could be found. Civil society groups have been criticizing that current social protection and anti-poverty interventions are mainly targeting the “active poor” or the “working poor” leaving out a growing non-working part of the population.<sup>36</sup>

There is no policy and legal framework for supporting social protection objectives or a clear understanding who the poor and the most vulnerable are that should benefit from social protection measures.

Although the current debates have revolved around generating additional resources and regional integration concerns, other concepts like solidarity, equity or the re-distributional effects of social protection measures, which are fundamental to social health protection, will need more attention.

***4. Development Perspectives***

***a. Development and pro-poor orientation***

With the introduction of the Poverty Eradication Action Plan (PEAP) in 1997 the government made an impressive step towards pro-poor and poverty-reduction led policies – including pro-poor budget allocation. While there has been high level of political commitment, the ownership of the PEAP and its implementation process has been of limited scope and success.<sup>37</sup>

A 5-Year National Development Plan (NDP 2009/10 – 2014/15) is being developed to become the successor plan to the PEAP. The national targets in the draft NDP (*Growth, Employment and Prosperity*) and the PEAP have a pro-poor focus and are consistent with the MDGs.

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<sup>35</sup> For a complete list please refer to annex 6

<sup>36</sup> Ebpdn (2008)

<sup>37</sup> Piron / Norton (2004); Shinyekwa / Hickey (2007)

Despite the above, the actual policies are mainly directed at the active and not the chronically poor.<sup>38</sup>

***b. Commitment and progress on MDGs 1 and 4, 5, 6***

With retained efforts, Uganda is likely to meet the targets for goals 1, 3, 6, 7 and 8 (eradicate extreme poverty; promote gender equality and empower women; combat HIV/AIDS, malaria and other diseases; ensure environmental sustainability; and develop a global partnership for development).<sup>39</sup> It is unlikely that Uganda will achieve the targets for MDG 4 and 5. Efforts in reducing under-five mortality stagnated since the 1990s and not much progress is being made in reducing maternal mortality.<sup>40</sup>

Uganda has made significant progress towards poverty reduction according to the UNDP's MDG progress report. However, while income poverty fell, not all sections of the population have benefited equally from the economic upturn and inequality has increased.

***5. Sustainable Development and social health protection concept***

***a. Holistic approach towards sustainable development***

As outlined hereafter, Uganda has experienced steady economic growth of well over 6% in each of the past 10 years. This raises the question to what extent the proposed NHI scheme helps in translating some of these positive economic developments into social progress. In particular, how the scheme could possibly contribute towards sustainable development by balancing social and economic interests in a way that would lead to more equity and stability in Uganda. Meetings with the MOFPED and the MOGLSD did not give the impression that there are ongoing discussions around this issue. This could be a missed opportunity.

MOFPED has policies that are geared towards privatization rather than social health protection and yet MOH has opposite objectives. That's why it is important to get MOFPED and MOGLSD involved in the discussion about health financing reform. However, in this discussion, private financing should be distinguished from the private provision of services. The latter is a reality in Uganda and will stay there although it could be better regulated and supervised.

Consultations with key stakeholders based on a holistic approach, including broader questions and principles of sustainable development may have helped to align the proposed scheme with overall development objectives and to shape it into a politically, economically and socially acceptable policy option towards Social Health Protection.

As already observed during earlier visits<sup>41</sup> the NHIS has not been sufficiently linked to the broader health reform process or embedded in a comprehensive approach towards Social Health Protection and sustainable health systems development. It is unclear, what effects the proposed scheme will have on the existing national health system, in particular the current financing mechanisms, public providers, community based schemes, etc. In addition, the proposed NHIS has not been linked to the development of a social protection framework or ongoing interventions such as cash transfers. The development of the scheme may have benefited from taking the broader health system, social protection and development issues into consideration – i.e. addressing the *bigger*

<sup>38</sup> Hickey (2003); Shinyekwa / Hickey (2007)

<sup>39</sup> UNDP, Millennium Progress Report (2007)

<sup>40</sup> PEAP (2004)

<sup>41</sup> see P4H travel report (February 2009)

picture of SHP in the context of developing a national social floor such as suggested by the UN System Chief Executives Board of Coordination (CEB).

To see to what extent issues of good governance (e.g. challenges of corruption) would influence the feasibility of successful implementation of certain SHP options needs further exploration.

***b. Process – transition towards Universal Coverage (UC) and Social Health Protection (SHP)***

Most low and middle income countries (LICs and MICs are in transition from high OOPs towards universal health coverage (UC) and SHP. Uganda is no exception and could be placed in the rather initial stages of this often complex and lengthy process. It is important that this transition is guided by sound policies and strategies. Although the concept of universal coverage and SHP is incorporated in the National Health Policy of 2000 – 2009 and the HSSP I 2000/01 – 2004/05 and HSSP II 2005/6 to 2009/10 and recently up in the new health sector policy 2010-2020, it is not yet fully reflected in the proposal on the NHIS. Adaptations and revisions of the NHIS would certainly benefit from the guidance of an overall health financing strategy.

The establishment of a health insurance task force (TF) has facilitated the involvement of key stakeholders; however it has been observed that

- the participation of representatives of key stakeholders has not yet led to meaningful involvement of the represented organizations and institutions. For example, the employees have been represented in the TF. But, a separate meeting with the organizations of employees revealed that their questions and critical issues have not been considered when drafting the National Health Insurance Bill. This could be partly due to the fact that the development process of the NHIS focus was on sensitization of stakeholders rather than on consultation and dialogue.
- the discussions about the proposed NHIS in the TF have not yet reached the delegating organizations, which could be due to representation and internal communication issues.
- the TF has not yet established mechanisms that would effectively deal with conflicting interests of different stakeholders and the risks and assumptions in the change process towards UC and SHP.

***c. The role of values***

The importance of almost universally accepted values<sup>42</sup> such as a right to health care, solidarity, participation, social justice still requires further discussions. It may be difficult to reach consensus on equity goals, in particular on re-distributional mechanisms and risk pooling if the support of underlying values is missing. So far there is little evidence that for example solidarity plays a significant role in the development of social objectives and interventions.

The apparent acceptance of a multi tier system in health care provision, one for the poor, a better one for the rich in private wards or in private facilities and company based schemes for their employees, with different packages of services, can hardly be seen as a sign of solidarity.

Some meetings with various stakeholders showed that they were skewed more towards their own interests than to interests of the broader society, not to mention the poor.

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<sup>42</sup> WHO (2008)

**d. Social health protection and national development planning**

Social health protection had not been integrated in the now outdated development planning document, PEAP (2004/05 -2007/08). Improved health outcomes had been stated as one of the objectives for “human development”, however proposed interventions emphasized the supply side. Even though social protection is mentioned as a cross-cutting issue in the PEAP, no reference is made to social health protection explicitly. Social protection is largely seen as social assistance and strengthening the social safety net at the community level.

While social health protection is not explicitly mentioned in the objectives of the draft NDP (2009/10 – 2014/15), the issue of “access” is highlighted as the fourth objective of the NDP as to “Increase access to quality social services” (indicators: “reduced threshold distance to safe and clean water, improved health services, improved access and quality of education service”).<sup>43</sup>

The draft sector paper<sup>44</sup> does not mention social health protection or the importance of improved access to affordable and equitable health services. The challenges in health financing are focusing only on the supply side without acknowledging the patient’s perspective (access and risk protection). Neither is social health protection nor fair financing mentioned in the proposed strategies for health system strengthening.

In the draft National Health Sector Policy (2010-2020) the concepts of universal coverage and social health protection (risk pooling and pre-payment) have been taken up. The document still needs to be approved.

**e. Concept of social health protection - goals and targets**

The concepts of Universal Coverage and Social Health Protection have so far not been prominent features of health financing policy. Current discussions are mainly focused on insufficient financial resources and the low spending of government on health. However, in the context of the proposed National Social Health Insurance scheme health financing has become an emerging topic in policy debates. No approved and adopted national policy paper could be found that defines the concept of social health protection in Uganda and there are no clear targets and objectives on social health protection.

However, in the draft of the National Health Sector Policy (2010-2020) the concepts of universal coverage and social health protection (risk pooling and pre-payment) have been taken up in the policy document.

Besides the lack of clear objectives on social health protection, there is no overarching concept or vision which role the proposed social health insurance would play in the transition towards universal coverage. Furthermore, the current draft bill does not incorporate the intrinsic values of solidarity and equity. The commitment on universal coverage and the inclusion of the poor still remain critical issues to be addressed.

While there have been efforts by the MOH to give the process on the development of social health insurance an inclusive and consultative character, stakeholder involvement seemed to have been limited while the objective of such regular meetings was more on sensitizing and advocacy for social health insurance than on consultation and participation.

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<sup>43</sup> National Planning Authority (2008)

<sup>44</sup> Uganda Health and nutrition thematic paper for the National Development Plan 2009/10 – 2013 (November 2008)

In several interviews cash transfers for the poor have been pointed out as a substitute for social protection coverage. While cash transfers can have significant impact on poverty reduction and therefore on the health status of the people, they cannot be considered a sustainable approach for reducing out-of-pocket spending and catastrophic payment as they are neither pre-payment nor risk pooling mechanisms.

***f. Effective development support to social health protection***

There is currently no national debate among all relevant stakeholders on social health protection in general; however there is an ongoing dialogue between various stakeholders on the introduction of the National Health Insurance Scheme (NHIS) led by the Ministry of Health.

Contributing to the ownership and an aligned national approach is the establishment of a Task Force (TF) on the National Health Insurance Scheme (NHIS), constituted according to a Cabinet Directive, it incorporates the public and private sector.

The establishment and the work of a Task Force consisting of all relevant stakeholders and actors (Annex 5) has contributed to facilitate an open dialogue, but a common understanding and approach to the proposed NHIS is lacking within the TF and there is the need for further consultations and the active inclusion of all stakeholders, including civil society, in order to build up ownership for the NHIS beyond the MOH.

So, country ownership at the centre of collaboration and support to social health protection are not yet harmonized and aligned.

***g. Mechanisms for harmonization and coordination among development partners?***

*The Uganda Health SWAp<sup>45</sup>*

MOH, government and development partners agreed on a health SWAp arrangement in 1999. The improved cooperation between government and development partners was also instrumental in the translation of the NHP into an operational plan – the Health Sector Strategic Plan I 2000-2005 (HSSP I) – which was launched in 2000, and followed by the HSSP II (2005-2010) in 2005.

A range of stakeholders and expert observers tend to agree that the first three years of the Uganda health SWAp were very successful.<sup>46</sup> The Memorandum of Understanding, guiding the SWAp process included two particularly important features: 1) an obligation from the government to steadily increase the budget for health; and, 2) a commitment from development partners to increasingly use general or sector budget support as the principal aid modality. Both government and development partners strove to implement and deliver upon their commitments. The resource flow to the health sector improved considerably; more staff was hired and new infrastructure (predominantly in the primary health care domain) was developed.

Progress in achieving the targets outlined in the HSSP I was visible a few years after the launch of the SWAp. New outpatient attendance rose from 0.4 visits per capita a year in 2000 to 0.9 in 2004-05, and child immunization showed similar sharp improvements.

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<sup>45</sup> Largely based on Örtendahl (2007)

<sup>46</sup> Progress in achieving the targets outlined in the HSSP I was visible a few years after the launch of the SWAp. New outpatient attendance rose from 0.4 visits per capita a year in 2000 to 0.9 in 2004/05, and child immunisation showed similar sharp improvements.

However, currently both government and donors face numerous challenges, which may be explained by a number of factors. The increase in real term government spending for health slowed, creating an increasing dependence on ad hoc, often project based, development assistance for health. These projects have tended to reflect specific areas of interest amongst development partners, and only partially reflect the balance needed between different sub-sectors in the health strategic plan. Leadership problems in the Ministry of Health made the SWAp mechanism more vulnerable, and funds from global health partnerships tend to skew stated government policies and priorities.

The problems experienced by the Uganda health SWAp have not gone unnoticed. They have opened new discussions between government and development partners on reforming SWAp processes and structures, based on the Paris Declaration on Aid Effectiveness. A number of initiatives in this respect have recently emerged. Local development partners and government have held discussions on improving Global Fund integration into SWAp processes. The Ministry of Health and development partners have also agreed, in principle, on improved integration of Technical Assistance (TA) into routine Ministry processes and structures.

The process of rationalizing and harmonizing aid partnerships has been going on for some time. The Uganda Joint Assistance Strategy (UJAS), designed collaboratively by a number of development partners, ultimately aims to reduce transaction costs by diminishing the number of active partners in each aid sector. The structures for co-operation between Ministry of Health and development partners have involved a very intricate and complex net of working groups and similar processes. Efforts have also been made to considerably reduce the number of groups and to sharpen their roles to avoid duplication.

The P4H partners see it also as their challenge to harmonize and rationalize as much as possible their efforts in supporting GOU in its health financing reform as part of the ongoing overall health reform.

## ***h. Economic and Political Environments***

### ***(i) Economic Environments<sup>47</sup>***

The economy is growing reasonably well, with an average GDP growth of over 6% in each of the past 10 years and particularly high in the last four years (8.5%).

Still, the per capita Gross National Income is about Int. \$ 920, which is low (compared to<sup>48</sup> Int. \$ 1,534 in low-income countries).<sup>49</sup> Eighty per cent of the Ugandan population lives in rural areas, mostly engaged in agriculture.

Between 2001/02 and 2007/08, the following indices rose favorably as a percentage of GDP:

- Private investment rose from 14.5% to 17.1%;
- Public investment stabilized at 5.1%;
- Domestic savings increased from 7.8% to 8.8% and
- Government domestic revenue rose to 12.7% from 11.2%.

Uganda has become less donor dependent with donor aid reducing from 11.0% to 8.6% over the same period.

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<sup>47</sup> Nayenga (2008)

<sup>48</sup> World Bank (2009)

<sup>49</sup> WHO (2009)

Economic growth will increase the capacity to pay contributions for health insurance, but the actual capacity also depends on the income distribution and the inflationary impact of the economic growth.

#### Income and expenditure<sup>50</sup>

- Per capita income: 320 USD in 2007<sup>51</sup>
- 11 percent increase in monthly household expenditure between 2002/03 and 2005/06.
- A 10 percent real increase in per capita expenditure in 2005/06.
- 45 percent of the household expenditure was on food, beverage and tobacco.

#### Labor force, employment and earnings<sup>39</sup>

- Total labor force increased by 11 percent between 2002/03 and 2005/06.
- By occupation, 70 percent of the working population was in agriculture.
- The average size of civil service increased by 6 percent in 2008.
- Food processing dominated the industry with a 65 percent share of total employment in 2008.
- Numbers of employees for selected manufacturing establishments decreased by 2%.
- Wage bill increased by 16 percent in 2008. In real terms, the labor cost index increased by 22 percent in 2008.

#### Poverty

- Living below the poverty line: declined from 52% (1992) to 31% (2005/06). 8.4 million people were below the poverty line in 2005/06, most of them living in the rural area and working in the agricultural sector. The poverty rates are higher in Northern Uganda at 60.4%. Although the highest poverty rates are found in the remote northern areas, these areas are sparsely populated, so that *most* of the poor are found in Central, Eastern and Western regions.<sup>52</sup> The proportion of the poor population reduced from 39 percent in 2002/03 to 31 percent in 2005/06.
- There was a generally rising trend of income inequality between 1992 and 2006. However, nationally, on average the income inequality decreased somewhat in between surveys, but only in urban areas.<sup>53</sup>
- The 2005/6 household survey revealed that more than half of the population is below 15 years of age; that 15 percent of children below 18 years were orphans while 18 percent of those aged 5-17 were engaged in child labor activities. The national disability rate was 7 percent, of which 20 percent had multiple disabilities. Approximately 80 percent of people with disabilities live below the poverty line, and 46 percent of people with disabilities (PWD) aged 14-64 declared that they were excluded from accessing employment opportunities.<sup>54</sup>

#### *(ii) Political Environments*

In the years following its independence from Britain in 1962, Uganda experienced considerable political instability. After 20 years of civil war, which displaced internally

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<sup>50</sup> All information from Uganda Bureau of Statistics (2002, 2009); CIA Factbook Uganda (2009)

<sup>51</sup> World Bank (2009)

<sup>52</sup> Shinyekwa / Hickey (2007)

<sup>53</sup> Uganda Bureau of Statistics (2006)

<sup>54</sup> Uganda Bureau of Statistics (2006)

over 1.5million people, a Cessation of Hostilities Agreement was signed in August 2006 by the government of Uganda and the Lord's Resistance Army (LRA). In December 2008, the Ugandan forces launched an offensive against the remnants of LRA in the neighboring DRC, the operation is ongoing.<sup>55</sup>

A long-standing ban on political party activity was formally lifted after a national referendum in 2005, and Uganda held its first multiparty elections in 25 years in 2006. There are currently 36 registered political parties in Uganda.<sup>56</sup> In 2011 presidential and parliamentary elections would be held – making 2010 a campaign year.

The structure of Uganda's civil society shows a very diverse picture, dominated by rather small but socially inclusive small community groups with a focus on social, rather than political activism.<sup>57</sup>

In terms of the legislation and legal framework, MOH is coordinating the drafting of bills, which are currently at different stages of development, such as Pharmacy profession and practice bill, Uganda Medicines Control Authority bill, Food and Nutrition Bill, Food and Drug act, National Health insurance Bill and, Complimentary Medicines Bill<sup>58</sup>. Overall, the process of reviewing legislation and policies has been slow.

Political, administrative, and fiscal responsibilities were decentralized to local (district) governments, but local governments still lack funding and capacity.<sup>59</sup>

#### ***i. Assessment of social and development perspectives***

While there has been a clear pro-poor focus in government policy documents, the ownership of this approach seems to have been limited to a higher political level and never trickled down the operational divisions that are implementing the approach.

The proposed NHIS in its current design does not manifest the confessed pro-poor orientation of the GOU.

The underlying concepts and values of social protection in general and social health protection such as solidarity and equity and their re-distributional effect do not play a role in the current national debates or documents that have been reviewed.

The discussions and efforts in the area of social health protection and/or the of the social health insurance are not embedded in the broader process of the development of the NDP health sector strategy and are therefore losing out on potential synergies and dynamics to move forward the social health protection in national agenda.

There are different approaches and debates around social protection measures and social health protection e.g. the introduction of social health insurances are fragmented among different stakeholders and ministries. Approaches and interventions do not share a common goal, like universal coverage and poverty reduction.

There seems to be no strong civil society movement that has been taken up the issue of social protection or social health protection that could play a neutral role in sensitizing and advocacy for the topic.

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<sup>55</sup> Dagne / Reeves (2008)

<sup>56</sup> Electoral commission of Uganda. <http://www.ec.or.ug/regdparty.html>

<sup>57</sup> CIVICUS ( 2006)

<sup>58</sup> GoU MoH (2009)

<sup>59</sup> World Bank (2009)



### **III. Towards SHP in Uganda**

#### ***Proposed Health Financing Reform***

##### ***a. Policy***

The National Health Policy is largely guided by the National Development Plan, which details priority interventions of the Government of Uganda in any sector. It is also formulated within the context of the provisions of the Constitution of the Republic of Uganda (1995) and the Local Government Act (1997) which decentralized governance and service delivery. The first National Health Policy and associated strategic plans have guided developments in health during 1999-2009. A number of changes have occurred during the period covered by the first National Health Policy. Introduction of the Sector Wide Approach (SWAp), implementation of the decentralization program, end of conflict in northern Uganda and the focus on recovery and development in the region, the huge increase in the number of districts, emergence of non-communicable diseases (NCDs) and negative health consequences of changing climates.

The national health policy calls for diversification of health care financing in support of the national goals of improved health status and equity. The new health sector policy includes the objectives of universal coverage and SHP, which is an important step towards the implementation of SHP. They will need to be discussed in more depth within the policy process of health financing reform and to be harmonized and coordinated with other social and economic policies.

Uganda also faces the challenge of growing demand for health care and a growing private health sector.

The government of Uganda provides subsidy to the private not-for-profit sector to enable them to reduce fees charged such that even the poor are able to access services from these facilities. The level of subsidy is about 20%. Subsidies have been extended to a few private hospitals too. No official user fee is paid in lower level health units and general wings of publicly owned hospitals whereas the private sector charges user fees. However, although utilization went up after abolishing user fees, so did OOPs and catastrophic payments. This development pleads for a tailored approach, using all possible instruments. NHIS will not be able to solve all problems by its mere existence. That's why NHIS should be discussed as a systems issue. The new health financing policy needs to provide clear guidance for health strategy and health financing strategy.

Efficiency is currently not well addressed in the way resources are mobilized, allocated and used. A portion of external funds remains off-budget. Suspension of GAVI and Global fund for AIDS, Tuberculosis and Malaria activities has disturbed the resource flow; however, the government has been able to back up the GAVI and the Global Fund activities with some money (UGX 62 billion). In the mean time, the Government of Uganda has corrected concerns raised by GAVI and GFTAM and funding of the respective programs has resumed.

Positive developments are further the reforms initiated in 2000-01 under the Health Sector Strategic Plan-1 included the following key strategies:

- Removal of user fees
- Strengthening of IEC campaigns for health
- Increased government spending, especially on medicines
- Addition of health care infrastructure

- Recruitment of health workers and pay reform

These strategies coupled with improvements in management and availability of inputs appeared to have resulted in an improved confidence in health care services and higher uptake of preventive, promotive and rehabilitative services. As a result, Ugandan health system has witnessed some positive developments in health care utilization. Information & education campaigns (IEC) appear to have enhanced health care seeking behavior among the people, while removal of official user fees helped to reduce the financial barriers to access, though informal fees still remain. Simultaneously, increased government and external resources improved the resource flow into the health sector. In addition, the creation of new health care facilities took health care closer to the people. This is coupled with the recruitment of an additional 7,064 health workers.

The Government of Uganda has accepted for its National Health Policy and its Health Sector Strategic Plans the following principles<sup>60</sup>:

- “Access for all to a minimum package of services
- Equitable distribution of services
- Effective and efficient use of health resources”

To achieve this, the GOU wishes to “ (i) increase budgetary allocations to the health sector; (ii) revise and expand contracting mechanisms with the private sector; (iii) ensure that public resources prioritize financing of the basic package which will be continuously monitored and adjusted based on epidemiological trends, resource envelope and cost effectiveness; (iv) promote alternative health financing mechanisms other than government budgetary provisions. These shall include national social health insurance and other community health financing mechanisms; (v) implement financing mechanisms that promote private sector growth for example through generous tax breaks; and (vi) strengthen programming of external funding for health though improved harmonization and alignment to sector priorities and improved reporting.”<sup>61</sup>

The MOFPED informed the P4H mission about privatization policies that eventually might lead to a private rather than social health insurance scheme. While details were not revealed in the discussion, experience proves that such a move might lead to exclusion and significant impacts on solidarity in financing.

#### ***b. Process***

The development process of the NHIS started in 1987 and has gone through several rounds of consultations with various stakeholders and experts since then. In addition, the task force had several sittings and debated issues arising out of various consultations. Still, there are challenges and concerns with the design and implementation of the NHIS, given that the health sector will be managed and controlled in an entirely new manner under the NHIS.

The Ministry of health formed a NHIS secretariat to coordinate the development of SHI. After several studies and country tours, the secretariat developed principles of social health insurance that were disseminated for consultation and sensitization to key stakeholders countrywide in 2004, 2005 and 2006. The sensitization started a social and economic debate that is increasing as further discussions take place this year.

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<sup>60</sup> Government of Uganda (April 2008)

<sup>61</sup> GOU/MOH (May 2009)

The Principles of Social Health Insurance were presented to Cabinet in April 2006 and adopted. This was in line with the NRM manifesto 2006, which places Social health insurance and community health insurance as a program to improve delivery of better health services. The program is supposed to protect both informal and formal sectors against expenditure on catastrophic incidences.

Subsequently the Cabinet<sup>62</sup> directed that the Minister of Health prepares a bill on Social Health Insurance. Drafting instructions of the bill have been sent to the First Parliamentary Council and a copy of the draft bill agreed on by the National Task Force was developed. The design process of the proposed scheme was further discussed in the cabinet<sup>63</sup>, which decided to hold a workshop to receive an update on the design process of the proposed scheme. The Workshop took place on 12 February 2009.

