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National Health Insurance in Uganda: Examining the Proposed Design and its Implications for Successful Implementation

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1. INTRODUCTION

In 2015, the Health sector in Uganda committed to Universal Health Coverage (UHC) in as demonstrated in its Health Sector Development Plan (HSDP) 2015 - 2020. The HSDP's goal is accelerating progress towards universal health coverage of good quality health and related services to promote health and productive lives (MoH 2015). The HSDP and health financing strategy 2015-2025 (Ministry of Health 2016) emphasise the need to improve access to healthcare services according to need, while at the same time limiting exposure to financial risk for those who seek care. These aspirations require a well-functioning health systems which can be strengthened through implementation of the appropriate health financing reforms. The National Health Insurance System (NHIS) has been proposed as one of the vehicles towards UHC in Uganda (Government Of Uganda 2015). The NHIS has for sometime been on the policy and political[1] agenda (Basaza et al. 2013) but little success has been made to actualize it. Evidence from the African region indicates that national health insurance (NHI) may not necessarily lead to achieving of UHC objectives at least in the medium term (Lagomarsino et al. 2012; Abiiro & Mcintyre 2013). The Success of NHI reforms is contingent on design and implementation approaches adopted (Carrin et al. 2008). The overall purpose of this paper is explore the merits and demerits of the proposed NHI model and consider implications for successful implementation of NHI scheme in Uganda.

2. BACKGROUND

2.1 General Context

Uganda has one of the fastest growing populations in the world at population growth rate of 3% per year. The projected population in 2018 was about 40 million people (Uganda Bureau of Statistics 2016a). Uganda also has one of the youngest populations in the world with about 80% of the population under 30 years. This creates a high dependency ratio of 105 (Ref). The total fertility rate is about 5.4 children per woman in child bearing age (Uganda Bureau of Statistics 2016b). In terms of economic growth, Uganda is still a low income country with GDP per capita of US$ 1,713.90 (PPP). The poverty rate improved from 49 % in 1995 to 19.7% in 2011 but slightly increased to 21.4% in 2016(UBOS 2016). The level of informality in the Ugandan economy is very high with 80% of the Ugandan population involved in the informal sector business (UBOS 2016).

2.2 Health System Context

Progress has been achieved in the health system over the last three decades. For instance, the life expectancy has improved from 49 to 62 years from 1990 to 2016 (REF). Maternal mortality improved from 435 in 2011 to 336 per 100,000 women in 2016 (Uganda Bureau of Statistics 2016b). The child mortality also reduced from 133 to 49 per 1,000 live births between 1990 and 2016 (ibid). However, several challenges still exist in regards to inadequate, maldistributed and poorly motivated health workforce, inadequate and inequitable financing as well suboptimal functionality of other systems components(MOH; et al. 2012). Physical access stands at 82.5% while service coverage index is at 44% (target 80%) as per the global UHC monitoring report of 2017 (REF). The health system faces a double burden of both communicable and non-communicable diseases. Disparities in access and health outcomes exist. Fig 1 below show disparities in nutrition outcomes along geographical and health income dimensions. Fig 2 shows inequities in access to health services along wealth levels.

1 For example as part of two manifestos of the National Resistance Movement Government

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2.3 Health Expenditure Profile

Table 1 below compares health financing indicators in Uganda to the average for Sub Saharan Africa (SSA) region. Uganda's health expenditure as a percentage of GDP is higher at 7.3% compared to 5.35 % while the current health expenditure per capita (purchasing power parity) is much lower at USD 138.5 compared to USD198.7 for SSA. The incidence of people incurring very high health expenditures or becoming poor due to accessing healthcare is higher in Uganda compared to average for the SSA region.

According to recent midterm review of the health sector development plan (MOH 2018),inequalities still exist along wealth, residence and region as regards a) access to