The Ministry of health established a multi-sector National Task Force (54) of senior and knowledgeable officials to spearhead the scheme design process and guide the drafting of the Bill. The Task force has been meeting quarterly and its four sub-technical committees met monthly to closely guide the drafting process bill. The National Social Security Fund (NSSF) which handles pension for the private sector was invited to join the Task Force but declined and is planning to start its own parallel health scheme. The Ministries for Finance, Public Service and Gender, Labor and Social Protection are also represented and active. The TF has developed a number of already rather detailed documents like a draft NHI Bill, proposals for the organizational aspects of NHI and its provider payment and accreditation systems. Also detailed guidelines have been developed for accreditation of providers.

Sensitization of stakeholders is ongoing and the bill is envisaged to be tabled in the Parliament as soon as preliminary requirements are met.

The GOU/MOH foresees a gradual implementation of NHI once the NHI Bill is adopted by Parliament. A start would be made with the formal public sector, to be followed in 3 years by the formal private sector and in 15 years by the informal sector. During the first phase MOH would like to see a National Health Insurance Board, its Secretariat and zonal offices to be established, capable of implementing the scheme. Besides the usual health insurance functions, the Board is supposed to also establish and implement an accreditation system of health care providers.

The P4H team met a number of times with the Task Force and separately with representatives of its member's constituencies. These meetings brought to light that there are fundamental differences in the understanding of the NHIS and its appreciation. There seemed to be only partly a consensus, understanding and compliance among stakeholders of building up a National Health Insurance Scheme that follows the criteria of solidarity, universality, transparency, accountability and credibility. Although most of the interviewed stakeholders did basically agree with the establishment of a NHIS, they were not convinced that the proposed step-by-step-strategy would be realized both in an efficient and effective way. Some of them even feared that a model starting with the coverage of civil servants in the public sector would mean to refinance health care benefits for privileged groups of the society by the majority of the Ugandan residents, thus even increasing inequality in access to health care service and providing health. Others were more concerned about losing benefits and the need to keep the status quo for the company based insurance and medical benefits schemes.

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<sup>62</sup> Minute 63 (CT 2006)

<sup>63</sup> Minute 21 (CT 2009)

***GOU/MOH may want to review the effectiveness of its current dialogue with other ministries and important stakeholders including the public and not only focus on “sensitization” of the stakeholders and the public but on organizing a substantive dialogue as wanted by several of the interviewed.***

The Task force could develop modalities of regularly engaging the top leadership of other stakeholders (for example employees, employers and providers). Several options can be discussed, from light to more heavy handed: (i) Ad hoc scheduling meetings if and when draft reports and/or health financing options are elaborated enough to allow for discussion, (ii) a set number of scheduled hearings for interested parties on dates set in advance, (iii) sharing drafts and minutes of meetings more widely, eventually on a dedicated website, or by (iv) creating a temporary or standing health financing advisory council with representatives of stakeholders, eventually instituted formally by GOU regulation.

A revised draft Health Insurance Bill could be the first document for which the TF invites other stakeholders to come and discuss with the TF or to send it comments.

MOFPED and MOGSLD should play an important role. Besides employers and employees organizations, also representatives of associations of doctors and nurses, of pharmacists, of hospital managers, of private for profit and private not for profit providers, of private insurers, community insurers and can be considered.

To effectively engage local governments it is first of all necessary to clarify their mandate and roles in a new system.

***MOH/MOFPED may further want to coordinate within the Cabinet of Ministers, plans of the MOH to start a social health insurance and the plan of NSSF to create a medical insurance. It is recommended to develop a universal coverage policy that is based on the principles of non-fragmentation, no opting out (as was suggested by the representatives of employers and employees) and a single purchaser, laying the foundation for a unified scheme.***

### ***c. The NHIS Coverage***

The proposed National Health Insurance Scheme would ultimately be a mandatory scheme covering all residents of Uganda, paid from contributions, offering a minimum health services package and implemented by an independent government agency.

## **IV. Challenges of establishing NHIS, perceived by the MOH**

The health care system in Uganda needs massive investments in both systems and infrastructure. The MOH presumes that the NHIS shall be a catalyst for such huge investments in the sector.

Implementation of the NHIS is a political decision from the highest state office. In all the countries the MOH has visited, health insurance started with challenges that get addressed during the process of making the scheme operational. Every country visited designs its own Social Health Insurance scheme taking into consideration of its unique socio-economic and cultural realities while continuously adapting the design to emerging issues. The MOH is of the opinion that it is high time Uganda faces the challenge of creating social health insurance and launches such scheme not only to improve revenues for health care and better management of services but also to catch up with other East African countries exhibiting perceived gains of health insurance.

The Scheme, according to the MOH, shall yield funding for health care services as planned. The SimIns (simulation) demonstrates collections to gradually increase from Ugx 32.2 billion in the first year to Ugx 72.7 billion in the sixth year of implementation as more people are brought on board. It further assumes improved equity in access and a substantial reduction of OOPs at the time of delivery of services.

MOH acknowledges the lack of provision to cater sufficiently for the indigent, although the government is shouldering this responsibility through better funding of public and private not for profit institutions. At a later stage a subsidy to encourage the poor joining the scheme shall be discussed.

The inception report of a study commissioned by the MOH raises the concern that there are significant risks that a poorly designed scheme could require unexpected government support, increase the degree of market segmentation and social exclusion, and thus impair progress towards priority national health goals, such as the pro-poor health priorities set by government.<sup>64</sup>

Knowledge and ownership of the NHIS proposal appear to be concentrated within the MOH established Task Force on Health Insurance. The NHIS is still seen very much as a MOH driven proposal rather than a Government of Uganda one, and as a result little attention has been paid to integrating the proposal into the overall financial and social protection system in Uganda. The NSSF has so far refused to take its seat in the TF, probably related to plan of the NSSF to establish its own medical insurance.

This clearly has potential implications for the feasibility of expanding the NHIS beyond formal sector workers and including both the informal sector and the poor. Since SHI schemes in several other African countries have failed to expand beyond the formal – or even the formal civil service – sectors, it is clear that adequate planning for this expansion must be done in advance during the overall establishment of the scheme to make sure that such an expansion is feasible. This is an issue, which extends beyond the competences of the MOH and therefore requires active involvement and planning from the relevant ministries and agencies.

## **V. Technical & operational observations on the NHIS**

Hereafter follow the observations of the P4H team on the proposed scheme. These observations are based on prior involvement of the team members and the organizations they represent in Uganda. They are further informed by meetings with stakeholders and the review of relevant documents as provided by MOH or in the literature.

### **1. Financing**

The current proposal and discussion on the NHIS is inflationary due to the proposed use of fee-for-service (FFS) payment systems and the absence of official copayments, which could make patients think twice before using the health care system. The resulting high premium will be a barrier to the extension of health insurance to the poor or the informal sector. Copayment with an exemption mechanism for the poor may constitute the better option in combination with a FFS based payment system in an open-ended financing mechanism like health insurance without copayment (especially for the better off formal sector workers). The inclusion of an income dependent copayment system may allow for

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<sup>64</sup> Ssentamu / Mwebaze / Yawe (2009)

a broader and deeper benefits package, which will serve the poor who could otherwise not afford the payment of additional benefits outside of the package. The burden on the employer and competitiveness can be short-term only because the labor market in Uganda is likely to have excess supply (of labor) and the employer may then try to reduce the increase in workers' salary.

Determining payment systems for providers will require political will and should not be driven by technical issues such as costing but by the feasibility for cost-containment and quality assurance. For hospitals, offering inpatient and outpatient care, Uganda could begin by introducing simpler classifications of case-based or DRG-based payment, combining inpatient and outpatient care using the same definition of a case or group. There is definitely a need for capping the total amount for a hospital to prevent case inflation and unnecessary re-admissions, and even more so if Uganda went ahead with FFS. A capitation system may be the preferred choice for primary care, possibly combined with some FFS elements so as to stimulate e.g. public health relevant interventions or neglected services such as participating in vaccination activities and screening on high blood pressure, diabetes and cervical cancer.

***The MOH is advised to reconsider the payment systems as proposed by one of the working groups of the Task Force on Health Insurance***

The contribution to NHIS from the government budget for the civil servants will create a large continuous financial obligation, which could reduce public (budget) resources available for the poor and can have a negative impact on the public health care system, which will remain dependent on budget funding. This is especially so because the poor will have to use the public health care facilities as long as they are not included in the health insurance system. The Government could use the premium amount of the budget to strengthen public health facilities, which can be more effective to achieve better health for the population in an equitable way. For better performance of public hospitals, the government is advised to provide some degree of financial autonomy to public hospitals, along with an effective budget allocation scheme, i.e. establishing a purchaser-provider split creating a strong purchaser function. A sound health care delivery system based on well-performing public or adequately regulated and supervised private hospitals is a basis for effective health care financing and would eventually promote the smooth introduction of social health insurance.

## **2. Coverage**

The real challenge in Uganda is attainment of universal coverage, as there are considerable gaps in health care seeking, provision and financing. Only a very small proportion (say, <1%) of Ugandan population probably receives adequate, appropriate and affordable health care. Many others receive partial health care from qualified or less-than-fully-qualified practitioners and incur household out-of-pocket spending; share of prepaid resources in private health spending declined from 0.3% in 1998 to 0.2% in 2007.<sup>65</sup> At the other extreme are people not receiving any care; only 33% of deliveries occurred in government or private not-for-profit facilities in 2007-08.<sup>66</sup> In the past, an increased government spending on health seems to have resulted in an increased health care coverage in Uganda.<sup>67</sup>

While the proposed National Health Insurance Scheme (NHIS) desires to cover all citizens and residents of Uganda, it is scheduled to take about 15 years to reach universal coverage.<sup>12</sup>

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<sup>65</sup> WHO (2009a)

<sup>66</sup> Government of Uganda (October 2008)

<sup>67</sup> Tashobya / Kirunga / Ssengooba / Cruz / Oliveira (2006)

**Civil servants first.** The proposed Bill offers protection only to civil servants for the first stage of implementation of the NHIS. Although civil servants come in many varieties and have different income levels, they are not the poorest category of society in Uganda. The proposal is to gradually expand the scheme, first with the formal private sector and thereafter with the informal sector. The informal sector includes the poorest people of the country and it will take a long time (15 years!) before they will be enrolled, if this will ever happen.

**Expansion and opting out.** The foreseen expansion of the scheme with the formal private sector is not secured upfront. Employers and employees would like to have the possibility to opt out and employees want to keep their current benefits. Granting such opting-out possibility would undermine the viability of the scheme and may make the expansion towards the informal sector impossible because of lowering of the contribution based revenues from this sector especially since these categories of insured would likely generate a high premium per subscriber if they stay in the scheme. The informal sector lacks the possibility to generate sufficient revenues to pay for the proposed package of benefits.

The Task Force has identified demands by some employee organizations that they have the option of keeping their existing health coverage and opting out of the NHIS. This has the potential of weakening the revenue base, especially since these groups of the insured would likely generate a high premium revenue per subscriber if they stay in the scheme. The current working position is that employers would consider joining the scheme after three years of performance of the NHIS.

**The poor.** The choice to start health insurance by covering the public sector employees leaves out those who are not in the public sector. Also after the next foreseen step, to include the private formal sector employees and their dependents, the poorer and most vulnerable categories of the population are still left out, together with the well earning professionals. This bill in its current formulation will not improve access for the poor and will not prevent them from impoverishment in case they are confronted with high health care costs.

The most disadvantaged populations have the maximum health care needs and they will probably have to wait for more than 10 years to see the fruits of NHIS. In other words, they will have to bear with issues of access, high out-of-pocket spending, and potential financial impoverishment for some more time. Given the fiscal and resource constraints, it may take even longer period to reach these population groups. From a social health protection point of view, this is a real concern.

To the extent the residents in the informal sector pay indirect taxes, they will be contributing to a scheme, which for a number of years favors the better-off while not receiving anything in return.

**Inequity.** The decision to commence with the formal (public) sector will lead to more inequity and may drain away health sector related human resources from the poor as these are shifted towards the implementation of the new scheme. Full coverage is planned 15 years after the start of NHI to reach the informal sector and the poor. In the meantime, these groups, which make up the vast majority of the Ugandan population.

**Inclusiveness.** From a political viewpoint, government would like to reach out to the majority of the population including the poor and disadvantaged. If the proposed NHIS excludes a vast majority and therefore, becomes unpopular, then it will be difficult to continue with the system because the government respects people's opinion. Therefore,

it is necessary to make the scheme inclusive. The feasibility of the scheme should not come in the way of covering the poor.

### **3. Solidarity**

In designing a new health financing system, i.e. using health insurance as one of the leading principles for achieving the objectives of equal access to health care, the principle of solidarity is key. Social health insurance systems are based on solidarity between the rich and the poor, between the healthy and the sick, between the working and non-working populations as well as between singles or small families and bigger families. Without these cross subsidies between different income groups it is difficult to imagine a NHIS with universal coverage. Because of the low revenue generating potential of the poorer categories of the population such solidarity, enforced by law, is a necessary ingredient of social health insurance. That's why in social health insurance contributions are related to income and are progressive, so via the percentage based contributions. Social health insurance does not use the principle of equivalence between risk and contribution as is seen in insurance in general and in private health insurance in particular. On the other hand, the level of redistribution is a particular challenge in LICs where the poor outnumber the formal sector 20-fold. A transparent and inclusive consultation process can be helpful in deciding about this level. To some extent the cross subsidy between income groups can be replaced by the role of tax subsidy towards the social health insurance system, added to the general insurance funds pool.

### **4. Two tier system**

The proposed implementation of NHI, to exist in parallel to the continued budget funding of public health care providers will create a two tier system, which may not bring equality in access to health services any closer. If the company based and private insurance-based systems remain then in effect a multi tier system will exist with all its inequalities in access to necessary care.

The current design (draft bill) points out that NHIS shall be mandatory for the categories specified by the MOH. It is presumed that in the path to national coverage this shall be a step-by-step approach. There are also health financing mechanisms other than the insurance, such as vouchers and the planned conditional or unconditional cash transfers. It is not clear the extent to which these will be integrated into NHIS, if at all. These instruments serve the different purpose of creating demand among the people, but may also be important elements of an overall health financing strategy, especially where the knowledge and acceptance of traditional health insurance mechanisms are low. They could act as financial incentive to utilize NHIS.

### **5. Multiple risk pools and weakened purchasing**

The proposed NHIS refers to a single insurance under a single authority. At the same time, it also talks about community-based insurance schemes. Moreover, it is not clear how the existing private insurance schemes will be handled. Under this circumstance, there is a possibility of a pool fragmentation and existence of multiple pools for health care funding, representing different health risks. The many pools may undermine the solidarity between the rich and the poor and between the healthy and the sick. There is also some confusion between the concepts of (i) multiple schemes under a single insurer and (ii) multiple insurers.

The new system may miss the opportunity to create a strong health services purchaser, which could contribute to increasing efficiency and improving quality of care provision via selective contracting of providers. On the contrary, the introduction of the NHIS is likely



to further fragment the already fragmented system. If the National Social Security Fund (NSSF) established its own medical insurance, if the MOH established the NHIS, and a voucher and a cash transfer systems for health care was being implemented, this would further contribute to the fragmentation and complexity of the health financing and SHP landscape:

- Social health insurance, financing a limited part of the costs of health care services across levels of health care and across the country, fuelling the establishment of private wards in hospitals and the creation of more dual practicing.
- National budget funded national hospitals with MOH in the lead role.
- National budget funded health care facilities with other ministries in charge (parallel systems)
- National and District budget funded district health care with the district authorities in the lead
- Private health insurance, implemented by until now four for profit insurance companies.
- Payroll tax funded and NSSF implemented medical insurance
- Health maintenance organizations
- Company based health care coverage
- Community health insurance, implemented by small scale entities, which will be inefficient, confronted with management capacity problems and lack of reserves to finance incidental catastrophic illness costs, therewith running the risk of collapse unless there is re-insurance and support from the government.
- Charity funded and implemented health care facilities
- Conditional cash transfers, implemented by distinct authorities
- Vouchers, implemented by distinct authorities
- Out of pocket payments (OOPs)

This would leave Uganda with 11 different schemes, payers and implementing agencies in the absence of sufficient pooling arrangements and strong management. The new to be created health insurance system would have little financial clout vis-à-vis the health services providers. The already scattered information about the production of health services providers would be further diluted, making performance review for the paying authorities, the purchasers, more tedious.

The proposal of NHI, with a new funds generating mechanism, a new pooling system and a new purchasing function, does not seem to be in line with the intention of the government to "... enhance funding to the sector by improving efficiency in mobilization, allocation and use of financial resources"<sup>68</sup>.

Community-based schemes are closer to the people and therefore, may be in a position to take NHIS to this level. But, of course, it requires careful planning to utilize their services and potential. While they are ideally suited to foster community mobilization and possibly revenue generation at the local level, they may fall short on technical expertise

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<sup>68</sup> GOU: Uganda Health and nutrition paper for the National Development Plan; 2009/10=2013/14, November 2008

to run the mechanics of a sophisticated health insurance operation. In addition, the risk pools at the community level may be too small to be sustainable suggesting that some type of re-insurance at a higher level may be advisable.

**NSSF medical insurance.** The NSSF, a government agency plans to create its own medical insurance scheme for its subscribers who are formal private sector employees, while plans of the MOH focus on coverage of civil servants at an initial phase and extend coverage to the formal and informal economy workers at a later stage. Community-based health financing is envisaged for the poor but no specific design or timeframe is indicated. Experience shows that multiple parallel insurance funds are often a barrier to the achievement of universal health care coverage. Hence it is recommended to develop a universal coverage policy for all population groups (informal and formal economy workers, civil servants, the poor etc) aiming at ultimately achieving a unified system that is based on the principles of non-fragmentation, no opting out and a single purchaser. Since both schemes, NSSF and the NHIS, are still in their design stage, there is a unique window of opportunity for harmonisation and laying the foundation for a unified scheme.

**Choice of insurer.** Demands by both employer and employee representatives for a choice of coverage from multiple insurers could result in mounting opposition to the current NHIS if implemented initially in the formal sector. On the other hand, if these demands are met, the result could be increased administrative costs, inefficiency, and the potential for providers to pit various insurers against each other, leading to cost escalation. This is a key issue that has not been fully addressed.

**The NHIS & decentralization.** The budget funding of public national and public district hospitals and of health centers will continue, i.e. a territorially decentralized system of funding and provision of health services will remain next to a new to be created vertically organized health insurance system. This fragments the already existing fragmented system even further and in a fundamental way. Fragmentation of health care funding leads to fragmentation of health care and therewith to inefficiencies in care delivery and an increase in overall administrative costs which the country can ill afford.

The financing from different sources of the national and the district health care providers will make the implementation of a referral system more difficult. National and district authorities will be tempted to shift as much of the health care burden and its costs as possible to the other authority. This will possibly leave the patient in uncertainty about where to seek care and the providers about who will reimburse them for services rendered.

## **6. Stewardship**

The introduction of the NHIS as separate from the budget funded system creates a new steward in the health sector, next to the MOH and District Authorities. This may make the new NHIS vulnerable to political strive for influence on the local level; it may create conflicting policies and hamper the effective purchasing by the NHIS agencies on all levels. The three captains on the health ship may all chart a different course due to their differences in political and financial objectives.

This may not be manifest at this moment but, if more categories of the population will have to be included and the local levels have a role to play in targeting and eventually paying contributions for the poor or simply handing out health insurance cards, they may be tempted to hand out cards not for poverty reasons but to attract voters. The three captains may also try to shift their health care burdens and costs to the other financier via unnecessary referrals, i.e. from District funded care to MOH funded care and from SHI funded care to Budget funded care.

## **7. Public health activities**

A further split in funding may also have consequences for the financing and implementation of public health activities like vaccination and screening of important diseases. Public health activities including promotive and preventive health care is an important component of population health. The insurance-based approach is likely to focus on curative care, unless specific efforts are made to include relevant interventions in the overall benefit package and provider payment mechanisms. A health insurance system, granting rights and entitlements to its insured, can be a vehicle to finance/insure individually oriented disease prevention and screening of important and preventable diseases. However, a health insurance system is not usually geared to the organization and payment of mass oriented prevention and screening, especially the functions of public awareness raising and public information campaign, inviting target populations to mass-organized diagnostic tests like breast and cervical cancer screening and the organization of quality assurance of such programs. A health insurance fund can be made to pay for these general public health and prevention activities, including vaccines, but these activities cannot be made dependent on the individual insured and its eventual demand for such services. MOH or District authorities need to be in charge of the mentioned general public health functions.

When changing the financing of health care providers, MOH may want to make sure that the intended mandate of the health care providers in the area of public health is or remains clearly formulated. The individual oriented prevention activities of curative health staff should be included in the benefits package and in the payment system while MOH continues the central organizing, implementation and quality assurance roles.

There needs to be a clearly defined mechanism to finance public health. Failure to do so may result in higher demand on the insurance resources in future through additional disease burden besides affecting population health status. One option that is pursued in other systems is the inclusion of performance-related incentives, as an add-on to the basic capitation payments for primary care, which focus on key preventive and promotive activities that are consistent with the overall national health strategy. For example, this could focus on antenatal and well-baby care (including nutrition interventions), as well as prevention activities related to priority communicable and non-communicable diseases (e.g., bed-net use, regular blood-glucose monitoring for diabetics).

## **8. Corruption**

A totally new NHIS may create new possibilities for corruption. Strong safeguards for transparency, accountability and oversight would need to be in place to prevent this as much as possible. But, even strong safeguards may not totally rule it out. The less fragmented a health financing system is, the easier it would be to prevent and fight corruption.

***Based on the aforementioned it seems that further discussion is warranted to look for a more optimal path to achieve the GOU's goals and to achieve sufficient social health protection, using effective financing tools in an efficient way. The P4H partners stand ready to support the GOU/MOH in such discussions and to provide practical solutions.***

## **VI. Organizational issues of the NHIS**

### **1. Preconditions to start implementing a NHIS in Uganda**

Although the P4H team recommends a fundamental rethinking of the current NHIS proposal before starting to design the implementation of a NHIS, the team nevertheless honored the invitation to comment on the proposed implementation arrangements of the NHIS and on related progress to date. These thoughts can also feed back into the policy process. The most quoted saying during the visit was: “the devil is in the details”. Looking at the practical consequences of the policy choices so far may help in revealing many details.

A number of conditions need to be fulfilled and some key questions answered before Uganda can embark on the establishment of a National Health Insurance. Some of the questions relate to political consensus and political will, others to the economic situation and the labor market. Last but not least there are many technical and administrative questions to answer.

The fact that there are several experts’ opinions available and different international missions on the issue of an optional NHI already conducted in Uganda indicates that some crucial steps have been taken already to answer some of those questions. However, the discussion about the draft of NHI is still ongoing. It may therefore be necessary to review the MOH strategy for the implementation of the objectives of the Government and to analyze the basic preconditions for NHIS, to assess concrete impacts of the planned NHI and also to assess alternatives. First of all a broad consensus is necessary among the stakeholders to implement such a NHI- scheme, to make any further steps towards operational implementation.

The review team did a short workshop together with representatives from the MOH on 11 August 2009, which showed that some important political and organizational preconditions for the implementation of NHI had not yet been fulfilled or not completely:

- Achieving consensus among Uganda’s political decision-makers and stakeholders, and getting the support of the President, the Cabinet of Minister and the Parliament.
- Support by international development partners
- Openness and comprehension of the reform among Uganda’s population
- Minimum of insured people in the beginning
- Sufficient management capacity, experience in insurance, purchasing and claims handling.
- A basic technical infrastructure and at least a sufficient budget to establish such infrastructure to run a NHIS
- Openness for external support and implementing the system with the help of a professional project management team
- The creation of a legal framework and reviewing/updating existing requirements
- An acceptable health care infrastructure, able to provide the health services referred to in the health insurance benefit package.

If Uganda embarks on the establishment of a NHIS then it is worthwhile to look for ways to cooperate with already existing institutions and to see if there are channels and capacities that can be used for e.g. the collection of taxes and contributions in the formal sector and for managing revenues and fund pools by e.g. the Uganda tax authorities and the NSSF; For the collection of contributions from the hard to reach informal sector and for public information campaigns and awareness raising for the informal sector cooperation could be considered with the community medical insurance

(CMI) organizations and health maintenance organizations (HMO's), especially in the first stages of development of NHIS.

## **2. Implementation plan**

It is evident that Uganda needs a transition period to achieve universal coverage if it would embark on a new and separate health insurance scheme. For many countries, introducing health insurance, it took often more than 20 years to implement universal coverage and some countries that started long time ago still struggle and have not reached universal coverage. Some of these experiences could provide valuable lessons for Uganda.

During the workshop on the organizational aspects of establishing health insurance, many steps were identified as necessary. These have not yet been taken by the MOH.

The comments on the draft health insurance bill in section VIII and its annexes refer also to many aspects on which a decision will be necessary in order to proceed.

## **3. Financial resources**

The necessary funding resources of health insurance depend basically on the definition of the contributors, beneficiaries and the benefit package. The ultimate shape of the benefits package will have to be based on an iterative process of actuarial work to see what is affordable. International experiences of existing health insurance systems might be helpful for answering the as yet unanswered questions in the Ugandan decision-making process.

The proposal identifies the sources of funding but excludes, until now, transfers from the Budget to NHI.

Due to the fact that currently available health insurance infrastructure in Uganda is insufficient to deliver a full range of quality services to the entire population it will be necessary either to invest in the basic structure from the government's side (including costs for basic investment in infrastructure like buildings, data-warehouses, insurance card etc.) or to refinance the investment on the private market, possibly through Public-Private Partnerships. The latter will lead to expenditures for interest and repayment.

## **4. Human resources for NHI**

Although private health insurance exists albeit on a limited scale, there is little capacity for social health insurance, quantitatively and qualitatively. Therefore, a massive capacity building effort is warranted. The human resources needed to run a health insurance system in an efficient way should reflect the basic functions of the planned NHIS at headquarters and its offices elsewhere in the country and the functions that are planned to be contracted out (like the collection of contributions)

## **5. Material resources**

Investments will be necessary to plan and execute the implementation of the Scheme. The initial cost to set up basic health insurance structures, consultative and sensitization campaigns is estimated by MOH at Ugx 16.5 billion over a period of 3 years.

Calculation of the material resources necessary for investments in infrastructure and for running the scheme will need to be done based on the policy and administrative

decisions as referred to in this report. The MOH estimate contains capital expenditure to:

- Set up and organize the NHIS central office
- Set up 12 zonal offices
- Hardware and software for central office, zonal offices and accredited providers
- Mass advocacy campaign
- As the scheme takes root, expenditure is expected to decrease to UGX Shs. 4.4 billion in the third year.

The review of a paper and a discussion with the Subgroup of the TF on Organizational issues left many questions unanswered especially the planned numbers of staff for such essential functions as provider performance review and the purchasing of services. The planned number of satellite offices is far too low to allow for adequate functioning of the NHIS.

Since the NHIS will require substantial infrastructure to operate effectively, additional resources are needed for revamping the existing structures, this will require significant start up resources. Though the proposed World Bank assistance of US\$ 100 million is directed at health systems strengthening, it is not linked or targeted towards the NHIS at the moment, neither are other resources in this regard. Part of the challenge lies in the dilemma of the initial start up of the scheme, whether to cover the entire population or to start with government employees or the informal sector and the poor. In the absence of a start-up investment, or even initial technical assistance and capacity building to develop a comprehensive implementation plan, there will be a big mismatch between the policy of covering all Ugandans and the capacity to deliver it.

## **6. Gradual implementation**

In August 2009 there was no evidence for a concrete definition and scheduling of the proposed step-by-step model, including how to get the “poorest of the poor” integrated into the system from the very beginning. This impacts the planning of the organization of NHI

## **7. Managementsystem**

The functions of the NHIS management and administration can be distinguished in internal and external management processes.

The external processes are:

- Benefits related processes (including all questions of benefit packages and services)
- Members'/Employees' oriented processes (memberships, data-collection, campaigns for new memberships)
- Contributions' oriented processes (collecting and controlling contributions, reminding, summary proceedings)
- Employers' oriented processes (memberships, data-collection, employers' consulting)
- Providers' oriented processes (data-collection, contracts, negotiations, quality management, monitoring)
- Supplier oriented processes (procurement, renting or leasing of office space, of goods, supplies and services, eventually including insurance focused research.
- External relations oriented processes (national and international stakeholders)

The internal processes are:

- Personal processes (human resources management, training, employment, dismissals, salaries)
- Administrative processes (infrastructure, buildings, procurement, data-warehouses)
- Financial processes (current accounts, budgeting, reinvestment, payments, transactions, pooling processes)
- Management processes (setting goals, controlling, delegation).

The bodies of the NHIS will need to have an organization that covers the external and internal processes in different departments with qualified specialists. The necessary qualifications will include account managers, customer advisors, public health managers, economists, actuarial staff, administrators, physicians, pharmacists, allied health professionals, contracting specialists, lawyers, security and support staff. To preparing the implementation of the NHIS it will be necessary to hire specialists and to train Ugandan professionals in the above mentioned fields and have them prepared at the start of the scheme.

To estimate the quantity of the needed staff it is necessary to have detailed information about the sectors in which the NHIS will start working and how it would like to operate in the various processes: outsourcing of functions, choice of provider payment system, the possibility to use ICT and smart software for the performance review of providers.

## **8. Constraints**

Moving forward with the implementation of NHIS will require answering many policy and organizational questions as indicated above and in the previous sections. By August 2009 there was basically a lack of:

- A solid target conception of the NHI (affects both personnel planning and capital spending)
- A valid inventory of potentially available management, staff and infrastructure
- Reliable budgeting
- Actuarial forecasting
- Operational manuals
- Quality management tools

## **9. Project-organization, setting priorities and mile-stones**

### **a. Macro level**

Preparing a more detailed analysis of needs and requirements could be one of the tasks of an operational project management team that is advised to be installed for the implementation of the NHIS. The GOU may consider hiring external insurance international experts, teaming up with national experts and staff of MOH, Uganda academia and other organizations. Such team needs to have sufficient budget, adequate basic infrastructure to work in (training capacities included) and both willingness and capacity to deal with resistance and set-backs.

The already existing Task Force could be in charge of advising how to clear up the political preconditions whereas the operational project management team would be

responsible for preparing the implementation of the required management tools and processes.

The basic steps of building up such a NHIS, starting with the planning process, are illustrated in Annex 7

Establishing priorities is one of the most important essentials for the further reform steps. An overview of basic milestones with an optional time-table is given in the next diagram:

AOK - Die Gesundheitskasse für Niedersachsen

### Milestones and Steps of Realization (Example)

Activities, Measures	Jan.-June - 2010	July – Dec. 2010	Jan.-June 2011	July – Dec. 2011	Jan.-June 2012	July – Dec. 2012
Projektorganisation- Preparing activities	XXXX					
Hiring project manager and project team	XXXX					
Training of operational task force		XXXX				
Training of multipliers		XXXX				
Supervisory Body is constituted		XXXX				
Health Insurance Bill is codified		XXXX				
Managing Director is hired		XXXX				
Establishment of Board of Directors		XXXX				
Press conference with President and Health Minister		XXXX				
National Health Insurance starts work in defined sectors and regions		XXXX				
Training of managers and multipliers for to expand the system			XXXX	XXXX		
Health Insurance expands and covers other sectors and regions					XXXX	XXXX

Dr. Drupp/P4H/OASIS Mission in Uganda/August 2009

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#### **b. Micro level**

The proposed organizational structure of the NHIS ends at the regional level although the political decentralization goes up to the district level. If NHIS desires to achieve social health protection, micro organization is very important wherein purchasing of services takes place. The role of the community, community health insurance (see separate section), civil societies, village health teams and community development workers is very important. A micro structure with appropriate representation of these groups of people will be an advantage for the successful implementation of social health protection through NHIS. Such an organization does not mean the creation of a new building or administrative structure. It could operate within the limits of local government or health centers, as long as it has political legitimacy and the respect of the population.

***As soon as there's clarity about the main policy directions on how to achieve SHP, the GOU/MOH is advised to create a project team along the above mentioned lines to start the implementation process and provide technical feedback to policy makers as they will need to be informed about the technical and financial implications of their original choices and decisions. P4H partners would be ready to consider support for such project team.***



## **VII. Financial aspects and fiscal space**

### **1. Health insurance context**

Health insurance exists only for a few (<1% of population) and is largely subsidized by employers on behalf of employees; only 0.2% of the private health spending is organized through any prepaid mechanism. A survey (only in Kampala) among the formal sector employers and employees revealed that 56% of the employees were covered by any form of health benefits<sup>69</sup>, 38% were currently insured and another 18% had some form (e.g., on-site clinic) of health care coverage.

Forty eight per cent of the employees expressed their willingness to join the proposed NHIS mainly because it is likely to cover people particularly when they are unlikely to have money (e.g., middle-to-end of a month) and promote health care such as wellness check-ups (of which the effectiveness can be questioned). Employees not covered currently are more likely (70%) to join the NHIS compared to those who are currently covered (51%). Half of the currently insured are likely to continue with their private insurance despite the government sponsored NHIS. Poor state of the government hospitals acts as a major disincentive for the employees. Over 70% preferred a mix of public and private health care providers. Fifty seven per cent employers supported the NHIS; they were willing to contribute 3-6% of the employee salary. The willingness was not different for employers offering health coverage or not.

The willingness of the general community for any type of insurance is unknown. But, one of the Task Force members mentioned that people may not be willing to pay for insurance or they may want a different form of insurance that takes into account their concerns. For instance, people ask 'what will happen to my money (premium) if I am not sick?'. Another member indicated that there might also be a kind of stigma associated with the term 'insurance' probably due to their bitter experiences in the past with respect to some form of (private) insurance. It is repeatedly stated by some policy makers that the biggest obstacle in the process of NHIS implementation is sensitizing the people to the need for and benefits of health insurance. For the people, it still remains a mystery although the media has probably carried different variants of dialogues about NHIS.

Another important issue is the general absence of a strong feeling of social solidarity, which is a pre-requisite for the kinds of social transfers (from the wealthy to the poor and from the healthy to the sick) inherent in social health insurance. It is not clear how this issue is to be addressed.

### **2. Community involvement<sup>70</sup>**

Currently there are 33 CHI schemes operating in Uganda, covering about 100,000 people. Some of these are community owned, while others are owned by hospitals and/or NGO's. All packages cover in-patient care, while some also cover out-patient care. Chronic conditions are usually excluded. All packages have a co-payment (equivalent to about 20% of the cost of the service), as well as an expenditure ceiling. The choice of providers is also dependent upon whether the scheme is being promoted by an individual facility or a community, although no schemes currently offer coverage beyond the immediate Geographic area. Public facilities are currently excluded as

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<sup>69</sup> Zikusooka (2007)

<sup>70</sup> Summary of Meeting with Community Health Insurance representatives

eligible providers. Coverage is typically 10% of the eligible population, but this is an estimate complicated by the lack of clearly defined catchment areas. Coverage is limited by both the lack of regular incomes and by chronically low incomes. There are regional variations, however, so these problems are evident in all areas where such schemes currently exist.

The available packages include pure insurance, as well as credit (12 schemes) and mixed insurance/credit approaches (3 schemes). The credit schemes operate through a lump-sum initial payment, followed by regular maintenance payments. If a subscriber has a major medical expense, it can draw on the available credit and even borrow to cover the cost. The loan is interest-free and is supposed to be repaid in 3 months, but enforcement of the timeframe has proven to be quite difficult. Repayments of 8 months and even a year are not uncommon. It is estimated that about 7% of the loans are not collectible but there currently isn't a process for writing off such loans.

The promoters tend to target organized groups and school-based schemes (covering both students and teachers) are becoming quite popular. Pure community-based schemes also exist. Some schemes have risk pools limited to individual groups, while others pool risks from different groups. Premiums range from UGX 3,600 to 20,000 per person per year, and the rates depend upon the groups targeted and the specific fund manager. Some schemes have premium subsidies for the poor. The dropout rate averages about 10% per year, although the rate in some schemes is much higher. There are also several NGO's (primarily CORDAID and EEP), who are supporting the CHI movement.

The umbrella group for the CHI's (the Uganda Community Based Health Financing Association or UCBHFA) would like to improve the regulatory framework for the schemes and pursue minimum standards. It is also very interested in working with the MOH and NHIS to promote CHI schemes in advance of the extension of SHI to the informal sector. However, it feels that the current timeline for this inclusion is too far away. UCBHFA also feels that it could play a useful role in vetting schemes to be included in the NHIS using accepted standards. It is not clear how the potential conflicts of interest (the Association is owned by its members) could be addressed if this was pursued. In order to play this promoting and vetting role, it would need some financial and perhaps material support. It is hoping to reach 8 sub-counties in the next 4-5 years using their own resources.

The Association pointed to Kenya as an example where the informal sector was brought into the NHIF through group contracts with CHI's. It also felt that the approach in Tanzania, where CHI's were being brought under the NHIF to both provide re-insurance and expand the scope of services beyond the specific community, should be monitored.

### ***3. Household out-of-pocket spending***

Since NHIS aims to start with public and private formal sector employees, it may not bring down OOPs but rather it may push it up if the cost of 'open market care' goes up as a result of dwindled free health care inputs due to NHIS. It may also push up the share of population without adequate health care.

In the short-term, increases in government health spending will mainly come from endogenous budgetary increases and DAH. This assumes that government health spending will respond in the same way to growth as it did in 2000-06. Nominal total government health expenditure and government per capita health expenditure are expected to triple and double, respectively, increasing the percentage of GDP spent on

health from 3.13% to 4.08% over the period 2007-15.<sup>1</sup> The impact of Uganda's high population growth rate mitigates the projected effect in per capita terms.

Expectations from public service employee representatives that they be "made whole" for the employee share of the NHIS contribution, on the grounds that the provision of some form of medical care coverage is part of the conditions of employment for public servants. This would mean that the entire 8% would come from the GoU budget, in effect making the public service part of the scheme totally financed by the budget. The Ministry of Finance is incorporating this expectation in their planning, likely making it more difficult to allocate the necessary financing for this scheme in the budget. Moreover, since public servants will be the first group to be enrolled, acceding to this demand would generate similar demands from private sector employees; the next group to be included. This could be expected to lead to further opposition from employer groups on the grounds that labor costs, corporate profit margins and Uganda's international competitiveness could be adversely affected.

#### **4. Absorptive capacity**

Absorptive capacity constraints make it difficult to effectively utilize increases in planned expenditure so that even if fiscal space exists it may not be used due the presence of such constraints. The need for additional health sector resources is indisputable, but without improving the absorptive capacity of the health sector, especially human resources and management capacity, additional resources may not be utilized efficiently. Providing additional resources beyond the absorptive capacity of a sector can have negative consequences if using such resources is not planned properly.

Without addressing the labor shortage and increasing the efficiency of existing staff, additional resources for health may lead to further inflationary pressures (e.g., increased wages for health workers) or displacement of some activities (e.g., maternal care) by others (e.g., HIV/AIDS counseling and treatment), which may not completely align with overall government priorities. Key priorities include addressing the human resource shortage in the short-term by reducing absenteeism, and in the long-term by increasing training of health workers and health managers, increasing the availability of drugs, medical supplies, and basic equipment, without which medical staff can achieve little. Moreover, the incremental nature of the budgeting process means that budgets cannot easily shift in response to changes in service delivery.

#### **5. Benefit incidence**

There has not been any systematic review of resource utilization, including the OOPs. At present, it is not clear what is being purchased out of the existing resources. People may simply finance unnecessary care, mark-ups, and inefficiency. Under NHIS, it is possible that people may be insured but still not receive care due to lack of facilities. Or they may have to spend on travel to get to appropriate facilities.

A crude benefit incidence analysis suggests that current health care utilization is pro-poor. However, this analysis masks the income-related differences in utilization patterns: poor households predominantly use health centers and wealthy households use hospitals. This suggests that focusing on improving access to health centers and dispensaries is an important pro-poor strategy. Over one-fourth of households report incurring health expenditures that can be deemed catastrophic, and a majority come from households in the lowest income quintile. Evidence suggests that out-of-pocket expenditures incurred for drugs and hospital/clinic charges have increased, which implies that the abolition of user fees had only a marginal impact on out-of-pocket expenditures.

## 6. Health system efficiency

There is considerable room to improve efficiency in the health sector. Table-1 provides estimates of the most significant leakages in the current public health care system<sup>71</sup>. Significant room also exists to improve programming methods of DAH, and to ensure overall budgetary coherence. However, it is recognized that the scope for doing so may be constrained by the policies of particular development partners. In addition, improving health workforce management and performance, strengthening procurement and logistics management for medicines and supplies, and aligning sector performance to defined results offer great potential to advance overall sector performance.

**Table-1**

### Calculations of waste: Financial Year 2005-06

Problem Area	Source	Wastage
PHC Non-Wage Grant leakages (UGX billion)	PETS	3.0
NGO PHC Grant leakages (UGX billion)	PETS	3.0
Questionable Expenditures (UGX billion)	Auditor General's Reports	2.4
Ghost Workers (UGX billion)	Payroll Clean-up Exercises	1.0
Health Worker Absenteeism (%)	Chaudury et al	26.0
Drug Leakages (UGX billion)	NMS (Expiry)	1.3
Total waste (UGX billion)		36.7
Total health expenditure (UGX billion)		285.0
Health expenditure wasted (%)		13.0

There is no referral system currently in place. People bypass lower level public facilities and go to higher referral level facilities meant for complex cases. This puts additional burden on the higher level facilities besides adding to the cost of patients and health care institutions.

The private health care and insurance sector is unregulated allowing a lot of heterogeneity among them. Most of the qualified formal private sector facilities, particularly for inpatient care, are located in urban areas. Some of the private facilities are also in debt trap and thus may see the NHIS as an option open to them to correct it. It is not clear how NHIS will affect the solvency of private health care providers.

## VIII. Quality assurance

The proposed health insurance implementing bodies will have to engage in the assurance of the quality of care provided to its insured by the health care providers. In this role NHI can or has to rely on already existing mechanisms that are outside of the mandate of NHI and it can establish its own tools.

<sup>71</sup> Source: World Bank Fiscal Space Study

**1. External mechanisms, like:**

- undergraduate and graduate education of health professionals and other health workers
- Registration and licensing of health workers (like the ones via the Councils for Medical, Dental, Nursing and allied health professionals; and the licensing of private practitioners).
- The licensing and inspection of labs, diagnostic centers, blood transfusion centers and of medical devices is not known to the review team.
- Mandatory continuous professional development
- Planning regulations. Unfortunately, Uganda has no explicit planning regulations by which it can steer the distribution of health providers over the country and levels of care, steer their capacity and set minimum service delivery standards. It has also no tools to influence the distribution of high tech and high risk intervention over the country.
- Independent health inspectorate or health commission/council, mandated to inspect providers, signal sub-par performance, demand for corrective actions and eventually close a ward or facility or start a procedure to suspend licensing or registration of a health professional. Such function seems not to have been established in Uganda, except for pharmaceuticals.
- An accreditation system of health care providers, currently not existing in Uganda

**2. Internal mechanisms (at NHI):**

- Selective contracting based on external qualifications (indicated above). More about contracting in the annex about the legal issues and the comments on the draft National Health Insurance Bill
- Certification of institutional providers, based on a limited number of minimal norms and standards as to see if these providers are able to provide the insured the benefits they are entitled to. The standards need not to only include quality of health care aspects but can also refer to governance and administrative issues as well as to referral agreements and procedures with other providers.
- Provider performance review, looking at the appropriateness and efficiency of the provided services, based on the review of submitted claims against existing standards and medical protocols done manually or with the use of ICT and dedicated software programs
- Any of the above external mechanisms if not or not sufficiently available.

NHI needs not to duplicate external quality assurance mechanisms and if they don't exist it is not directly up to NHI to establish these. This can be left to MOH to legislate and to implement by itself, by the Districts or by specific dedicated agencies or even NGO's.

***In any case, NHI is advised to have in-house capacity for selective contracting and for performance review of providers.*** External support will be necessary to establish such capacity.

**3. Accreditation.**

The proposed system of "accreditation" of health care providers, in the draft Bill formulated as a task of NHI, can also be introduced as separate from the implementation and existence of health insurance. It is preferred to have accreditation, at least on the long run, as a separate system, aiming at continuous quality improvement for all providers irrespective of their eventual acceptance as a provider of care to insured patients.

The simultaneous introduction of health insurance and accreditation may cause capacity and management problems for the new NHI body. However, a future NHI scheme and hence the NHI Bill should link to all existing quality assurance and external quality assessment mechanisms for health care services i.e. accreditation can be seen as a necessary condition but may not be sufficient for a payment relationship with NHI, i.e. a contract.

It is advised that providers should be accredited for separate levels of care to be reimbursed by the NHIS i.e. a provider is either accredited to provide primary or secondary care. This will help to prevent the confusion that may be associated with accrediting a provider to provide primary and secondary services.

***It is therefore advised that MOH takes the lead in establishing an accreditation system as part of a comprehensive approach to quality assurance, separate from NHI which can become implemented by an autonomous public or private accreditation body and which will not add to the burden of NHI establishment and implementation.***

## IX. Legal

The draft bill offers a clear overview and outline of how the Government of Uganda (GOU), i.e. its Ministry of Health (MOH) sees the legal elements of the proposed health insurance system in Uganda. The structure of the law is a good one. It includes basic legislative regulations and the main topics to be regulated that are necessary to implement a National Health Insurance (NHI) system, though some important elements are missing, like contracting of health care providers while other elements can be strengthened.

Detailed comments on the Bill are provided in annex 8, which reviews the Bill against the principles of SHP, the GOU's own objectives for the health sector, against the objectives mentioned in the current draft and against principles of clarity, cost-containment and quality assurance tools of the planned NHIS. Based on this review, the P4H team reaches the conclusion that ***the Bill in its current form is not considered sufficient for achieving Social Health Protection, does not offer a realistic perspective of accomplishing the GOU's own health objectives and is also therefore in need of improvement if it is to provide the vehicle for reaching the goals as mentioned in the Bill. The P4H partners would be happy to consider further request for assistance in these legal matters.***

## X. Options for reaching SHP, Pros & Cons

### 1. Universal coverage

The real challenge in Uganda is attainment of universal coverage, as there are considerable gaps in health care seeking, provision and financing. Only a very small proportion (say, <1%) of Ugandan population probably receives adequate, appropriate and affordable health care. Many others receive partial health care from qualified or less-than-fully-qualified practitioners and incur household out-of-pocket spending; share of prepaid resources in private health spending declined from 0.3% in 1998 to 0.2% in 2007.<sup>72</sup> At the other extreme are people not receiving any care; only 33% of deliveries

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<sup>72</sup> WHO (2009a)

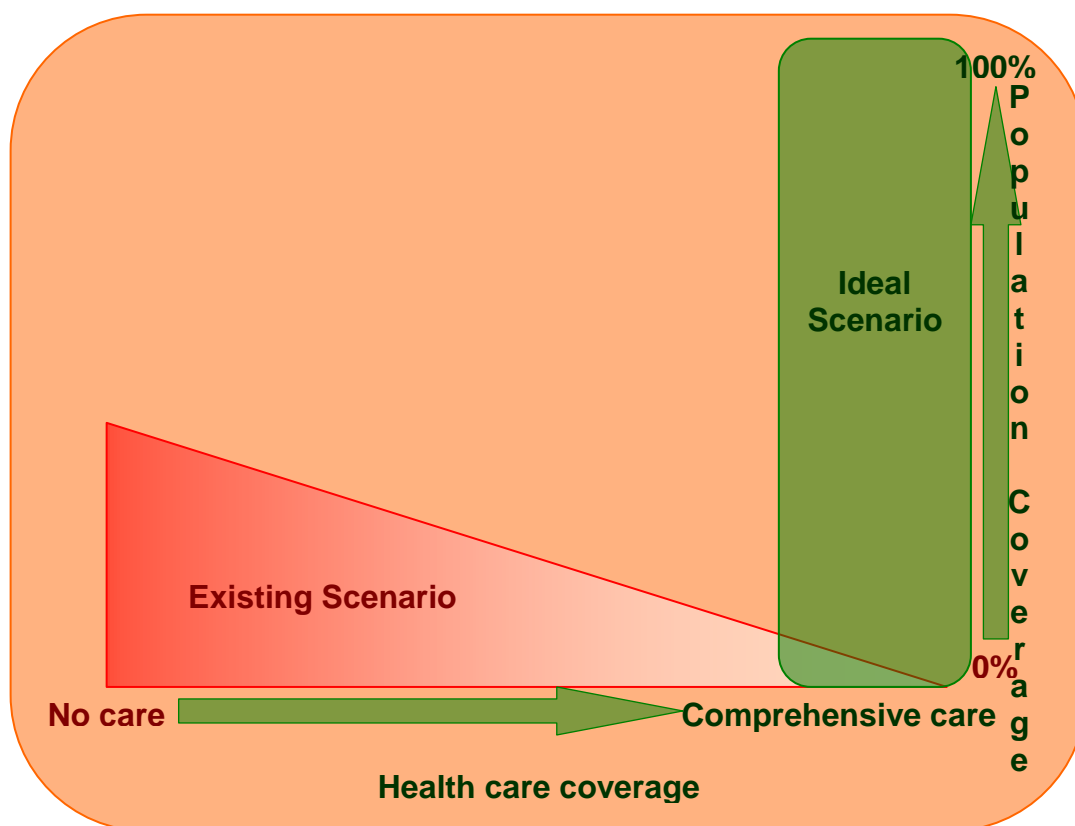
occurred in government or private not-for-profit facilities in 2007-08.<sup>73</sup> In essence, the health care triangle (Figure-1) needs to be reworked. In the past, an increased government spending on health seems to have resulted in an increased health care coverage in Uganda.<sup>74</sup>

The current approach of focuses on “private wings” of public health care institutions to provide NHIS benefits. This carries substantial risks of exacerbating human resource, capital and other pressures on the remaining parts of the public health care facilities. There is also the possibility of it leading to a deterioration in access and/or quality of care for non-insured persons. There will be substantial incentives to ensure that private wing patients can be accommodated, which could result in having staff sitting idle in the private wings, “just in case”, while the “public” part of the facility is increasingly short-staffed.

There is also a danger that the limited health care workforce may be pulled out of rural areas. This is especially so if they are not covered by good quality infrastructure and sufficient financial incentives to attract the insured and the health care workforce. The initial NHIS focus on a relatively small and geographically concentrated segment of the population will intensify the potential difficulties. This may occur when many health facilities will cover a handful of NHIS beneficiaries are also expected to provide a full range of insured services.

Figure-1

**Universal coverage - a long hard way to go**



Source: Varatharajan Durairaj, WHO

<sup>73</sup> Government of Uganda (October 2008)

<sup>74</sup> Tashobya/ Ssengooba/ Cruz (2006)

## **2. Rationale and description of alternative options**

The hereafter proposed alternative health financing options all pretend to contribute to poverty reduction by limiting and hopefully preventing impoverishment in case of using essential medical care for objective medical needs. Further, making health care accessible for the poor and therewith improve their health status will as such improve their prospects of making a better living and improve their earning capacity.

### ***a. Multiple options under a single insurer***

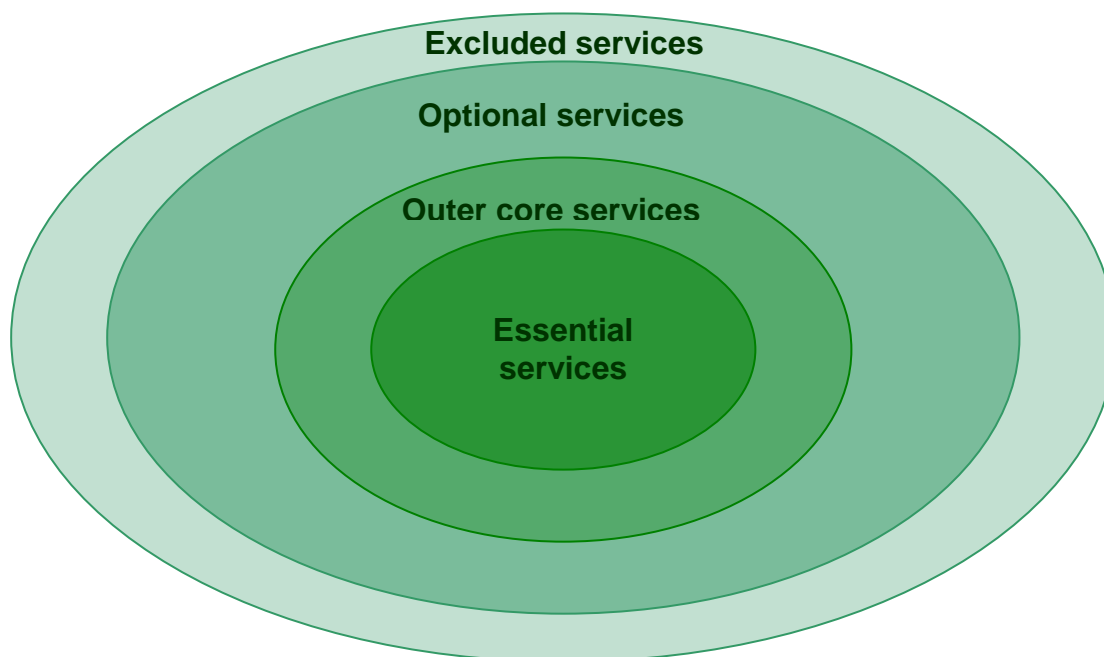
Equitable health care may not be possible from the onset as a result of the variation in health care infrastructure across the country. Although a uniform premium will be contributed, care received would vary between the urban and rural centers. Urban areas may thus have access to health care services while rural areas may get inferior care or substantially less access to care (including choices with respect to providers) despite also being insured. It is already known that about 60% of the people first visit a less-than-fully-qualified practitioner before getting to the formal sector. It is not known how many of those seeking care from less than qualified practitioners (LTFQs) proceed further to receive subsequent care from formal health care providers. In other words, LTFQs may be the first and final contact points for some people. This reality needs to be taken into account while devising strategies to reach qualified health care to the doorsteps of all Ugandan citizens and residents. The existence of obtaining services from the LTFQ is a by the TF envisaged reality. However, the TF is of the opinion that the proposed health insurance scheme should gradually address the imbalance in the availability of professional health services by providing incentives to health providers to work and stay in hard to reach areas. Therefore the options as proposed in the Chinese schemes could be incorporated in the current design of NHIS. Also the LFTQ's could be offered a chance towards continuous professional development.

A perfect financing scheme with an imperfect health care delivery system may not be acceptable to the people. Therefore, it may be ideal to have a multi-tier insurance system coupled with non-insurance transfers, which is sensitive to the health care options with the scope for gradually improving towards a higher quality of care. Graded premiums with free insurance for the poor and the highest premium for the rich could be optimal (Figure 2 suggests a possible framework. Rural residents could be backed up with cash transfers for transport to ensure access to the most appropriate health care facility.



**Figure-2**

**The suggested multi-tier insurance**



**Source: Varatharajan Durairaj, WHO**

Targeting the poor under any system is expensive. But, targeting geographic areas is relatively easy and inexpensive. Therefore, it may be useful to have a dual insurance model - one for urban areas and another other for rural areas with options built into each one. This is very much in line with the approach seen in China, where there are different schemes for the urban workers, the urban residents, and the rural residents (workers and non-workers alike). Related to this issue is the graded accreditation of facilities so that there are options with guarantee for minimal standard. However, this option is inequitable. As soon as feasible it should be succeeded by a system of universal coverage and equal access to quality services.

***b. Beginning SHI with Informal Sector and the Poor***

This option is based on the following rationale:

Several concerns were expressed by Cabinet. These include:

- the poor and the informal sector of the economy being left out of the SHI program for a long time, requiring a solution on how to reach those sectors with social health protection;
- the unresolved issues with respect to the inclusion of private sector formal employees;
- differing employee and employer perspectives which show no signs of resolution and could have an impact on the viability of SHI depending on how they are resolved;
- the initial coverage of public servants being a purely budget-financed scheme using a third-party purchaser; and
- Unresolved questions regarding the impact of “private wings” on the broader public health service delivery system.

In recognition of these issues, this option would advocate a focus on the provision of health insurance to the informal sector and the poor followed by the inclusion of formal sector. This would not preclude the continued extension of health benefits to private sector workers by their employers, or Government measures to enhance health coverage for public servants. At some point, it is possible, and indeed preferable, that the new NHIS include most if not all of these two groups, but this option does not include this as an operative assumption.

A key element of this option would be to leverage the existing government funding for health services provision as a key element of the new health insurance scheme. In terms of recurrent expenditure alone, this amounts to UGX 11,441 per capita (\$5.72) in 2009/10, including UGX 5,969 per capita (\$2.98) for the central MOH, and UGX 5,474 per capita (\$2.74) for support for district health services. If this funding is channeled through the NHIS, supplemented with premium revenue collected from the informal sector, and used for the active purchasing of a minimum package of health services, it is expected that both increased efficiency and access would result. Premium subsidies could be implemented for the very poor (full subsidy) and the poor (50% subsidy), covered either by development partners, the MOLGSD or the MOH itself. In this scenario, even a nominal premium of UGX 3,600 per person per year (the minimum amount currently charged by Community Health Insurance Schemes), would generate about UGX 100 billion per year, which is about 29 percent of the current MOH budget. If this could be increased to UGX 5,000 per person per year, the additional revenue of UGX 140 billion represents about 40% of current spending. Efforts have to be made to determine an appropriate premium structure for the varying groups of potential subscribers.

The question might be asked why people who presumably get free health care anyway would sign up for health insurance. The main inducement would be that subscribers would get access to all contracted health care providers in the NHIS network, including public, private, and not-for-profit. This means that public providers would need to deliver high quality health services in order to maintain their patients, and with money following the patient there would be a clear incentive to do so. Compared to existing community health insurance schemes, there would also be a portability of benefits to neighboring districts or even to higher levels of care. However, to ensure that the integrity of the referral system is enhanced/ maintained, a special fee would be charged to those who go to a higher level facility directly without first getting a referral. This should not be an impediment to care, since a clear, no-cost option for referral care would exist.

Under this option, increased provider autonomy at the facility level is necessary, so that they could organize themselves to deal with the changing dynamics of the health financing system. Also, the existing (and expanded) community health insurance mechanisms could be restructured to focus on community mobilization and revenue collection, leaving contracting and claims processing to the NHIS. Communities or other organized groups could be signed up as subscriber groups, perhaps at preferential rates. This is similar to the process, which is currently going on in Kenya for signing up the informal sector with the NHIF.

In summary, this approach would address the issue of the substantial delay associated with the proposed approach to commence with the public formal sector, allow the addition of substantial resources with even relatively low premium levels, and provide time to resolve the outstanding issues in the formal sector. By using, and building on, existing health care delivery structures, it would also address the potential problem of creating a two-tier, parallel public sector delivery structure, with the related possible fragmentation of resources.

The proposal to sustain 'free care' alongside insurance till full coverage under the NHIS is unlikely to work unless the quality under the NHIS is clearly distinguishable and detachable. Giving NHI the possibility of selectively contracting of services could advance this. Why should people pay for the same health care service, which is free? Probably for this reason, paid services such as beds in public institutions will be under-utilized while free services are overcrowded. Dual system will also introduce new administrative challenges.

Given this context, it is ideal to insure every Ugandan citizen/resident and provide health insurance (identity) cards to everyone, i.e. every resident is insured. The price of the card may be determined differently based on their eligibility; it could even be graded according to the socioeconomic or Geographic status of the people. Geographic targeting is easier than income targeting. The card would entitle the holder similar health care services irrespective of their socioeconomic or geographic status; individuals are different only in terms of financing, not in terms of health care benefit. In this way, disadvantaged people can have access to care. Moreover, the card allows collecting, compiling and storing of certain valuable socioeconomic, health, and health care data of the entire Ugandan population.

In order to finance the disadvantaged people based on this suggestion, it is necessary to split the government health spending into two - salary and non-salary. While the salary bill could go through the usual budgetary channel, the non-salary component needs to be organized differently. The non-salary budget could be deposited into the NHIS pool along with contributions and could be spent under the NHIS rules to purchase health care from the designated providers. The purchase of care will be for all the insured, including the disadvantaged. In this way, public and private providers would compete for NHIS resources. Of course, reimbursements for public sector facilities will be restricted to non-salary cost with appropriate adjustments to take into account geographic and other facility-specific constraints. On the other hand, private facilities will have a price inclusive of salary cost. Thus, public facilities will have a comparative price advantage over private facilities. This will not be perceived as fair competition by the private providers, especially the not profit ones, who complained about the high debts they incur because of offering free treatment to the poor. On the contrary they are hoping that the new scheme would offer them the possibility of solving their chronic debts. Further, splitting the salary from the non-salary component will not be helpful for the creation of a strong purchasing function and prevent the creation of more management freedom in hiring and firing staff. Further, in this option, NHI should also be allowed to do selective contracting.

Since pooled resources under the NHIS would include newly 'crowded out' resources due to the addition of contributions, the same could be used to subsidize the purchase of cards for the disadvantaged people.

#### ***d. Expanding the budget funded scheme***

To achieve universal coverage the simplest solution is to expand the current budget funded system and make it more effective and more efficient. That is to say is it really necessary to further fragment the already fragmented health financing system and enter into a new financing scheme with all its extra admin costs and unavoidable learning curve effects once the introduction starts? As the World Bank fiscal space study highlights, there are still possibilities to improve efficiency and thus to direct saved monies to other needs. Have all options to improve the current system been exhausted?

To fund such extension, collection of taxes must be improved and evasion of taxes by the rich prevented. New sources of taxes for instance 'sin taxes' on tobacco, alcohol and

sugar, and a solidarity tax from company-based private health insurance may be considered. In case GOU deems the increase in taxes or the improvement of tax collection not feasible than the question arises if the current proposal, which will be paid fully from taxes in its first stage of implementation, will be feasible.

The GOU could begin by adding the revenues from 8 % of the wage bill of the public sector workers it will have to furnish to cover the first tranche of the implementation of the NHIS. These revenues can be used to improve quality of care, to facilitate a purchaser provider split in parallel the creation of management autonomy for publicly owned health facilities and the establishment of a purchasing function or a public health authority. This establishment could later be renamed as NHI Board if and when a NHIS seems feasible and financially viable.

Although this option has been debated in the TF and rejected, it may still be useful to keep it on the table for further discussion as part of the dialogue with the other ministries and the other stakeholders.

#### ***e. Big bang***

This option considers the inclusion of the formal and informal sectors in the NHIS from the onset. This could be done by consolidating the current budget for individual care with the revenues from an insurance system in one revenue pool, called the National Health Insurance Scheme. From this pool the costs of health care for the poor and other beneficiaries can be paid. Thus, there will be a direct possibility of improving access and quality of care for the informal and formal sectors simultaneously.

This approach has the advantage of creating a big single payer and therefore a strong purchaser. It also solves the problem of having a decentralized budget funded system next to a health insurance based system as this new system will have a unified approach to management and will be much better in e.g. steering investments via selective contracting and in enforcing a referral system.

This option will require more preparation time as to sort out the possible revenue basis and the breadth and depth of the benefits package. However, it may have several advantages as compared with the current proposal: it offers universal coverage of a broader package from the start, it prevents a two tier system, and it would require less admin costs.

This approach will however require more preparation time as to identify the possible revenue sources and the breadth and depth of the benefit package.

The advantages of this option are more compared with the current proposal. It offers universal coverage of a broader package from the start, prevents a two tier system, and will require less admin costs.

### ***3. Demand creation and linking with the community***

Given that not many people are utilizing formal health care facilities as their first point of contact, there is a need for demand creation for NHIS. In fact, formal health care facilities may be two or three steps short of reaching the people for various reasons. Involving the community-level platforms offered by Community-based insurance (CBHI) or other mechanisms is important for this purpose. Such mechanisms could act as a link between the NHIS and its clients. It has the knowledge about the socioeconomic profile of its target people and so, it is easy to tailor the NHIS according to their needs. More importantly, they also hold more information and probably data about the performance of local health care providers. Such information could be used to enhance NHIS performance. Community-based mechanisms could particularly help in the identifying

the poor, monitoring of health care seeking behavior, provision and financing, needs assessment, development of provider and client incentives so as to retain health workforce and clients, and price negotiation.

Community involvement could be carefully analyzed by assessing the existing community level platforms - what they offer and what they don't. In general, there is a need to link the local government, health care institution and the community in order to reach the poorest effectively. Community based schemes require a different kind of analysis other than the one used to analyze private or social insurance because their viability should not be assessed in a strict economic sense. They offer a lot of non-economic benefits to enhance access and thus achieve universal coverage.

Not much is known in Uganda about the capacity and competency of community-based health financing initiatives although a bit is already known about their economic viability. Therefore, it is necessary to understand their dynamics - what do they offer and what they don't - in order to program them into the NHIS.

## **XI. Conclusions and recommendation**

The P4H team would like to conclude as follows:

MOH has made a lot of effort to prepare for a NHIS, including technical arrangements, the drafting of a National Health Insurance Bill and establishing a process of involving the stakeholders and sensitizing the population about its NHIS plans and its significance for them. The review team would like to commend MOH for its tremendous efforts in this difficult endeavor.

Although the proposals and draft Bill in their current shape may seem to offer the perspective of achieving social health protection and of the GOU's own objectives, a further analysis of the implementation plans and trajectory has left the review team with the impression that some serious risks exist if the GOU/MOH plans go ahead unchanged:

- a) The poor may be worse off after the implementation of the current proposal because of the relative shift in financial and limited human resources to the insured categories of the population, while the inclusion of the poor in the scheme is not secured, despite the intentions of MOH.
- b) The proposed package of benefits may not be sustainable if the NHIS is extended over the whole population.
- c) The Bill in its current form is not considered sufficient for achieving Social Health Protection, does not offer a realistic perspective of accomplishing the GOU's own health objectives and is also therefore in need of improvement if it is to provide the vehicle for reaching the goals as mentioned in the Bill.
- d) The already limited efficiency of the health sector may be further lowered due to the creation of the parallel funds flow, absence of increased pooling of funds and the increase in administration costs if coordination and efficiency within and between various schemes are not ensured.
- e) The chance is missed to create a strong purchaser, which could use its clout for selective contracting of efficient quality health care services of public and private providers.

The current proposal is unnecessarily burdening the process of health financing reform by at the same time trying to create an accreditation system, albeit only for the those facilities that want to be paid from health insurance funds.

The implementation of health financing reform plans will demand substantial investments in physical and human resources, currently not sufficiently budgeted for.

The main recommendations of the review team are:

- To reconsider the current proposal and the draft NHI bill and to engage in further discussion and review of alternative options as suggested in this report in order to advance social health protection.
- To review the effectiveness of the current dialogue with other ministries and important stakeholders, including improved inter-ministerial coordination within the Government itself, and not only focus on “sensitization” of the stakeholders and the public but on organizing a substantive dialogue.
- To ensure that the governance of the NHIS involves representatives of key stakeholders.
- To organize guided public debates on advantages and disadvantages of various financing options outlined in this report
- To revise the draft Health Insurance Bill, taking into account the comments and revisions proposed by the P4H team.
- To align and harmonize the NHI Bill revision process with ongoing policy and strategy development in the health sector, as well as the social protection framework process.
- To separate the development of an accreditation system from health financing reform and create an independent accreditation system as part of a systemic quality assurance system/framework for the health sector applicable to all health facilities irrespective of the way they are being paid, i.e. via health insurance.
- To start capacity building for health financing reform implementation on national and sub-national levels as soon as the directions of the reform are clear.
- To consider the introduction of a purchaser provider split, create greater autonomy of public hospitals and develop capacity for effective purchasing of health services, including the development of a system of contracting of providers.
- To clearly formulate the role, if any, of a community based health financing system under the NHIS after carefully assessing its potential (resource mobilization, risk pooling and purchasing potential).
- To carefully choose the systems of payment of providers that allow for cost-containment and quality assurance while staying within the overall available budget envelope.
- To coordinate via the Cabinet of Ministers that MOH and NSSF plans for health/medical insurance are well aligned, coordinated and unified, i.e. to prevent further fragmentation of the health care funding system, while NSSF could play a useful role in the collection of contributions.
- To create a project team as soon as there is clarity about the main policy directions on how to achieve SHP team to start the implementation process and provide technical feedback to policy makers as they will need to be informed about the technical and financial implications of their original choices and decisions.

## **XII. Next steps**

### **MOH**

The P4H team hopes that MOH will find the time to review the report and to consider the comments and pieces of advice in the report for further informing the health financing reform.

### **P4H team**

The P4H partners very much look forward to engaging in further dialogue with the GOU and offer their support to achieve social health protection. We would welcome a reaction of GOU/MOH to such dialogue as soon as possible

### XIII. Annexes

#### ***Annex 1 - List of persons met during August 2009 visit of P4H team***

Baingana Emmanuel	NOTU
Baryahabwa, Francis	NSSF.Ag.Chief Operations Officer
Basaza, Dr. Robert K.	MOH.Principal Health Planner
Bekunda Mr. George,	MOGLSD, Director Social Protection.
Bosworth, Dr.Joanne	DFID Social Development Advisor
Byarugaba B.B., Dr.	MULAGO/MOH
Kaggwa, Luzze Andrew	UMA- TF Member
Kagimu, Isaac	UCMB / HRA
Kahirita, Christopher	COFTU- TF Member NSSF-Director
Kasozi, Dr. H.	UPHUA / KADIC Medical Director
Kembabazi, Patience	MOH
Kenya-Mugisha, Dr. Nathan	MOH.Director Health Services
Kiggundu, Joseph	CHeFA-EA. Regional Coordinator
Kunihira Agnes	Treasurer Women Committee NOTU
Lambda, David	NSSF, Social Protection Specialist
Lukwata, Dr. Hafsa	MOH -TF Member
Luwaga, Dr. Patrick	AAR. HMO spokesperson
Lwomoki Dr. Sam,	COFTU
Magimbi, Dr. C.	UOMD
Masaba, Fred W.	MULAGO/MOH Business manager
Mijumbi Cephas	MULAGO / MOH
Mrs.Beatrice	MOGLSD
Mubiru, Christine R.	MOH / PPA
Muhirwe, Lorna	UPMB / ED
Nkayenenoya, J	Mulago Hospital, Area Manager
Namirembe Agatha Arembe	Organizing & Education Sec UPEU
Namwanja, Dr. Paul	UOMB
Ndiku, Dr.John C.	MOH.Uganda Medical and Dental practitioners Council Registrar
Nduhuura Dr. Richard,	MSH (GD)MOH
Nkalubo-Muwemba, Evelyn	Uganda Insurance Commission
Nkojjo, David	NOTU



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Ntanyungura Jude	MOH/ PAU
Nyanzi, Emily	MOH
Obella, Oode	MOFPED.Assitant commissioner aid liaison dep.
Okotha, George S.	Uganda Insurance Commission
Olupot – Tukei, Michael	MOFPED- TF Member
Orach, Dr. Sam Orochi	UCMB Ag.Executive Secretary
Rubondo, Solomon M.	Uganda Insurers Association.
Runumi Mwesigye, Dr.Francis	MOH Commissioner Health Services (Planning)
Ruuskanen, Dr.Olli-Pekka	Uganda Insurers Association. CEO
Saweka, Dr.Joaquim	WHO Country Office for Uganda
Ssenabulya, Rosemary. N.	FUE-ED TF Member
Tumwesigye, David L.	NSSF.Performance Intelligence Manager
Udongo, B.N.A.	Allied Health Professionels Council. Registrar
Wandawa, Milly	UMMB / Accountant
Werikhe, Peter C.	NOTU Secretary Gen.
Zaramba Dr.Sam,	DGHS- MOH

**Annex 2 - Schedule of meetings**

Date	Time	Activity	Venue	Responsible person(s)
Sunday 2/8/09		Arrival of the OASIS mission (part of the mission)	Collection by WCO CO	JN
Monday 3/8/09	8.30-9.00 hrs	Courtesy call on WR (OASIS)  Health financing review	WCO	JN
	9:00–10:00 hrs	Planning meeting of the mission (program and TOR) and agreeing on activities to be undertaken and output at the end of the mission	WCO	JN & RB
	10:30–11:00 hrs	Courtesy call on MSH (GD), PS, DGHS and CHS (P)/DHS (P & D)	MOH HQ	JN & RB
	11:30–12:30 hrs	Working with the planning department to, discuss the mission, steps to developing a health financing strategy and discuss the first sections of the health financing review tool	WCO	JN & RB
Tuesday 4/8/09	9:00-12:00 hrs	Health financing review and development of a Health Financing strategy (OASIS)	WCO	JN & RB
	2:30–4:00 hrs	Meeting with the SBWG (OASIS)	MOH Level 2 Conference Room	RB and RE
	21.40 hrs	Arrival of P4H Mission	Collection by WCO	JN
Wednesday 5/8/09	8:00–8:30 hrs	Courtesy call on WR (P4H)	WCO	JN
	9:00–11:30 hrs	Planning meeting for the visiting team (Oasis+ P4H, WCO)	WCO	JN, RB, FR, EN, PK
	2:30–4.00 hrs	NHIS TF meeting on introduction of the team and issues to be addressed	MOH Level 3 Conference Room	Ag. DHS ( P&D) & CHS (P)
	4.30-5.30 hrs	Meeting of worker's organizations representatives and consultants from P4H	WCO	RB, EN and Workers Representatives on TF
		Continuing with health financing review (OASIS)	MOH HQ	HL
Thursday 6/8/09	9.00-11.00 hrs	Meeting with TM of MOH ( both OASIS and P4H)	MOH HQ level 3 conference room	RB, FR and DGHS
	11-1.00 hrs	Meeting with the sub – Committee on organizational Structure  Meeting with Health Development partners.	MOH level 3 Conference room  WCO	JN, RB, FR, EN, PK
	14.00-15.30 hrs	Meeting with Employers( FUE), Manufacturers and Private Sector Foundation and consultants from P4H	MOH level 3 Conference room	EN, RB, FR and members of these

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				organisations on the TF
	16.00-1730 hrs	Meeting with Private Commercial Health Insurance Schemes, UIC and Uganda Insurers Association	Uganda Insurance Commission	GSO, RB, Ag.DHS (P&D)
Friday 7/8/09	09.00-11.00 hrs	Meeting with MOGLSD and P4H ( Social protection Directorate)	MOLGSD Board room	RB, FR and Rep of MOLSD on the TF
	11.30-13.00 hrs	Meeting with MOFPED ( Director Economic Affairs ( MFPEP) And P4H	MOFPED Board room	Desk officer for Health MOFPED and Ag.DHS (P&D)
	14.30-16.00 hrs	Meeting with Health Maintenance Organisations both teams	MOH level 2 Conference room	Representative of HMOs on the task Force and RB
Saturday 8/8/09		Internal meeting of the entire process both teams 10-13,00 hrs	MOH level 2 Conference room	MA
		Travel to Jinja Town –the Source of the River Nile by both teams 15.00 hrs		RB and Ag.DHS (P&D)
Sunday 9/8/09		Visit a Regional Referral hospital and nearby Health Centre 10-13.00 hrs Return to Kampala ( 16.00hrs)	Jinja Town	RB and MS Jinja Hosp
Monday 10/8/09	09.00-12.00 hrs	Meeting on the entire sector financing health of services	WHO Conference room	RB and RE
Tuesday 11/8/09	1430-16.00 hrs	I ) Meeting with the sub committee legal and regulations and consultant NHI Bill  II) ) Meeting with the Sub committee on Actuarial & Economic analysis and consultant working on economic analysis of SHI (P4H)  iii) Meeting with the Sub committee on Accreditation and Provider payment mechanisms and consultant working Drafting Accreditation guidelines and Consultant on PPM  iv) Meeting working group on Medicines	Ministry of Health Headquarters Board Rooms Level II & III and Room A 213  WCO Board Room	Legal Consultant RB, EN and consultants join Relevant groups according to their expertise
		Review of docs and internal meeting of the two teams for the rest of the day	WCO	RB,&EN
Wednesday 12/8/09	9.00-12.00 hrs	Meeting with health care providers	MoH Headquarters	Dr. Luwaga, Dr. Prof Kasozi, and Dr. Mbonye ( private providers) UMMB,UPMB,U CMB & UOMB
	14.00-15.00 hrs	Meeting with Health Development Partners (Donors )	Ministry of Health Headquarters	JN, EN and FR

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Thursday 13/8/09	09.00- 11.00 hrs	Meeting with the SBWG	MOH HQ level 2 Conference room	FR and RE
	11.00– 1.00 hrs	Meeting with Senior management committee of MOH	MOH level 3 Conference room	Secretary SMC MOH, JN and RB
Friday 14./8/09	9.00- 11.00 hrs	Wrapping up with MOH and Task Force		

**Annex 3 - Terms of reference:**

**Social Health Protection in Uganda**

**Draft terms of reference for a P4H mission, 5-14 August 2009**

*Background*

Uganda's draft national health policy (2010-2020) acknowledges the existence of significant gaps in health care provision and financing and calls for the delivery of a minimum health care package, optimum provision and allocation of health resources, strengthening public and private partnerships for health and strengthening of district health systems. Accordingly, the government of the Republic of Uganda is in the process of reviewing its health financing policy and designing a National Health Insurance Scheme (NHIS).

Preparations for development of a NHIS date as far back as 2001 when a GoU commissioned feasibility study on SHI cautiously recommended a careful introduction of a NHIS. Consultations continued among government officials and in 2006, GoU asked MoH to design a NHIS through a cabinet minute 63(CT 2006). As part of the preparatory process, several study tours have been undertaken to Tanzania, Nigeria, Ghana and Rwanda. A draft bill has been developed by the task force on NHIS including Ministry of Health, Ministry of Finance, WHO, World Bank, Trade Unions, Private Sector, Providers and Federation of Uganda employers. Lessons learnt from the study tours have been incorporated into the Draft NHIS Bill.

On the request of the Uganda Ministry of Health (MOH), the World Bank mission undertook a mission (8-12 October 2007) to look at the evolving design and issues of the NHIS. The specific tasks of the mission were 1) to review the current status of the preparation of the HI scheme by assessing related preparatory technical activities and remaining constraints; (b) to identify the next steps and remaining tasks that need to be undertaken to launch the HI scheme; and (c) to explore areas within the HI work program that cooperating partners can support.

Considering the out-dated actuarial study undertaken by the Harvard/Makerere group ("A Feasibility Analysis of Social Health Insurance in Uganda") in 2001, the WB study recommended the use of the WHO's "Simulation Insurance" (SimIns) Model for actuarial analysis of HI. Following a formal request from MoH, WHO carried out a SimIns revenue and expenditure analysis. Secondly, the mission recommended an orientation workshop on SHI for various stakeholders to reach a common vocabulary and understanding of health insurance concepts. This workshop was held and attendance included the two state Ministers responsible for labour; namely Minister of state for Public Service and the Minister of state for Labour; plus the Minister of state for Health (General Duties). Members of the private sector and federation of Uganda employers also attended. The meeting proposed that the scheme would start with the formal sector. Other areas include the development of accreditation criteria (currently in draft), developing and costing the benefit package (done as part of expenditure and revenue analysis) and provider payment mechanisms (in draft).

The MoH further requested WHO to support the country in the development of the NHIS. The general objective of this mission was to assist the Uganda health sector set up a social health insurance scheme.

The specific objectives were:

- a) To finalise and present the actuarial analysis of social health insurance scheme in Uganda,
- b) To sensitise the key stakeholders about principles of social health insurance,
- c) To carry out country assessment of the process, structures and overall country preparedness of establishment of social health insurance,
- d) To make recommendations on the steps towards launching SHI scheme in Uganda.

A P4H visit in 11 – 13 Feb 2009 included meetings with Members of the National Health Insurance Task Force, Federation of Uganda Employers, Cabinet, Senior Management Committee (SMC) of MoH and Health Development partners. Key concerns to addressed were raised among which was the early inclusion of the poor, broader stakeholder involvement, integration of the scheme in related reform and development processes, target setting, re-assessment of assumptions and risks, as well as low capacity for implementation.

P4H was again contacted by the Ugandan Director General of Health Services to assist the Ugandan health sector carry out further preparatory work in design of the scheme<sup>75</sup>. Subsequently, a P4H team visited Uganda during 15-18 June, 2009 and held discussions on the draft National Health Policy (2010-2020). The concepts of Universal Coverage and Social Health Protection (SHP) were taken up in the policy document and suggestions for corresponding policy statements have been discussed and included. It was also agreed to organize a comprehensive P4H mission in August to contribute to the development of new health sector strategy. Following the P4H quest for harmonization of various activities related to SHP, it was proposed that a previously planned health financing review by WHO would be time wise and conceptually linked to the upcoming P4H mission.

#### *Mission goals*

A two-week mission is proposed during August 5-14, 2009. The overall objective of the mission is to assist the Government of the Republic of Uganda in the process of developing a social health protection framework suiting the Ugandan context. In collaboration with the Government, the specific objectives of the proposed mission are as follows:

- To discuss a possible revision for the proposed SHI Bill and propose an adaptation, in particular by considering the concerns raised by the public and various stakeholders,
- To discuss the implications and potential relevance of the recent health financing study tour to east Asia (Thailand, Vietnam, China)
- To design options for the proposed NHIS scheme, in particular concerning the lack of social health protection of the poor, considering the current high out-of-pocket spending and associated impoverishment due to seeking health care.
- To explore
  - ways of linking the proposed NHIS to broader social protection and social health protection issues
  - the possibility of mobilising additional funds for SHP, e.g. through the health systems component of GFATM support (link to German BACKUP Initiative, example from Rwanda).

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<sup>75</sup> Details of requested support in annex 1 of TOR

## Components of work

The mission will have the following essential components:

<p>Brief history of development process of NHIS and health financing discussion in Uganda (<i>starting with SHI feasibility assessment in 2001; motivating factors, key results; policy decisions taken</i>)</p> <p>Stock taking of main SHP issues including a health systems and health financing overview, as well as SHP relevant Social Protection issues. The overview shall among others include the macro picture, fiscal space, health financing context, and gaps in social health protection of the current public health system, effects of decentralisation, size and role of private sector.</p> <p>Lessons learned from past experiences on social health protection in Uganda; what worked and what did not? in particular in terms of sustainability and workable options</p>	
Essential elements of SHP and SHP milestones in Uganda	Level of universal coverage, health care and financing gap, financing health care of the most disadvantaged, prepayment options to reduce or streamline out-of-pocket spending, cross subsidization, and risk pooling
Design features of SHP in the light of developing a NHIS	Needs assessment, equitable institutional and regulatory framework to reach the most disadvantaged, coordination, financing, provision of care (direct provision by government, contracting, direct provision of not-for-profit private and direct provision by for-profit private), packaging of services, pricing, exemptions and subsidy, and community involvement.  SHP goals and objectives, strategy and plans
Potential stakeholders	Government, coordinating agency, regulatory authority, health care providers (institutions), health workforce, insurers, microfinance institutions, community and patients
Linking the development of the NHIS to SHP and the broader SP framework	Role of proposed NHIS for better SHP; common objectives of SP, SHP and NHIS; opportunities for possible synergies; options for including the poor and vulnerable at an early stage in the NHIS.  Review of current NHIS bill and development of options for potential broadening of the NHIS bill (harmonisation with SHP goals and objectives).
Link to (upcoming) health care financing strategy	Provide inputs to the development of the upcoming health financing strategy, contribute to defining goals and objectives for SHP; role of proposed NHIS in addressing these objectives, in particular the access challenges of the poor.
Policy and legislation, coordination, financing of NHIS	government revenue, external resources, domestic philanthropic resources, pre-payment and insurance, health care provision (public-private mix, skill mix, geographic distribution, distribution across population groups & quality of care
Regulation and accreditation	Rules and regulations, location, spacing and functioning of facilities, packaging of services, accreditation of providers, quality assurance, pricing, and conditions for financing, and exemption rules.

Pricing, financing and exemptions	Pricing of services for accredited providers, premium grading and fixation, financing options, fiscal space (ring fencing, external resources, domestic philanthropic resources, earmarked taxes, and social security contributions), and exemption limits
	e.g. through the health systems component of GFATM support (link to German BACKUP Initiative)

For better harmonization of SHP support of P4H partners in Uganda, the P4H August mission will be intertwined with an earlier planned health financing review of WHO.

#### *Mission team*

Given the above terms of reference, the mission team would have to comprise expertise in organization management, health insurance regulation, accreditation, health economics, macroeconomics, social health protection policy. Experts will need to be identified in these areas; more specific ToR will also need to be developed for each major component of the work to be undertaken.

The mission team will be led by the P4H coordinator.

#### *The process*

- The mission includes four essential components. These ToR serve as an overarching guide for more specific ToRs that need to be prepared for each component.
- There will be a preparatory meeting among the team members to agree on the common strategy and division of labour prior to actual visit to Uganda in August.
- The P4H mission will be linked and synchronised with a debriefing meeting with the WHO team undertaking a health financing review in Uganda.
- The P4H team will individually and collectively meet with senior officials of the Ministries of Health, public service, labour and finance.
- The team will also meet other stakeholders and NGOs relevant for the purpose of developing the SHP framework.

#### *References*

1. Letter from Dr. Sam Zaramba, Director General of Health Services to the WHO Representative in Uganda dated 7<sup>th</sup> April, 2009.
2. Government of Uganda. Draft National Health Policy. Kampala: Ministry of Health.
3. Travel report of the P4H Team on its visit to Uganda during 15-18 June 2009.
4. Email correspondence of Dr. Robert K. Basaza, Principal Health Planner, Ministry of Health Uganda with the P4H Coordinator on 6<sup>th</sup> July 2009



***Annex 4 - The planned National Health Insurance Scheme (NHIS)***

**THE PLANNED NATIONAL HEALTH INSURANCE  
SCHEME (NHIS)**

**A briefing paper to Providing for Health (P4H) - Geneva**

***August 2009***

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## 1.0 Introduction

This brief serves to provide a background to the health care system in Uganda and update P4H on the design of the proposed National Health Insurance Scheme (NHIS). Work to establish Social Health Insurance (SHI) started in 2003 based on recommendations made in a study '*the feasibility analysis on Social health Insurance*' by Harvard University and Makerere University School of Public Health that was commissioned by the Ministry of Health in 2001.

## 2.0 The health Care system in Uganda

### 2.1 Ministry of Health and other National level institutions

#### A. Ministry of Health

The core functions of the Ministry of Health are:

- i) Policy formulation, setting standards, and quality assurance
- ii) Resource mobilization
- iii) Capacity development, training and technical support
- iv) Provision of nationally coordinated services, e.g. Epidemic control
- v) Coordination of health research
- vi) Monitoring and evaluation of the overall sector performance.

The MoH retained responsibility for such central services as health emergency preparedness and response, epidemic prevention and control. Other nationally delivered services are by specialized institutions under the stewardship of the Ministry of Health.

#### B. National level institutions

The autonomous National level institutions include the National Referral Hospitals, National Medical Stores, National Drug Authority, Uganda Virus Research Centre, Uganda Cancer Institute, National Blood Transfusion Service, National Public Health Laboratories and the Uganda Natural Chemotherapeutic Research Laboratory. The Regional Referral Hospitals and the National Blood Transfusion Services have been accorded self accounting status and not fully fully autonomous. The National Health Research Organization is responsible for coordination of health research.

#### C. Health Services Commission

The Health Service Commission is a statutory body established in the 1995 Constitution. It is responsible for reviewing the terms and conditions of service of health workers. It reports directly to Parliament from which it gets its budget. The Health Services Act, governs the operational aspects of the Commission and establishes the code of conduct of all health workers.

### 2.2. Hospitals

Hospitals represent the top end of a continuum of care providing referral services for both clinical and public health conditions to the District Health Services. They play an important complementary role to primary care and constitute an important and integral part of the National Health System.

A National Hospital Policy has been formulated to streamline the role and functions of hospitals within the National Health System. Given the present challenges and health sector reforms of recent years, well-defined role and functions of hospitals in

Uganda is essential. The objective of the policy is to improve the performance and accountability of the hospitals in order to contribute to the overall economic growth of the country by ensuring a healthy and productive population. The guiding principles of the policy are:

- i. Ensuring equity of access to hospital services.
- ii. Creating an enabling environment for the delivery of hospital services through effective management, an improved referral system and resource mobilization.
- iii. Guaranteeing that hospitals provide quality and affordable services consistent with the National Minimum Health Care Package.
- iv. Creating a conducive environment for the development of private hospitals in the country.

The policy is expected among other things, to define the role and functions of the hospital sub-sector by tier, clarify its linkage with the overall sector plan in line with new partnership arrangements, and define mechanisms for assuring its resources and accountability. The operationalisation of the new hospital policy will be an integral part of HSSP II.

#### a) Hospital structure

In Uganda, hospital services are provided by public, private not-for-profit and private health institutions (PFP). The degree of specialisation varies between hospitals. The public hospitals are divided into three groups according to the level of services available and their responsibilities: general hospitals, regional referral hospitals and national referral hospitals. The private hospitals are designated as general hospitals but the services they provide vary, with some providing specialist services usually found only in referral hospitals.

Of the 102 hospitals in the country, two are the national public referral hospitals, 11 are regional, and 43 are general – giving a total of 56 public hospitals. 42 are private not-for-profit hospitals and four are private health practitioner hospitals. The private for profit hospitals are not designated as referral institutions although they offer secondary and tertiary specialized services. Lack of adequate resources is limiting hospitals in their effort to provide the services expected from them. In many instances basic emergency infrastructure, supplies and equipment for support services are inadequate.

b) General hospitals: These provide preventive, promotive, outpatient curative, maternity, inpatient health services, emergency surgery, blood transfusion, laboratory and other general services. They also provide in-service training, consultation and research in support of the community-based health care programmes.

c) Regional referral hospitals: In addition to the services offered at the general hospital, these hospitals offer specialist services such as psychiatry, Ear, Nose and Throat (ENT), radiology, pathology, ophthalmology, higher level surgical and medical services, including teaching and research.

D) National Referral Hospitals: In addition to the services offered at the regional referral hospital, they provide comprehensive specialist services and are involved in teaching and health research.

All hospitals are also expected to provide support/supervision to the level below i.e. general hospital to lower level health units in the districts; Regional Referral to General Hospital and HC IV; and National Referral to Regional Referral through

specialists programme. All hospitals maintain linkages with the communities through their Community Health Departments. The level of effectiveness in fulfilling the related functions varies widely, with many not in regular contacts with the lower units and communities they are supposed to serve.

e) Hospital governance and management

The public general hospitals are under the respective local governments. The hospitals are managed by the district local governments in collaboration with guidelines from the Ministry of Health. These hospitals have Management Committees appointed by the respective district councils.

The regional referral hospitals have been granted self-accounting status by the Ministry of Finance, Planning and Economic Development. Some of the hospitals have Management Boards appointed by the Minister of Health on the recommendation of the district councils within the catchment area. In future these will be prepared for autonomy on a case-by-case basis. The two national referral hospitals, Mulago and Butabika, have interim boards and preparations for full autonomy are ongoing. All the PNFP hospitals have self accounting status granted by the legal owners (trustees) and they are governed by Boards appointed by the Trustees. The Board in turn appoints a team of managers.

### **2.3 District Health System**

In line with the 1995 Constitution and the 1997 Local Governments Act as ammended, the new roles of the Local Authorities (in the context of the health sector) are:

- Health service delivery
- Recruitment and management of personnel for District Health Services
- Passing by-laws related to health, and
- Planning, budgeting, additional resource mobilisation and allocation for health services.

The District Health System is a more or less self-contained segment of the National Health System. It consists of various tiers under the overall direction of the District Health Officer. The District Health System comprises a well-defined population living within a clearly delineated administrative and geographic boundary and includes all actors in the recognized spheres of health within the district. It is expected that the activities of the diverse partners in health are reflected in the District Health Sector Strategic Plan, which in turn is an integral part of the rolling District Development Plan. The NHP established the Health Sub-District as a functional subdivision or service zone of the district health system to bring quality essential care closer to the people, allow for identification of local priorities, involve communities in the planning and management of health services and increase the responsiveness to local need.

1) District health teams

Under decentralization, the roles and responsibilities of the centre and the districts were redefined. The transfer of responsibility for service delivery to the Health Sub District necessitated redefining the roles and responsibilities of the DDHS Office. The District health teams (DHTs) retain the functions of planning, budgeting, coordination resource mobilization, and monitoring of overall district performance. Poor logistics, inadequate staffing, weak management capacity and poor working conditions have been cited as the main factors that have dictated the pace and general effectiveness of this policy change.

HSSP II will give priority to capacity development of DHTs based on needs assessment in areas of human resource development and management, logistics and working environment. In order to strengthen the public-private-partnership in health care delivery, the expanded District Health Team will include district representatives of PNFP and other Civil Society service providers that are active in each district. A new structure of local government will be implemented during the course of HSSP II.

ii) Health Sub-District

The National Health Policy devolved operational responsibility for delivery of the minimum package to the HSD. Each HSD management team is expected to provide overall day to day management oversight of the health units and community level health activities under its jurisdiction. Its specific functions include:

- a) Leadership in the planning and management of health services within the HSD, including supervision and quality assurance
- b) Provision of technical, logistical and capacity development support to the lower health units and communities including procurement and supply of drugs.

Although significant progress has been made, many of the 214 HSDs have encountered difficulty in meeting the policy expectations. Constraints related to inadequate funding; recruitment, deployment and housing of personnel; high rates of turnover of recruited staff; heavy workload resulting from combining clinical and health management functions of senior HSD personnel; low rates of completion and operationalisation of infrastructure have all contributed to the lower than expected performance of the HSDs observed during Health Sector Strategic Plan I.

iii) Referral Facility (General Hospital or Health Centre IV)

The leadership of the HSD is located in an existing hospital or a HC IV (Public or PNFP) located within the HSD. Its functions are primarily the:

- a) Provision of basic preventive, curative and rehabilitative care in the immediate catchments
- b) Provision of second level referral services for the HSD including life-saving medical, surgical and obstetrical emergency care such as blood transfusion, caesarean section, and other medical and surgical emergency interventions
- c) Provision of the physical base of the HSD Management Team. In 29 out of 214 HSDs, the function of HSD management has been delegated to the PNFP referral facility.

iv) Health Centre III

The health centre III offers continuous basic preventive, promotive and curative care and provides support supervision of the community and HC IIs facilities under its jurisdiction. There are provisions for laboratory services for diagnosis, maternity care and first referral cover for the sub-county.

v) Health Centre II

The HC II represents the first level of interface between the formal health sector and the communities. HC IIs provide only ambulatory services, except in strategic locations (e.g. poor access to HC III or HCIV) where as interim strategy maternity services are being provided. An Enrolled Comprehensive Nurse is key to the provision of comprehensive services and linkages with the Village Health Team.

vi) Village Health Team (Health Centre I)

The NHP calls for the establishment of a network of functional Village Health Teams (VHTs) to facilitate the process of community mobilization and empowerment for

health action. Each village would have a VHT comprised of 9-10 people to be selected by the village (LCI). Women's participation in the VHT is promoted through an affirmative action measure of requiring at least  $\frac{1}{3}$  of the team members to be women, thus ensuring their active participation in health activities at this level. The VHT is responsible for:

- Identifying the community's health needs and taking appropriate measures;
- Mobilization of additional resources and monitoring of utilization of all resources for their health programs including the performance of health centres;
- Mobilization of communities using gender specific strategies for health programs such as immunization, malaria control, sanitation and construction, and promoting health seeking behaviour and lifestyle
- Selection of Community Health Workers while maintaining a gender balance;
- Overseeing the activities of Community Health Workers;
- Maintaining a register of members of households and their health status and
- Serving as the first link between the community and the formal health providers.

## **2.4     *The Health Partnership***

The National Health Policy and the Health Sector Strategic Plan are implemented through partnerships described under the broad framework of the Health Sector Wide Approach or SWAp. Under this framework, the Government of Uganda, through the Ministry of Health, has the lead role and responsibility for delivering the outputs of HSSP. Various other partners have defined roles to play and contributions to make. A series of memoranda of understanding or other formal arrangements such as government regulations, policy documents and contracts, are in place or are under development to govern these relationships.

## **2.5     *Government of Uganda / Development Partners partnership***

The Sector wide Approach (SWAp) was developed as a mechanism to “addresses the health sector as a whole in planning, management and in resource mobilization and allocation”. The SWAp supports Government in mobilizing and managing resources for the sector. Although support to the government's budget (either general or sector specific) is the preferred financing mechanism, where partners cannot follow this approach, project support can be provided. The revised Memorandum of Understanding between the Government of Uganda and the health development partners (HDPs) spells out the obligations of the main parties and describes the structures and procedures established to facilitate the functioning of the partnership. The following are key structures and processes:

- The Health Policy Advisory Committee (HPAC) has proved beneficial in providing overall policy guidance to the sector. The HPAC Working Groups continue to carry out functions assigned by HPAC
- The annual GoU/DP Joint Review Missions enable the joint monitoring of the sector performance. The JRM receives the Annual Health Sector Performance Report and determines whether overall performance has been satisfactory. JRM also sets the priorities for the following year at the strategic level, through the identification of priority technical programmes, agreeing undertakings (or key process outputs) and determining broad allocations for the budget cycle. The HPAC Secretariat ensures that the participants receive in a timely manner, electronic copies of the relevant documents for each Joint Review Mission.

- The Health Sector Working Group (SWG), established under the auspices of the Ministry of Finance, Planning and Economic Development, is the structure focused on the budget cycle and managing the approval and alignment of project inputs to the sector. New projects should follow GoU standards, guidelines and systems, be fully aligned with HSSP II priorities and minimize overheads as project resources are now counted as part of the total allocation to the sector and can displace budget resources. The budget process for FY 2005/06 – 2007/08 includes guidelines to SWGs on gender and equity budgeting.
- The National Health Assembly (NHA) was created to provide an annual forum for the broader health partnership (central and local governments, civil society, and development partners) to review sector policy, plans and performance. It provides an effective medium for wider consultation, political mobilization for health, and for consensus development among the stakeholders. The NHA first convened in 2003. As part of HSSP II the scope and mandate of the NHA will be clearly defined and its organization improved so as to derive maximum benefit from the effort. The Assembly is consultative and advisory. The NHA convenes once a year, with the MoH providing the secretariat.
- The Health Development Partners (HDPs) are responsible for their own co-ordination through the HDP group, which provides a forum for information sharing, consensus building and collating and coordinating responses to government. It is intended to reduce transaction costs for all parties, but especially government partners. The lead agency role is rotated on an annual basis.

## **2.6 Public Private Partnership for Health (PPPH)**

The National Health Policy objective of making the private sector a major partner in national health development has to a large extent been achieved for the Private-Not-for-Profit sub-sector. A central PPPH coordinating office has been established within the MoH and a focal person for PPPH designated. The National Policy on Public Private Partnership in Health has been drafted and contains components addressing partnership with the PNFP and PHP. The component addressing partnership with the Traditional and Complementary Medicine Practitioners is not yet drafted. The related implementation guidelines for the PNFP and the PHP sub-sectors once approved will be applied.

## **2.7 Health infrastructure**

Uganda has a total of 3237 health facilities (all levels combined) as of the health facility inventory of October 2008; for a population of about 30 million people. Of these 2301 are owned by government, 659 by NGOs and 277 are private. The details by level are shown in Table 1.

Table 1. Health Facilities by level and ownership.				
	OWNERSHIP			
LEVEL OF FACILITY	GOVT	NGO	PRIVATE	TOTAL
HOSPITAL	60	46	8	114
HC IV	147	12	1	160
HC III	762	186	7	955
HC II	1332	415	261	2008
TOTAL	2301	659	277	3237

## 2.8 Intersectoral Collaboration

While the PEAP 2004 recognizes that improving health outcomes “*will be the achievement of several sectors*”, the central role of the health sector cannot be lost sight of. Harnessing the contribution of the health related sectors is an important aspect of the stewardship functions of the MoH and DDHS Offices. In collaboration with the Office of the Prime Minister, MoH will support central and district level health managers in developing capacity in fostering effective intersectoral partnerships.

During the last plan period some promising collaborative initiatives were forged between health and agriculture, education, water, gender, etc. HSSP II will progressively consolidate and expand these partnerships by applying proven partnership principles. The principles to be followed include development of a joint plan of action for achieving concrete outcomes specifying resource needs and their sources, defining and accepting assigned roles and responsibilities, respecting the mandates of each partner, recognizing the comparative advantages of partners and agreeing on common working arrangements including joint monitoring of partnership outputs and outcomes.

Ongoing collaboration in areas such as maternal and child health, HIV/AIDS prevention and control, information and education for health, water and sanitation, school health and human resource development, malaria control, and accident prevention will be strengthened. Similar effort will be given to building partnerships for improving nutrition, gender sensitivity, and in humanitarian assistance to internally displaced persons (IDPs) and refugees. Improved coordination in health infrastructure development with sectors such as roads and communications, water and electricity could make significant contribution to improving both physical access and

Imaginative use of existing local government structures (District Sectoral Committees, District Technical Planning Committees, District Planning Meetings, Meeting of Heads of Departments, etc) could yield significant gains in intersectoral collaboration.

## 2.9 Human Resources for Health

The Health Sector Strategic Plan II recognises the critical role of the human resources both in terms of quality and numbers in the delivery of the minimum Health Care Package. Since its (HSSPII) launch, the Ministry of Health has directed its efforts towards increasing the staffing levels, improved training both in terms of Quality and Quantity as well as the provision of tools and an enabling environment for improved work performance and service delivery. The above efforts were further enhanced by the GHWA Kampala Declaration (March 2008) which emphasized the



need for collective and sustainable Political, Structural, Systematic and Economic al Interventions to check the global health workforce crisis. During the same period 2007/2008 the Ministry developed a Master Plan for improved Health Service delivery which further underscored the significance of Human Resource for Health, among others.

### **3.0 The proposed Health Insurance scheme**

#### **3.1 Work so far done**

- a. The Ministry of health formed a NHIS secretariat to coordinate the development of SHI. After several studies and country tours, the secretariat developed principles of social health insurance that were disseminated, for consultation and sensitization to key stakeholders countrywide in 2004, 2005 and 2006. The sensitization started generating a social and economic debate that is increasing as further discussion take place this year.
- b. The Principles of Social Health Insurance were presented to Cabinet in April 2006 and adopted. This was in line with the NRM manifesto 2006 which places Social health insurance and community health insurance as a programme to improve delivery of better health services. The programme is supposed to protect both informal and formal sectors against expenditure on catastrophic incidences.
- c. Subsequently the Cabinet under Minute 63 (CT 2006) directed that the Minister of Health prepares a bill on Social Health Insurance. Drafting instructions of the bill have been sent to the First Parliamentary Council and a copy of the draft bill agreed on by the National Task Force was developed. A copy with some detail is attached.
- d. The design process of the proposed scheme was further discussed in the cabinet and under Minute 21 (CT 2009) the cabinet agreed to hold a workshop and receive an update on the design process of the proposed scheme. The Workshop took place on the 12th February 2009.
- e. The Ministry of health established a multi-sectoral National Task Force of senior and knowledgeable officials to spearhead the scheme design process and guide the drafting of the Bill. Representatives of the WHO and World Bank country offices are members of the Task Force. This National Task Force also comprises of representatives of private for profit and private not for profit health care providers, Trade Union (NOTU and COFTU) representatives, employers organisations through the Federation of Ugandan Employers (FUE), the Private Sector Foundation, the Uganda Manufacturers Association, The Uganda Insurance Commission and Insurers Association, representatives of the Civil Society and Community Based Health Insurance Association. The Task force has been meeting quarterly but its four sub-technical committees have been meeting monthly to closely guide the drafting process bill. The National Social Security Fund (NSSF) which handles pension for the private sector was invited to join the Task Force but declined and is planning to start its own parallel health scheme. The Ministries for Finance, Public Service and Labour are also represented and active.

Consultation and sensitization with stakeholders is ongoing and the bill is envisaged to be tabled in the Parliament as soon as preliminary requirements are met.

### **3.2 Challenges of establishing NHIS**

Start up funds for implementation of the Scheme. The initial cost to set up basic health insurance structures, consultative and sensitization campaigns is estimated at Shs 16.5 billion over a period of 3 years. The estimate contains capital expenditure to:

- ❖ Set up and organize the NHIS central office,
- ❖ Set up 12 zonal offices,
- ❖ Hardware and software for central office, zonal offices and accredited providers;
- ❖ Mass advocacy campaign.

As the scheme takes root, expenditure is expected to decrease to UGX Shs. 4.4 billion in the third year.

The Scheme shall yield funding for health care services as planned. The concluded actuarial study demonstrates collections to gradually increase from Shs. 32.2 billion in Year one, increasing to Ushs 72.7 billion in the sixth year of implementation as more people are brought on board.

ii. Lack of provision to cater for the indigent. While government is shouldering this responsibility through better funding of public and private not for profit institutions, at a later stage a subsidy to encourage the poor joining the scheme shall be discussed.

### **3.3 Conclusion**

The health care system in Uganda needs massive investments in both systems and infrastructure. It is presumed that SHI shall be a catalyst for such huge investments in the sector.

Implementation of Social Health Insurance is a political decision from the highest state office. In all the countries visited; health insurance started with challenges that get addressed as the scheme is operationalised. Every country designs its Social Health Insurance scheme taking into consideration its unique socio-economic and cultural realities and keeps adopting the design according to emerging issues. It is high time our country faced this challenge and launched the scheme not only to improve revenue for health care and better management of services but also to stop lagging behind the East African countries that have demonstrated the gains of health insurance.

## ***Annex 5 - Composition of Task Force on Health Insurance***

Representatives of:

- Ministry of Health,
- Ministry of Gender, Labor and Social Development
- Ministry of Public Service
- Ministry of Finance, Planning and Economic Development
- National Organization of Trade Unions
- Central organization of Free Trade Union
- Private Health Providers
- Health Consumers Organization
- Private Sector Foundation Uganda
- Uganda Manufacturers Association
- Uganda Manufacturers Association
- National Social Security Fund (NSSF), which has so far refused to take up its position, apparently because of the NSSF's plan to create its own health insurance.
- Uganda National Farmers Federation
- Uganda Community Based Health Financing Association
- Uganda Insurer's Association
- Health Care Maintenance Organizations

**Annex 6 - Examples of existing Uganda social protection programs and their location<sup>76</sup>**

<b>Program</b>	<b>Ministry/ Organization</b>
Orphans and Vulnerable Children (OVC) programme implemented with support from UNICEF and USAID. It was started in 2005, targeting all orphans and vulnerable children, not just those due to HIV/AIDS.	Ministry of Gender, Labour & Social Development
Universal Primary Education → Provides free primary education to all children of primary school going age. Started in 1997. Enrolment increased from 3million when it was started in 1997 to over 7.6million in 2005/06.	Ministry of Education
School Feeding Programme (in parts of Northern and North Eastern Uganda) – The program was started in 2004 and is targeting 1.3million school children.	Ministry of Education, WFP
Northern Uganda Social Action Fund (NUSAF) → Supported by the World Bank. Offers support in form of cash grants, training etc.. It started in 2003, additional funding for another 5yrs has been granted in 2009.	Office of the Prime minister
Implementation of the Community-Based Rehabilitation Programme for persons with disabilities (PWDs) → Being implemented in 13 districts	Ministry of Gender, Labour & Social Development
Community HIV/AIDS CHAI project <ul style="list-style-type: none"> <li>Offering support to individuals and households with HIV/AIDS in form of cash, training, etc.</li> </ul>	Ministry of Health-Uganda AIDS commission
Nutrition and early Childhood Development Programme	Ministry of Health
Government Pension schemes for retired civil servants	Ministry of Public Service
National Social Security Fund <ul style="list-style-type: none"> <li>Provides social insurance for retired workers</li> </ul>	MGLSD
NGO programmes (various) e.g. UWESO World Vision, SOCADIDO, etc <ul style="list-style-type: none"> <li>Provide social support for orphans and vulnerable children (education and basic necessities)</li> </ul>	Respective NGOs

<sup>76</sup> Ebpdn (2008)

## **Annex 7 - Organizational Aspects**

Hereafter follows a number of steps to be considered and to be taken for establishing a health insurance system

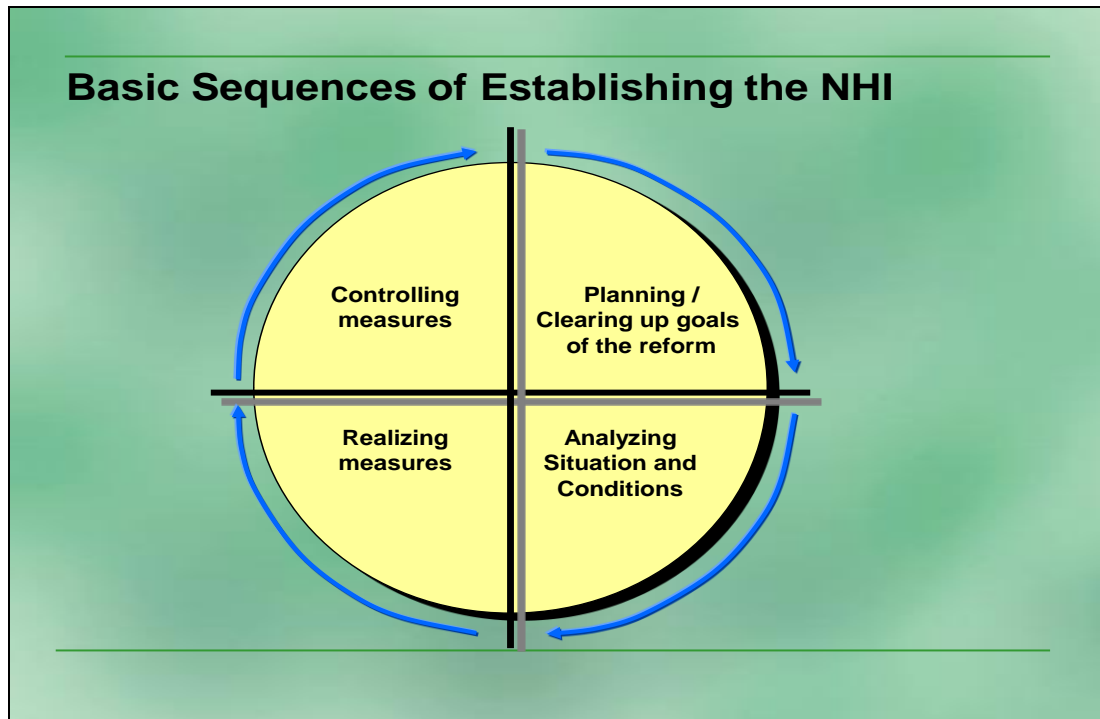
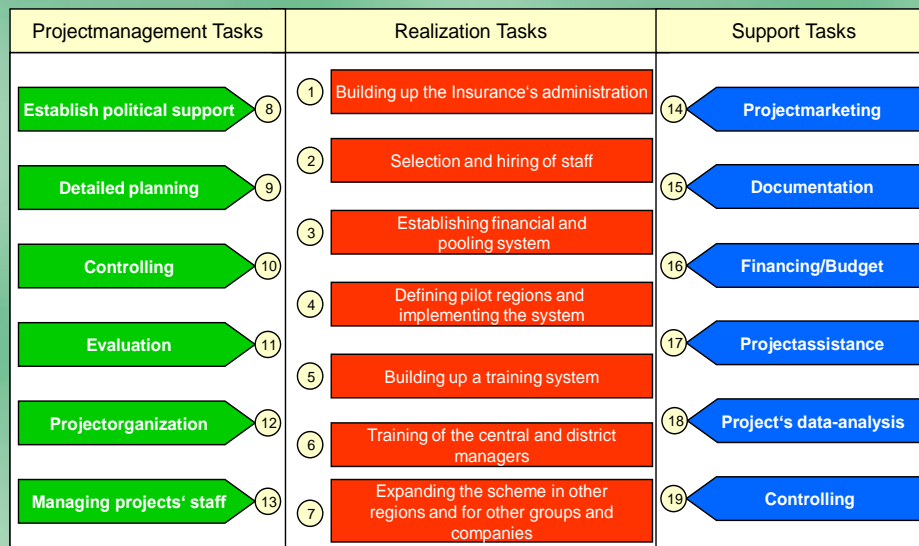


Figure 1

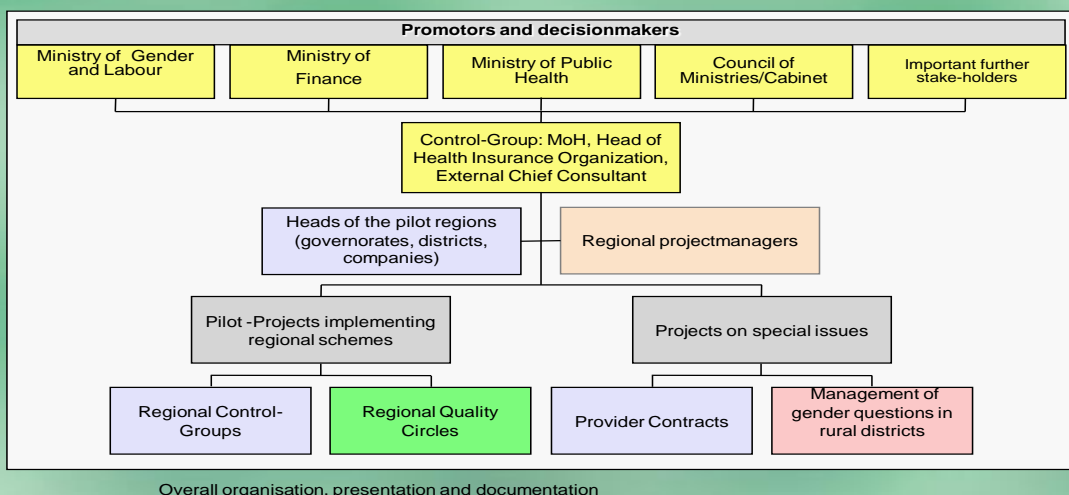
For a realistic perspective it is necessary to describe the different tasks of the project organization, to integrate the stakeholders into a professional project structure, to establish priorities and to define the concrete milestones and steps of realization. Examples for basic tasks in order to realize the reform are indicated in diagram 2:

## Basic tasks for realizing the reform



Government's stewardship is a basic prerequisite and a crucial factor for the success of the process. The implementation plan should therefore include a professional structure to manage the further reform steps. When establishing this structure it would be helpful to get those stakeholders involved that will be part of the later supervisory body of the NHI. An optional structure is demonstrated in diagram 3:

## Optional Structure to manage the NHI



## **Annex 8 - General comments on SHI Bill**

### **Uganda Health Insurance Bill, draft, 2008 Comments**

*Disclaimer:* The proposed bill in its current form is not considered sufficient for achieving Social Health Protection (SHP). Thus, any (specific) comments in this document should not be interpreted as agreement or endorsement of the overall intentions and design of the Draft Health Insurance Bill. In reviewing the Bill, the review team of the P4H Partners has taken an unbiased and neutral approach in its review of the Bill and of the proposed National Health Insurance Scheme.

#### **A. Introduction**

The draft Health Insurance Bill<sup>77</sup> is reviewed in reference to the following *yardsticks*:

- Does the Bill offer a credible, viable and sustainable instrument to advance Social Health Protection in extending or creating equitable access for the population of Uganda, in particular the poor, to quality health services and will it prevent the population from impoverishment due to unbearable and necessarily to made health care costs.
- Does the Bill advance the health policy objectives of the Uganda Government
- Are the content of the Bill and the attached schedules conducive for the objectives as stated in the Bill
- Does the Bill provide for the tools to guarantee the entitlements of the insured and to provide cost-effective quality health care to the insured in case of medical need. Has the proposed SHI the ability to help controlling the current and future costs of the health care services (volume and price), i.e. by avoiding the provision and payment of unnecessary or unnecessary costly care and by allowing for simple and cheap admin procedures for all partners, involved in the implementation of the law.

*Consistency with existing laws/regulation and enforcement procedures.* It has to be noted that these comments are mainly based on the review of the Health Insurance Bill itself. However, this Bill is and needs to be embedded in and consistent with existing laws/regulations that influence the health sector, i.e.

- Generic laws like
  - The Civil code
  - The Penal code
  - The Law on Local Government
  - The Insurance Act

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<sup>77</sup> The version of the Bill that is used for comments is available as separate annex to the P4H Report, after this one. There seem to be different successive versions, but these are not numbered or dated. So, it's not sure if the used version is the latest.

- Any laws that relate to the flow of finance and to banking.
- Procurement regulations
- Specific laws for the health sector like
  - Planning laws,
  - Laws on health professionals and health institutions,
  - Laws on patient rights,
  - Laws on quality of care
  - Regulations on health care products, e.g. drugs, medical devices and supplies, blood and blood products)
  - Regulations on the current benefits package, which may require a transitional regulation as to prevent patients having to stop their treatment halfway through it.

The review team is not familiar with the above regulations and their very existence has not been explored, except for the Insurance Act and the regulations related to the Medical and Dental Council, the Council for Applied Health Sciences and the Licensing of private health institutions. The latter is based on considerations of quality of care. It is further known that no planning act exists to regulate the distribution over the country of health services, their capacity and their level of health care.

Current law enforcement procedures and the effectiveness of law enforcement as well as the working of the judiciary sector may also need to shape the Health Insurance Bill and the regulations based on it, i.e. on contracting, the creation of appeal and arbitration procedures and the like. The review team is not familiar with the effectiveness and efficiency of the current law enforcement and judiciary systems in Uganda and hence have not yet reached an informed opinion about the effectiveness of the Bill as regards the ulterior possibilities of beneficiaries, health care providers and contributors to enforce their rights in case the Health Insurance implementing bodies, health providers and other actors as defined in this Bill are thought to have failed to do so. Some anecdotal information points at slowly working courts, having backlogs and long procedures to follow, making it difficult for the average person to wait for a ruling.

*It is assumed that the legal departments of MOH and the Ministry of Justice will take an active interest to ensure the consistency with specific health sector laws respectively generic laws and will take into account the enforcement aspects.*

## **B. General Comments**

The draft bill offers a clear overview and outline of how the Government of Uganda (GOU), i.e. its Ministry of Health (MOH) sees the legal elements of the proposed health insurance system in Uganda. The structure of the law is a good one. It includes basic legislative regulations and the main topics to be regulated that are necessary to implement a National Health Insurance (NHI) system, though some elements are missing which will be discussed in the specific comments section and in the annotated Bill, which is annexed to the report.

The general review of the Bill against the yardsticks, mentioned in the Introduction section, is followed by some alternative options for the proposed Bill.



## **1. Advancing social health protection?**

**Civil servants only.** The proposed Bill offers protection only to civil servants for the first stage of implementation of a National Health Insurance scheme. Although civil servants come in many varieties and have different income levels, they are not the poorest category of society in Uganda. The proposal is to gradually expand the scheme, first with the formal private sector and thereafter with the informal sector. The informal sector includes the poorest people of the country and it will take a long time (15 years!) before they will be enrolled, if this will ever happen while the poor are known to have higher health risks and poor access to care.

**Extending the scheme.** The foreseen expansion of the scheme with the formal private sector is not secured upfront. Employers and employees would like to have the option to opt out and the employees want to keep their current benefits. Granting such opting-out possibility would undermine the viability of the scheme and make the expansion towards the informal sector impossible because of lowering of the contribution based revenues from this sector especially since these categories of insured would likely generate a high premium per subscriber if they stay in the scheme. The informal sector lacks the possibility to generate sufficient revenues to pay for the proposed package of benefits.

The choice to start health insurance by covering the public sector employees leaves out those who are not in the public sector. Also after the next foreseen step, to include covering the private formal sector, the poorer categories of the population are still left out, together with the well earning professionals. This bill in its current formulation will not improve access for the poor and will not prevent them from impoverishment in case they are confronted with high health care costs.

It is therefore very much advisable to include the poor and the informal sector from the onset of health insurance.

To the extent the residents in the informal sector pay indirect taxes, they will be contributing to a scheme which for a number of years favors the better-off while not receiving anything in return.

This choice for the formal (public) sector will lead to more inequity and may drain away health sector related human resources from the poor and shift these resources towards the implementation of the new scheme. Full coverage is planned 15 years after the start of NHI, reaching the informal sector and the poor. In the meantime, these groups, which make up the vast majority of the Ugandan population, will be faced with continuing and possibly aggravated issues of access, high out of pocket payments, and potential financial impoverishment. Given the fiscal and resource constraints, it may take even longer period to reach these population groups. From a social health protection perspective, this is of real concern.

**Size of benefits package.** It is unlikely that a benefits package that is designed for an 8 percent contribution from public sector workers is going to be affordable for other segments of the population without substantial subsidies. While the available data is sparse and relatively old, it suggests that 8 percent of non-agricultural, non-public sector wages would generate only about 57 percent of the revenue per subscriber when compared to 8 percent of public sector wages. For the agricultural sector, 8 percent would generate only 21 percent of the public sector amount per subscriber. This implies that either a smaller benefit package would be needed for

these groups (which would not be compatible with social health insurance principles), or that subsidies of 43 and 79 percent would be required for non-agricultural, non-public and agricultural sectors respectively. It is not clear whether this is affordable and sustainable, or that the planning to date has adequately dealt with these revenue variations.

***This would lead to the conclusion that the proposed Bill may not be considered a credible, viable and sustainable instrument to advance Social Health Protection in extending or creating equitable access for the population of Uganda, in particular the poor, to quality health services. The proposed design is unlikely to reduce the currently experienced impoverishment rate due to seeking health services.***

## **2. Consistency with Government Health Policy?**

The Government of Uganda has accepted for its National Health Policy and its Health Sector Strategic Plans the following principles<sup>78</sup>:

- “Access for all to a minimum package of services
- Equitable distribution of services
- Effective and efficient use of health resources”

These principles are in consonance with the principles of social health protection. So, the same conclusion needs to be drawn as in the previous section. ***The proposed draft Health Insurance Bill is unlikely to help the government in achieving its health policy objectives.***

## **3. Unwanted consequences?**

The current proposal and some of the policy decisions behind the law may have some unwanted or unwelcome consequences that should be subject to further discussion:

### **a. Economic consequences.**

The introduction of a payroll based health insurance system may have consequences for the enterprises and the public sector. Mandatory health insurance will most likely increase the production costs of enterprises. These new costs may drive enterprises into bankruptcy or in the shadow economy. The new financial obligations for enterprises may also reduce their international competitiveness and hence harm the Uganda Economy. Have these consequences been thought through and has the support of the business community been solicited and promised, not only for the first tranche but also for the planned expansion into the formal private sector and further on for the informal sector with which the private sector will have to show solidarity.

### **b. Two tier system.**

The funding of public curative health care services from the budget will continue. In the current proposal, public providers can attract extra funding from SHI for private wards and private providers can also be accredited and contracted. This will lead to a two tier system: one for the poor and one for the rich. This would not matter much if the SHI acted only as a kind of supplementary health insurance, not covering

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<sup>78</sup> Government of Uganda (April 2008)

essential health services but only paying for luxuries and amenities like a private room, private bathroom, telephone, TV etc.

However, the current approach of focusing on “private wings” to provide NHIS benefits appears to carry substantial risks of exacerbating human resource, capital and other pressures on the remaining public health care system, possibly leading to a deterioration of the access and/or quality of care for non-insured persons. There will be substantial incentives to ensure that private wing patients can be accommodated, which could result in having staff sitting idle in the private wings, “just in case”, while the “public” part of the facility is increasingly short-staffed. Private patients may be automatically seen by registered Consultants/specialists while public patients will be offered the services of general Medical Officers, albeit under the supervision of a specialist, as was seen in a hospital visited by the review team. Such policy can certainly impede the quality and outcome of medical care, especially in emergencies. Further, in case of overcrowding in the public wards, public patients may have to lay on the floor, while private rooms are empty, as was noted in the same visited hospital. This may generate critique from a patient rights point of view, dependent of dominant Ugandan values.

The initial NHIS focus on a relatively small, geographically disbursed segment of the population will intensify the potential difficulties, since there may be many health facilities which will cover a handful of NHIS beneficiaries, but will still be expected to provide a full range of insured services.

***c. Health impact for the poor.***

The benefits package of the new SHI will offer more than luxuries and amenities. So, public patients may miss out in timely receiving essential health services, which may have health impacts of yet unknown size.

***d. Inefficiency increase.***

If public providers will be funded partly from the budget and partly from health insurance than this will likely lead to inefficiency and higher admin costs. It may also lead to uncertainty for providers and patients about who pays for what, if the services will paid at all, unless there is a precise delineation of the packages of services offered from the budget respectively from health insurance.

***e. Purchasing.***

The creation of a SHI scheme next to budget funding will lead to further fragmentation of the purchasing function. Thus the health sector may not benefit from the advantages of a single payer system such as relatively low admin costs for payers and for providers of services and better leverage of the financier vis a vis the health providers as regards the effective review of appropriateness and efficiency of the provided services.

***f. Public Health.***

An eventual split in funding may also have consequences for the financing and implementation of public health activities like vaccination and screening of important diseases. A health insurance system, granting rights and entitlements to its insured, can be a vehicle to finance individually (insured) oriented disease prevention and screening on important and preventable diseases. However, a health insurance system is not usually geared to the organization and payment of mass oriented prevention and screening, especially the functions of public awareness raising and public information campaign, of inviting target populations to mass-organized diagnostic tests like breast and cervical cancer screening and the organization of

quality assurance of such programs. A health insurance fund can be made to pay for these general public health and prevention activities, including vaccines, but these activities cannot be made dependent of the individual insured and its eventual demand for such services. MOH or District authorities need to be in charge of the mentioned general public health functions.

When changing the financing of health care providers, MOH may want to make sure that the intended mandate of the health care providers in the area of public health is or remains clearly formulated and the individual oriented prevention activities of curative health staff is included in the benefits package and in the payment system while MOH continues the central organizing, implementation and quality assurance roles.

#### ***g. Stewardship.***

The introduction of SHI as separate from the Budget funded system creates a new steward in the health sector, next to MOH and District Authorities. This may make the new SHI vulnerable to political strive for influence on the local level, it may create conflicting policies and hamper the effective purchasing by the SHI agencies on all levels. The three captains on the health ship may all chart a different course due to their differences in political objectives and financial objectives.

This may not yet be manifest at this moment but, if more categories of the population will have to be included and the local levels will have to play a role in targeting and eventually paying contributions for the poor or simply handing out health insurance cards as to have their population included in the SHI scheme, they may be tempted to hand out cards not for poverty reasons but to attract voters. The three captains may also try to shift their health care burdens and costs to the other financier via as such unnecessary referrals, i.e. from District funded care to MOH funded care and from SHI funded care to Budget funded care.

#### ***h. Gradual Introduction of SHI.***

In case the GOU decided to implement the SHI Bill as planned it would then be advisable to make the regulations referring to implementation of the “step-by-step-model” more concrete and obligatory for the government and Ministry of Health of Uganda, i.e. the Bill should firmly indicate the scheduling and definition of target categories of the population to be included within a defined time after the start of the scheme.

### **C. Alternatives**

The proposed health insurance scheme and the draft Bill are a mismatch with the GOU’s own objectives and with SHP goals. The proposed scheme leaves many uncertainties about its viability and long term sustainability. That’s why the P4H team likes to inform GOU about alternatives in pursuit of SHP

#### ***1. Universal coverage?***

- a. ***Expanding the budget funded scheme.*** To achieve universal coverage the most simple solution is to expand the current budget funded system and make it more effective and more efficient. I.e. is it really necessary to further fragment the already fragmented health financing system and enter into a new financing scheme with all its extra admin costs and unavoidable learning curve effects once the introduction starts? Are all options to improve the current system exhausted? To fund such extension, not only current taxes may be observed for more coverage via an improved collection system and preventing the richer part of the population from tax evasion, but also new taxes can be considered like a sin tax

on tobacco, alcohol and sugar and a solidarity tax from company based and private health insurances.

In case GOU deems the increase in taxes or the improvement of tax collection not feasible than the question arises if the current proposal, which will be paid fully from taxes in its first stage of implementation, will be feasible.

- b. **Big bang.** If the health insurance system will go ahead anyway, the formal and informal sectors can already be included in SHI from the very start. This could be done by consolidating the current Budget for individual care with the revenues from an insurance system in one revenue pool, called the National Health Insurance Scheme. From this pool the costs of health care for the poor and other beneficiaries can be paid. Therewith the poor will also have a direct chance that their health care access and quality of care will be improved together with the formal sector?

This approach will require more preparation time as to sort out the possible revenue basis and the breadth and depth of the benefits package. However, this option has several advantages as compared with the current proposal: it offers universal coverage of a broader package from the start, it prevents a two tier system, and it will require less admin costs.

- c. **Handing out health insurance cards to all residents.** Unless the quality under the NHIS is clearly distinguishable and detachable, the proposal to sustain 'free care' alongside insurance till full coverage under the NHIS is unlikely to work. The question might be asked why people who presumably get free health care anyway would sign up for health insurance. Probably for this reason, paid services such as private beds in public institutions are under-utilized while free services are overcrowded. The dual system will also introduce new administrative challenges and incur extra admin costs.

Given this context, it is ideal to insure every Ugandan citizen/resident and provide health insurance (identity) cards to everyone. The price of the card may be determined differently based on their eligibility; it could even be graded according to the socioeconomic or geographic status of the people. Geographic targeting is easier than income targeting. The card would entitle the holder similar health care services irrespective of their socioeconomic or geographic status; S/he is different only in terms of financing, not in terms of health care benefit. In this way, disadvantaged people will continue to receive free care under the changed system. Moreover, the card allows collecting, compiling and storing of certain valuable socioeconomic, health, and health care data of the entire Ugandan population.

In order to finance the disadvantaged people based on this suggestion, it is necessary to split the government health spending into two - salary and non-salary. While the salary bill could go through the usual budgetary channel, the non-salary component needs to be organized differently. The non-salary budget could be deposited into the NHIS pool along with contributions and could be spent under the NHIS rules to purchase health care from the designated providers. The purchase of care will be for all the insured, including the disadvantaged. In this way, public and private providers would compete for NHIS resources.

Of course, reimbursements for public sector facilities will be restricted to non-salary cost with appropriate adjustments to take into account Geographic and other facility-specific constraints. On the other hand, private facilities will have a price inclusive of salary cost. Thus, public facilities will have a comparative price advantage over private facilities. This would, however, mean that public providers would need to deliver high quality health services in order to maintain their

patients, and with money following the patient there would be a clear incentive to do so.

Since pooled resources under the NHIS would include newly 'crowded out' resources due to the addition of contributions, the same could be used to subsidize the purchase of cards for the disadvantaged people.

- d. If these options are all considered as unattainable for the moment, than at a minimum it is advised to clearly lay down in the Bill the **proposed “step-by-step-model”** of implementing a NHI and to instruct the Government on when which categories of the population will be included as to achieve universal coverage.

## **2. Improving the current health financing and delivery systems.**

Many of the actions proposed in the draft bill can also be used in a budget funded system, e.g.

- (i) Reshaping the payment system and introducing performance related reimbursement of providers;
- (ii) Introducing a purchasing mechanism, implemented by a public regional health authority;
- (iii) Operating a system of contracts with health care providers, public and private;
- (iv) Granting more autonomy to public providers;
- (v) Increasing the funds available for the health sector and reducing out of pocket payments at the point of service etc.

If there have been any attempts to try the above, why have they failed and can their causative factors be overcome by the creation of SHI? It would be useful to analyze this in order to prevent SHI missing its objectives or, worse, ending into failure.

The Minister of Health and the Government of Uganda are advised to consider the above alternatives before making a final choice about health finance reform.

## **D. Specific comments on the structure and content of the Health Insurance Bill**

Hereafter specific comments are provided. More detailed comments are inserted in the draft bill itself, which is separately annexed. As mentioned at the beginning: these comments are not an expression of consent of the P4H Partners or the review team but have to be seen as merely technical comments on the current draft Bill, as requested by MOH, to help prevent as much as possible the draining of scarce resources, to make the Bill an instrument for cost-containment and quality assurance and to protect the rights of the insured (though not of the population at large)

### **1. Explanatory Note**

It is advised to have a more extensive Explanatory Note or Introductory Memorandum in the Bill to highlight the need for the introduction of health insurance, the main choices made and their consequences on important health, equity and economy related parameters, as referred to in the above. Further to explain the process followed so far to draft and submit the Bill and reflecting on the role of the Task Force. The review team also advises to commit to and announce in this

explanatory note a planned evaluation of SHI against the formulated objectives and by when such evaluation will be presented to the Parliament.

## **2. Framework law**

The Bill is to some extent a framework law which delegates the adoption of more detailed implementation aspects to the Government and/or MOH. This allows for flexibility and the timely reaction on emerging health and social economic issues and on new developments in health technologies and health services delivery, e.g. the adjustment of a drugs list or the beneficiary's requirements for identification and filing claims. The detailed comments, inserted in the Bill itself, propose to shift more detailed regulations to byelaws or schedules.

Despite the need to create flexibility in implementation of the Bill, the main principles, rights, responsibilities for making bylaws/schedules and the procedures to be followed should be clearly stated. E.g. although the benefits are included in Schedule 6, the principles and main rights of the beneficiaries would better be clearly stated in the law itself as to create clear entitlements. Clear for the beneficiaries and for the SHI implementing bodies. Same for providers of services.

## **3. Instructive and declarative**

The Bill is a mix of instructive and declarative regulations. I.e. it instructs the Government, MOH and the health insurance board to create and implement the envisaged SHI scheme and SHI bodies respectively it creates entitlements for the beneficiaries and obligations towards the mandatory contributors. This mix has consequences for oversight and supervision.

## **4. Oversight & Supervision**

The Government should oversee the implementation of the SHI scheme, evaluate the process of implementation, its goal attainment, especially as regards the health policy objectives of the government, its financial performance and economic impact. It is therefore not enough to only use the *financial audits* as these will be done by the Auditor General and/or by the Insurance Commission. The Government is advised to also have a *functional assessment or audit* being done by an appropriate oversight body or by MOH itself. The functional assessment should look at the extent to which the beneficiaries have been provided the services they are legally entitled to and at the cost-effectiveness of the services provided. E.g. has the SHI body exercised its provider performance review in an effective way, avoiding over-servicing and under-servicing, have due contributions been collected to the extent possible and have the appeal and arbitration functions been justly performed?

The SHI Board itself is in first instance in charge of running the scheme according to the regulations and to guarantee the rights of the insured, contributors and other entities involved in the day to day implementation of the scheme.

## **5. Insurance Commission.**

According to the Insurance Act, the new health insurance scheme falls under the jurisdiction of the Insurance Commission, like any other insurance. However, the Insurance Commission looks only at the limited aspects of a health insurance, like general governance regulations and financial performance of the insurance schemes and insurance companies, at solvency and financial reserves. Although in a way it therewith protects the rights of the insured, the Insurance Commission has no mandate to do a functional audit: to assess the performance of a health insurer as

regards the realization of the entitlements of the insured and if there has been under- or oversupply of services. Two options exist to fill this gap:

- (i) To extend the mandate of the Insurance Commission, which requires a change of the Insurance Act, or
- (ii) Establish a separate oversight body. This separate body can be MOH or a special body established for this purpose.

In any case, the financial and functional assessments should go hand in glove, and the knowledge and skills of the Insurance Commission should be appropriately evaluated on its effective use for the new NHI.

## **6. *Instruction & reporting relationship between MOH and insurance body.***

The Bill is supposed to be an instrument for health policy implementation. MOH is in charge of health policy formulation. For the implementation of its health policy, the Ministry should have the possibility to instruct the Health Insurance Board and to demand the HI body to report to it. The ministry should also have the possibility to revoke decisions by the Board of the body within a reasonable time frame of e.g. 30 days, while the Board should inform MOH within two days about all its decisions about main. The Board should be granted the possibility to challenge the MOH action in a suitable administrative court. A schedule can be drafted to indicate what can be considered to be important decisions, subject to eventual revoking by MOH.

## **7. *Accreditation***

To avoid confusion it is advised to follow the international nomenclature<sup>79</sup> in the definition of accreditation as a “public recognition of the achievement of accreditation standards by a healthcare organization, demonstrated through an independent external peer assessment of that organization’s level of performance in relation to the standards”. This implies that the current proposal would be better named as certification or as recognition, in this case meaning that the provider is included by the HI body as an entity to which the beneficiaries of the scheme can turn to for SHI reimbursable health care.

## **8. *Quality assurance in health insurance***

The health insurance system should assure that its beneficiaries receive quality care. This is rightly addressed in the Bill. However it is not the prime task of a health insurance body to assure itself the quality of provided health services in a country or to be in charge of the improvement of care quality. SHI can rely on existing general systems for quality assurance and assessment, like

- (i) Regulations for the practicing of health professionals and allied health professionals, e.g. the registration of health staff by the Councils in Uganda for doctors, dentists, nurses, allied health professionals etc.
- (ii) The licensing of Uganda practitioners to establish private practices and clinics, and
- (iii) The existence of a private or public accreditation system of health care providers (if this would exist).

The proposed system of “accreditation” of health care providers can also be introduced as separate from the implementation and existence of health insurance. It is preferred to have accreditation, at least on the long run, as a separate system,

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<sup>79</sup> Shaw (2004)



aiming at continuous quality improvement for all providers irrespective of their eventual acceptance as a provider of care to insured patients.

The simultaneous introduction of health insurance and accreditation may cause capacity and management problems for the new NHI body. However, a future NHI scheme and hence the NHI Bill should link to all existing quality assurance and external quality assessment mechanisms for health care services. I.e. accreditation can be seen as a necessary condition but may not be sufficient for a payment relationship with NHI, i.e. a contract.

The proposed incorporation of accreditation in SHI may have as consequence that a provider, complying with accreditation standards, has an automatic entitlement to payment by NHI, while there is perhaps no need for this particular provider or of his services on the offered level of care. This will make the health system inefficient and will needlessly cost the NHI more money than necessary to serve its beneficiaries.

It may therefore be more appropriate that MOH takes the lead in establishing an accreditation system which can become implemented by an autonomous public or private accreditation body.

## **9. Contracting**

Many of the objectives that NHI would like to achieve with its in-house accreditation system can better be facilitated by a system of individual contracts between SHI and the health care provider. In such contract a reference can be made to accreditation as basis for the contract and for eventually revoking the contract in case the provider has lost his accreditation and has no perspective of regaining it any time soon.

Although the word "contract" is used in the Bill, it is not defined in Part 1. Section 2. It is advised to do so.

A contract in a health insurance context can be seen as a mutually agreed legal document that states the joint objectives, the obligations of the parties to the contract, and the procedures and criteria to continue or cancel the contract. It is advised to replace the existing sections on accreditation with sections on contracting and replace all references to accreditation, accredited etc. with contracting, contracted or contract.

The Bill should subsequently include the main features of a contract, the procedures for contracting, the relationship with the package of benefits regulations and with other relevant regulations (like the civil code and the regulations on health care workers and institutions). The Bill should state that the insured are entitled to care from contracted providers only, and instructs parties to establish an arbitration process in case of conflicts between the contract parties as to speed up conflict resolution and preventing parties from going to Court and enter into a long procedure with unknown results.

Instead of focusing on an accreditation system it would be much better to invest in the establishment of a system of *selective contracting* of health care providers. I.e. selecting providers and the type and amount of their services based on a number of criteria like the needs of the insured in the particular area, the quality and price of their services, their history in billing (no fraud and no inappropriate services).

Such contracts can refer to existing regulations and mechanisms for, among others, quality assurance like the existing systems for the registration of health professionals, nurses and allied health professionals, to the licensing of private health facilities and of privately working health staff, and to an eventual accreditation system or other quality assurance systems. Such contracting system is not worked out in-depth in the current proposal but is advised to be included, with the main elements in the Bill and the specifics in the contracts itself.

Where important regulations are missing, like a health planning law and the regulation of the public and private sector as regards distribution of providers and of health care technologies, the Health Insurance Bill can fill this void by contracting

only those providers and their services that really are necessary to serve the insured. The same can be done for quality assurance.

**Dual practicing** and its negative effects on health services delivery and accountability can also be mitigated via a contracting system. The health insurance bodies can ask, as part of their contracts with the public and private providers, these providers to be transparent and accountable on this topic, thus help preventing absenteeism and paying for substandard quality of care and duplication of infrastructure.

***Establishing a contracting system will require quite some effort and cannot be done overnight. It needs to be planned for. P4H Partners are ready to provide further support.***

### **10. Paying providers**

The draft offers a limited number of options for paying the providers. It is advised to leave the details of payment mechanisms to bylaws/schedules as well as to the contracts which will have to refer to these bylaws/schedules. It suffices to have in the law the principles: payment will be based on a contract and will be according to payment schemes that are performance oriented, towards fostering appropriate quality care, and that prevent misuse of scarce health resources.

**Combining outpatient and inpatient care provided** by hospitals in one and the same payment has the advantage of stimulating the provider to do as much as possible in outpatient care, which is cheaper and most of the time more comfortable for the patient. This is especially true for case based payment systems and DRG based systems. This element is missing in the current draft.

### **11. Mandatory contributors**

The health insurance board should have the possibility to demand or perform itself an audit of the mandatory contributors, including those of public employers, to check if all the mandatory contributions have been transferred to the health insurance fund account. In case the collection of contributions is contracted out to e.g. the NSSF or the tax-office, the NHI Board should have the possibility of asking for an independent audit of these offices as regards their due diligence in collecting and transferring the contributions in full. The current draft does not include these options. It is advised to insert these in the draft.

Similar safeguards may be necessary in case of voluntary members as to check on their contributable income.

### **12. Definition of salary and/or income**

The current Bill does not provide a definition of salary or income of which the mandatory contributions need to be paid. Even in case of public servants the term salary may not be clear in itself, unless it is defined in another law. If the latter is the case, then the Bill should refer to that regulation. The following questions can arise: are any extra payments for e.g. overtime, shift work, bonuses, jubilee etc included in the definition of salary or not?

What constitutes an income also needs to be defined. It is advised that the Minister of Health can provide further regulations on what can be seen as income of which contributions need to be paid.

The option of the MOH issuing detailed regulations in schedule on what constitutes an income becomes even more important if and when the informal sector, including professionals, is included. Then e.g. questions may arise about income in kind.

### 13. Benefits Package

From a patient rights perspective and from a cost-containment point of view it is suggested to include in the Bill the principles for composing the package and to indicate the conditions for entitlement of the insured in concrete cases: i.e. “the beneficiary is entitled to outpatient and inpatient care, to pharmaceuticals and assisting devices as defined in or by this Bill and specified in the by-laws/schedules and on the conditions stated in these bylaws/schedules. The beneficiary is only entitled to these services in case there is a real health need to use the particular service on the particular level of care, which needs to be of scientifically proven effectiveness, appropriate and cost-effective for application in the particular case. The minister of health can issue and adjust the bylaws or schedules and formulate the conditions for the avilment of specific benefits. “

A legal description of a benefits package should not stop with a list of services describing **what** is covered but also include and/or refer to **who** is providing the benefits, on which **conditions** and **where**.

- a. **Entitlements.** The following options exist for the general description in the law and bylaws/schedules of the entitlements, i.e. what is covered:
  - (iv) **Disease oriented**, listing the diseases or medical conditions to be covered as well as what kind of services can be obtained, or
  - (v) **Services oriented**, listing the specific services, institution based, individual professional or health function based. E.g. “the insured are entitled to individual preventive, curative, rehabilitative and palliative health care from health centers (I,II, III and IV), District and national hospitals, to services from midwives and family physicians and to pharmaceuticals and medical assistive devices as detailed in the bylaws/schedules and on the conditions as stated by the Minister of Health in the respective bylaws/schedules

The disease oriented description makes it possible to focus on important medical conditions like pregnancy and delivery, TB, HIV/AIDS, diabetes etc. However, such description of entitlements formally leaves out the diagnostic aspects before a conclusion can be drawn about the specific condition. This may create uncertainty for the patient and the health care provider if the care is included. Such description will also raise questions about concurrent diseases, e.g. in the case of asthma during pregnancy. The second option is therefore the preferred option. This option is also used in the existing benefits package.

The detailed description of the benefits can be done by using a *system of positive and/or negative lists*, eventually with exceptions. Both types of lists have pros and cons:

- (vi) **Positive list:** clearly formulated but restricted entitlements. Gives clarity to insured and provides good options for cost and quality control, but is not flexible: an explicit decision by the mandated health authority is necessary to add to or delete from the list. Positive lists are frequently used for pharmaceuticals and assistive devices. The positive list can come with exemptions like restricting the use of certain drugs to specific medical indications.
- (vii) **Negative list:** refers to a general entitlement of e.g. hospital or inpatient care and excludes e.g. transplants, dialysis, cosmetic surgery or dentistry. The general and rather open description of e.g. hospital care offers flexibility: new health technologies can be easily introduced, allowing for medical progress and quality improvement. An explicit decision is necessary to exclude a new or existing technology. This may be difficult as such decision comes after the fact and has to redress the already used technology to which patients are yet

accustomed. The negatively listed interventions can have exemptions like congenital malformations mutilating cancer surgery for cosmetic surgery.

**Freestanding labs and diagnostic centers.** One of the difficult questions for Uganda may be the eventual inclusion of an entitlement to laboratory and diagnostic (e.g. imaging) services from independent laboratories and diagnostic centers, not part of a health clinic or hospital. These independent centers and labs may be a fact of life in Uganda but if a specific entitlement exists than problems may arise with cost control because the test ordering doctors are elsewhere (in health clinic or hospital). They will drive the volume and hence the costs of lab and diagnostic services. Best thing is to have these services included in the entitlements to hospital and health clinic care and make the hospital respectively the clinic responsible for cost control via the contracts with these hospitals and clinics and by having a case based payment system which includes all necessary lab tests and diagnostics. The hospitals and clinics in turn can conclude contracts with the labs and diagnostic centers.

Freestanding labs and clinics may be very costly in case the test ordering doctors have a financial interest in such lab or diagnostic center or own these. This will most likely lead to unnecessary high volumes of tests. The current dual practicing possibilities and the wish to stimulate private services may increase a trend towards freestanding labs and diagnostic centers. This may require the attention of MOH and a future NHI Board.

**Pharmaceutical services.** A similar situation can occur when drugs prescribing doctors have a financial interest, directly or indirectly, in pharmacies, leading to unnecessary and unnecessarily costly prescriptions. These problems can be countered by assessing the prescription patterns of contracted doctors and to see if these are in accordance with accepted clinical practice guidelines and medical protocols. Another possibility exist in contracting pharmacies and insert requirements about the ownership of the pharmacy and accountability.

b. **Conditioning entitlements.** Next to describing what is covered it is suggested to also consider the following elements as related to the entitlements, meant for clarity and cost-containment:

- (i) **Who will deliver the services, i.e. to whom will the patient have to turn to:**
  - Only public providers?
  - Also private providers?
  - Only licensed providers?
  - Only accredited providers?
  - Only providers contracted and listed by the health insurance body
  - Specific providers for specific medical conditions or services, e.g. highly specialized services?
- (ii) **Where will the services be delivered: at home or at an institution, in ambulatory or in inpatient care?**
- (iii) **Are there any territorial restrictions: a provider close to home has to be used or patient is free to go to whatever provider in their District or elsewhere in Uganda, e.g. if care is not available in his District.**
- (iv) **If covered care is not available in Uganda: is there a right to go abroad?**

**(v) How can patients materialize their entitlements, i.e. what conditions have to be fulfilled? e.g.**

- Paying a co-payment or user fee? If so, what kind of co-payment:
  - General deductible
  - Fixed amount for specified services (e.g. per bed day, per lab test, per drug, if demanding services without mandatory referral from a lower level of care;
  - Percentage of the costs of the services or of the usually charged, predetermined fee;
  - The amount over a specified threshold for the cost of services. This is e.g. used in an internal price reference system for pharmaceuticals, also called a limited reimbursement system. The internal price reference system needs to be distinguished from the external price reference system, which sets maximum levels for drugs prices to be imported and marketed in a country;
  - A combination of the above;
  - Up to a certain maximum per period, eventually income dependent;
  - Exemptions for categories of patients, e.g. poor people, pregnant women, children etc.;
- Having a referral letter from a lower level of care; and
- Getting a pre-approval of the health authority or third party payer, e.g. for hospital admissions or very expensive interventions or drugs.

**(vi) Benefits in kind or..? What system will be used (there is a principal legal difference between the three):**

- Benefits in kind, i.e. patients are entitled to the services as listed and the providers will be directly paid by the third party payer, i.e. bulk billing or a cashless system for the patient;
- Reimbursement system, i.e. the patient will be entitled to reimbursement of the costs of services as listed and the patient will be paying the provider. This system is more costly to administer than the benefits in kind system because of the individual billing. In this system, the patient will have to find a suitable provider, willing to treat him and he cannot ask for support by the third party payer. Such system offers also less options for cost and quality control unless the third party payer creates an expensive information system and uses also a system of contracting; A reimbursement system is mainly seen in private health insurance; or a

- Benefits in cash system, i.e. if the defined health risk materializes than the patient will receive an amount of money and he is free to spend it on whatever he likes, even outside the health sector. It is obvious that this will not be the preferred option in Uganda.

The benefits in kind system seems the most appropriate for SHI and offers the best possibilities for cost and quality control.

#### ***14. Waiting time for getting benefits***

In case of voluntary membership it is important to avoid persons postponing membership and only applying for membership to get treatment for already existing medical conditions at the moment they need such treatment, except at the very start of the scheme. This can be discouraged by either excluding the costs of pre-existing illnesses for a specified period or by introducing a general waiting time for getting benefits of e.g. 6 months after enrollment. Such measure need to be accompanied by careful information campaigns, informing the public about the consequences of non-enrollment.

#### ***15. Financing NHI***

In the first stage of NHI as foreseen in the current Bill, covering only the formal public sector, all monies will come from the Budget albeit that they will be named contributions. For the future expansion especially with the informal sector and especially the vulnerable groups unable to pay contributions, budget transfers will be necessary. It is advised to already anticipate this step and include the necessary regulations in the current draft to allow for budget transfers. Details can be left to bylaws or schedules. The current draft does not identify the possibility of tax transfers!

#### ***16. Contribution rate***

The current draft fixes the contribution rate directly by law. This provides no flexibility. It is advised to have the contribution set by the Government, based on the forecasted needs of the scheme and reckoning with imponderable factors in the development of both expenditures and revenues, e.g. against the background of global and national economic trends.

#### ***17. Co-payments***

The draft Bill does not offer the possibility of charging co-payments or asking for user fees at the point of services. Although co-payments are thought to mitigate moral hazard and to prevent unnecessary use of the insured health services, they can also hamper access to necessary services, especially for the poor. That's why the poor should be exempted from paying user fees. Further, preventive care and maternity and child care should be exempted.

However, co-payments are a means of co-financing the package of benefits. There are tradeoffs between a small package and no copayments and a bigger package with copayments:

## Reduced BP or Copayments?

- |  |   |
|--|---|
| <ul style="list-style-type: none"> <li>• <b>Pro:</b> <ol style="list-style-type: none"> <li>1. Simplicity</li> <li>2. Have the ends meet</li> <li>3. Increase personal responsibility (private payments or insurance for supplementary care).</li> </ol> </li> <li>• <b>Contra:</b> <ol style="list-style-type: none"> <li>1. Two tier system (only the rich can afford the supplementary care/package)</li> <li>2. No access to essential care provides health risks for individual and/or society</li> </ol> </li> </ul> | <ul style="list-style-type: none"> <li>• <b>Pro:</b> <ol style="list-style-type: none"> <li>1. Package solidarity, i.e. the rich contribute to health care for the not so well off</li> <li>2. Replaces informal payments</li> <li>3. Better control of services (cost and quality)</li> </ol> </li> <li>• <b>Contra:</b> <ol style="list-style-type: none"> <li>1. Higher admin costs, especially in case of a income dependent co-payment system</li> </ol> </li> </ul> |
|--|---|

It is advised to introduce in the Bill the option of setting user fees, exempting the poor and preventive services, to leave the details to the package of benefits regulations (bylaw/schedule) and to carefully consider the pros and cons of every co-payment to be introduced and to monitor its effects on access to essential health services. The various copayment options are described in section 21.

### **18. *Balancing the budget of NHI***

An insurance system is in essence an open ended system, i.e. the justified claims of the insured have to be paid. Same for a health insurance system with legally grounded entitlements to benefits. That's why the Bill rightly instructs to have a reserve fund to cover the expenditures in a given year. The Bill provides also the authority to the Board to borrow money. This borrowed money can also help making the ends meet. However, borrowing money and digging into the reserve fund can only be temporary actions. In the end, the reserve fund will need to be refilled and the loans paid back.

For the longer term, the Government, respectively MOH or the Board have the following options:

- Adjusting the contribution rate
- Adjusting the package of benefits (this may require some transition arrangements as to allow finishing a started therapy by the insured and not to stop it at the effectiveness day of the new benefits schedule)
- Introducing co-payments or increasing the amount of copayments
- Adjusting the payments of providers, drugs and devices

## **19. Relationship with other schemes**

It is advised to spell out in more detail the relationship of NHI, private health insurances, community based schemes and existing (pension) schemes (in particular NSSF). This would include e.g. the objective of and means for such relationships, showing the path towards universal coverage for a benefits package of essential or minimum services.

## **20. Accreditation system**

Instead of focusing on an accreditation system it would be much better to invest in the establishment of a system of selective contracting of health care providers. Such contracts can refer to existing regulations and mechanisms for, among others, quality assurance like the existing systems for the registration of health professionals, nurses and allied health professionals, to the licensing of private health facilities and of privately working health staff, and to an eventual accreditation system or other quality assurance systems. Such contracting system is not included and described in-depth in the current proposal but is advised to be included, with the main elements in the Bill and the specifics in the contracts itself.

## **21. Investments in capacity building**

The introduction of health insurance will require a huge capacity building effort as regards human resources, management, information and communication infrastructure, physical and admin infrastructure and public information. Capacity building will not be a one off exercise but is necessary on a continuous basis because of changes in staff, in health insurance and in external circumstances. Besides the need for careful planning of the introduction of health insurance and having everything and everybody ready to start, the capacity building will require substantial initial investments before even a penny has been collected in contribution to the scheme. The draft bill does not mention this. Although the Board has the option to borrow money, it is not explicitly mentioned if this borrowing can be done for paying for the initial investments.

## **22. Borrowing**

As mentioned above, the Bill provides for the option of borrowing money. Besides taking a loan from a commercial bank, it is advised to also consider the options of borrowing from other social funds, like NSSF, or from the treasury as these options will come with much lower interest rates, despite the Government of Uganda being the guarantor of the scheme which as such should qualify the scheme for low commercial interest rates because of the absence of a risk for the commercial bank.



## **Annex 9**

### **Comments by the NHIS Task Force on Health Insurance on October 2009 P4H report and reply (R) by P4H team (under the specific comments)**

#### **A. General issues**

1. There is much reference to experiences in other existing schemes (except for the Chinese health insurance system) and health systems and how lessons for the Ugandan sector.

R. There is a reference to China on p. 48, discussing multiple options under a single insurer (alternative a.)

2. More details could be provided on how the proposed scheme could address the poor of the poorest ie the poorest quintile)

R. This can be done by focusing on alternative b, c, d or e. However, it has to be noted that improving financial access for the poorest of the poor may need to be complemented by improving geographical access and quality of services in the areas where the poor actually live. This is also an area where the P4H partners can consider further assistance.

3. As soon as the draft Bill is agreed by MOH and MOJCA, the Task Force could consider actively consulting decision making organs of stakeholders before presentation to the Cabinet (Page viii).

R. That's excellent. MOFPED and MOGLSD should also be included in the consultations.

#### **B. Specific issues**

Medical equipment situation in the PNPF/PFP not elaborated and discussed.

R. It's true, the report does not pay attention to medical equipment, same for blood and blood products and the quality of pharmaceuticals, among others. However, medical equipment issues are easier to solve than HR problems, especially as regards distribution of staff and levels of competence, also in light of the international brain drain

Inadequacy of the health work force: How the scheme will operate in this environment and the recommended levels of work force have not been provided or alternatively what the scheme/government can provide as mitigation measures.

R. This depends also of the preferred alternative.

All issues in the background related to health work force could be brought together.

R. Sure, this will require a separate HR study. P4H partner could commit to this. Health finance alternative a. pays attention to differences in access to quality care, based on geography. Provider payment systems, managed by an active single purchaser could be helpful.

Medicines should be separated from other issues and addressed in detail. Also all issues in the background could be brought together.

R. P4H partners could decide to support MOH by doing a separate and comprehensive study, including the relationship with health financing modalities.

Efficiency and equity not elaborated and discussed.

R. Efficiency and equity are mentioned in relation to the creation of a single purchaser, which would enhance efficiency in administration as well in care delivery. The proposed NHIS Bill does not offer equity in access to services, at least not in the short run. The proposed focus on the poor would do exactly that.

However there is a discussion on purchasing, payment and fiscal resource allocation. The text should highlight issues of costing, pricing of services in Uganda and how this affects service delivery especially in the proposed NHIS.

R. These issues depend very much of the chosen health financing system and of the provider payment system. P4H partners could offer more assistance in these areas.

Increase in number of districts: the degree, extent of the strain on health services as well as the discussion the current increase in number of districts has not been addressed.

R. It is mentioned that these new Districts pose a strain on the management capacity and HR (page 14)

#### *Health care utilization*

TCMP: what is its impact of TCMP on the proposed scheme, proposed ways to address current level of seeking care from TCMP could be included in the report.

R. This can be dealt with as part of the review of the benefits package of a new scheme and the criteria that can be applied for its design (see page 90). A consideration could be to leave this to private pockets, because traditional medicine has always been financed that way.

#### *Page 10: Social health protection*

The recommendation on page 53 on inclusion of social health protection in the overall government strategy of social protection could be part of executive summary.

R. There is some reference to it. Further elaboration is possible in an updated version or final report, or in a follow up report, dependent of the outcome of the P4H discussions during the follow up February 2010 visit.

The report could propose modalities of inclusion of the proposed NHIS into the broad social protection.

R. See above

#### *Page 18: Process*

The Task force could develop modalities of regularly engaging the top leadership of other stakeholders (for example employees, employers and providers). P4H could also propose how this can be enhanced.

R. Several options can be discussed, from light to more heavy handed: Ad hoc scheduling meetings if and when draft reports and/or health financing options are elaborated enough to allow for discussion. A set number of scheduled hearings for interested parties on dates set in advance. Sharing drafts and minutes of meetings more widely, eventually on a dedicated website. Creating a temporary or standing health financing advisory council with representatives of stakeholders, eventually instituted formally by GOU regulation.

#### *Page 20*

(f) P4H could elaborate on what nature the national debate on the proposed NHIS should take.

R. The intention of the P4H comment was to not do only advocacy and marketing but to start listening to the stakeholders and to work together on solutions and/or to reach consensus, as much as possible.

The TF agrees with the need further consultations and active inclusion of all stakeholders in order to built ownership of NHIS beyond the Ministry of Health. P4H could propose other stakeholders to include.

R. MOFPED and MOGSLD should play an important role. Besides employers and employees organizations, also representatives of associations of doctors and nurses, of pharmacists, of hospital managers, of private for profit and private not for profit providers, of private insurers, community insurers and local governments can be considered.

The Task Force could address this concern as soon as the proposal is available and when the draft Bill is agreed on by MOJCA.

R. It is hoped that this draft Bill can then still be subject of discussion and can be changed

#### *Political environment (Page 22)*

Local governments: the report could propose strategies on how to engage local governments and how to build their capacity.

R. First of all as it seems, by clarifying their role and mandate in the current setting and in the proposed future setting. Further, it will also have to address the issue of competence of local governments. P4H partners could offer to provide support for this as the process develops

#### *Social and development objectives (Page 17)*

The report could propose ways of poverty reduction within the broad goal of social health protection.

R. The proposed alternative health financing options all pretend to contribute to poverty reduction by limiting and hopefully preventing impoverishment in case of using essential medical care for objective medical needs. Further, making health care accessible for the poor and therewith improve their health status will as such improve their prospects of making a better living and improve their earning capacity. P4H partners could offer further support for this

The TF proposes that civil society be considered under capacity building for all stakeholders. After this undertaking, interested CSO could take on the neutral role of sensitizing and advocacy of the topic.

R. Makes sense.

#### *Options for SHP Universal coverage (Page 46)*

The Task Force acknowledges this challenge of the two wings and proposes gradual integration. This could be after the scheme has taken care of the poorest of the poor and modalities are in place for everyone to access membership of the scheme.

R. P4H partners are happy to further discuss the how to questions

#### *Alternative options*

- (a) Single insurer: The existence of obtaining services from the LTFQ is an envisaged reality. However, the scheme should gradually address this imbalance by providing incentives to health providers working in hard to reach areas and incorporating the proposed options in the report. The options proposed as in the Chinese schemes could be incorporated in the current design of NHIS.

R. True. Although also the LFTQ's could be offered a chance towards continuous professional development.

- (b) SHI in the informal sector and the poor: This is best addressed under the option (a) and after identifying the source of funding.

R. Option b and c also offer this option.

- (c) Free care in different formats: this options needs further exploration on advantages and how this will increase further coverage, identification of beneficiaries. It is not clear how NHIS members could benefit.

R. Every resident is declared a member in this proposal

- (d) Budget funded scheme: this option has been debated and dropped in our cabinet submission.

R. It may still be useful to keep it on the table for further discussion as part of the dialogue with the other ministries and the other stakeholders.

- (e) Big bang: there is no capacity to manage this big bang: avail the providers, the benefit package, work out contribution rates for the informal sector, collect their contributions and even assure the contributors that this will work.

R. As is mentioned on page 51, this alternative requires more preparation time. P4H partners can consider offering the preparation of an implementation plan, showing the feasibility of this alternative. It has to be noted that none of the proposals will be without its own learning curve. Like in most countries, health reform and health financing reform are continuing stories, there is always a need to adjust to changing circumstances

Demand creation: This will be harmonized with option a (p47).

#### *Group 2 discussions Page 16- 30*

##### *Page 16*

- Health is a need for all hence civil society structures are not major determinants in the health bill
- The Bill still need to have political backing to receive priority from other many bills being tabled in Parliament.
- There s need to equip the more decentralized centres in terms of funding (for medicine, equipment and other medical supplies) and capacity since decentralization tends to create an administration gap. Refer to Public Expenditure Report 2007.
- The Bill is pro poor but needs to specify on the source of funding for the poor.

##### *Page 17*

- No single civil society organization can take up the entire social protection agenda because of its wide nature. These organizations can instead only take up sections of social protection.
- Report needs to specify what percentage of the subsidy is being referred to.
- The increase in OOPs and catastrophic expenditure after abolition of user-fee shows the ineffectiveness of the latter.

R. This is due to the lack of drugs and supplies in hospitals. It is therefore advised to undertake a thorough pharmaceutical and supplies management review and to look for efficiency improvement.

Further: It is understood that abolishing OOP's was a political decision. When re-opening the discussion about the benefits package it will make sense to come back on the issue of OOP. There are trade-offs between a small package with absent OOP and a bigger one with OOP, albeit that the poor should be exempted or at least see their OOP's capped at a certain, income dependent level.

Page 20

- Efficiency is lacking in allocation of resources though donors take advantage of this and promise funds which never get to Uganda

Page 25

- MOFPED has policies that are geared towards privatisation rather than social health protection and yet MOH has opposite objectives  
R. That's why it is important to get MOFPED and MOGSLD involved in the discussion about health financing reform. However, private financing should be distinguished from the private provision of services
- More information needed on NSSF parallel scheme in the making.

R. P4H partners would also like to be informed about the most recent developments and about eventual political backing or the lack thereof.

Page 26

- Clarify on 1<sup>st</sup> paragraph, last line, committee approved by the board to carry out the accreditation, not the board.  
R. The Board is responsible, albeit only for establishing the accreditation committee and overseeing its mandate. Anyway, this is a textual issue. The principle of accreditation taking up as part of NHIS is more important.
- There is a need for further dialogue between task force members to ensure members speak the same language.
- There is need for further deliberation on the fact that the scheme is to start with public sector, having refinancing of health care benefits for privileged groups by majority.
- Possibility of funding scheme for the poor, the scheme could finance through investments over the fifteen years.
- Inter-ministerial committee is already in place  
R. That's an excellent step.

Page 27

- There is a need for adequate planning.

Page 28 - Financing

- Introducing copayments contradicts the abolition of user fee charges.  
R. See the above reply on OOP
- The Bill should combine both capitation and FFS payment systems  
R. It might be better to leave the payment systems open and have the NHIS decide on this and/or to provide MOH with the possibility to set the rules of the payment of providers systems as to make it adjustable according to needs and changing circumstances.

- There are guidelines on management of the private wing that are being developed on the management and financial autonomy of health providers

R. Will this solve the HR and divided loyalty issues as well as the creation of a dual tier system. Besides, as the report mentions: why would people pay if they can get the same services for free?

#### Page 29 - Coverage

- The Bill in its current form and the WB report does not provide for opting out.

R. True, however employees/employers want to see this possibility included.

#### Page 24

- Benefit to the rest of the population that is not part of the scheme at the outset should be articulated clearly in the guidelines.

R. If there are such benefits in the proposed NHIS for those being left out, except for a chance of getting less services because of the shift of HR etc to the NHIS members

- Providers should ensure they have adequate staff to provide value for money.

R. That is something an accreditation system, working in tandem with a single purchaser can pursue.

#### Page 31 - Multiple risk pool and weakened purchasing

- NHIS will be a regulator for all schemes, community based insurance schemes and private health schemes.

R. These different roles, including offering itself health insurance, may be confusing. Anyway, the regulatory tasks of the general Insurance Commission, as based on the Insurance Law, will also have to be considered.

- NSSF proposed medical scheme is to be covered by the inter-ministerial committee.

R. If it is allowed to exist as indicated than it will undermine the proposed NHIS. Indeed, it requires the attention of the Cabinet of ministers

#### Page 33

- Choice of insurer – There is need to strike a balance, not too few and not too many insurers.
- NHIS & decentralization – funding is through one ministry (finance) so no fragmentation

R. But different purchasers will remain, causing fragmentation of the purchasing function. Besides the roles of local governments.

#### Page 33

- Stewardship – Supervision and administration of the scheme should be well streamlined to avoid shifting of health care funding i.e. budget funding vs scheme funding. Clearly spell out what the scheme offers.
- Public health activities - Preventive and public health services will still be provided by the government.

Page 34

- Current government policies will be used to fight any corruption tendencies

Page 35 - Organizational issues of the NHIS

- Recommendations made have been noted.

Page 36

Implementation Plan

- Benefits package need to be re designed.
- HR, Material resources and financial resources – Government has plans underway of sourcing funding for these resources.

P4H	Retreat	
<b>ORGANISATIONAL ISSUES OF THE NHIS</b>		
1. Preconditions Political Will/ Conesus Economic  . Labor Market    . Issues of 11 <sup>th</sup> August 09	<p>There is to an extent – e.g Inter-ministerial Committee till Executive Pronouncement -Sensitivity to stakeholders, business cost. Corruption, Public confidence. Awareness of community</p> <p>Labor Market constraint-Lack of Minimum wage Existing negotiated Union/e MPLOYER medical Schemes Additional labor Cost to the employers Why start with Public Servants? Why not start with the informal and rural community All above need consensus</p> <p>In agreement</p>	
2.IMPLEMENTATION PLAN- P 29		
a)Prerequisite  . What are these steps referred to as having not been implemented?	<p>Universal Coverage: Review attainment of universal coverage strategy, e,g Community based HI as the thrust – which might influence the design period of 15 years</p>	
3. Financial resources Govt Budget not captured in the bill	Agree	
4. Human Resource for NHI	Solicit for assistance of successful African countries in areas resource mobilization, NHI, Human, Resource at the onset	
5. Material resources	<p>Agree</p> <p>Changed from Zonal and Regional</p>	
6. GRADUAL IMPLEMENTATION –P 31		
. Agree with P4H's functions	Support and encourage CBHI as the Engine for driving NHI, resources committed for this purpose to include the poor	
7. Management System	Agree	

External & Internal	
8. CONSTRAINT	Agree other than Actuarial forecasting
9. PROJECT ORGANISATION, SETTING PRIORITIES AND MILESTONES	
Macro & Micro and the milestones	Agree
VII. FINANCIAL ASPECTS AND FISCAL SPACE – P 34	
1. HI Context	Again Support of NHIS to the CBHI for social solidarity
2. Community involvement	Should be adopted
3. Household out of Pocket	Address the plight of employees and employers costs Prevent increase in OOP expenditure at all costs
4. Absorptive Capacity-	As per HR recommendations
5. Benefit Incidence -	Studies need to ensure these observations if they were not taken care of by earlier studies.
6. Health System efficiency – P- 37	Concur with need to create efficiencies in the health system
VIII. QUALITY ASSURANCE –P 38	
1. External Mechanism	Agree except with comment that Uganda lacks planning regulations Accreditation committee to work with Medical Council – should be debated
2. Internal Mechanism	As above
3. Accreditation	As above
IX. LEGAL	
The draft Bill	Need discussion of the comments at an appropriate time before the next P4H visit



## Annex 10

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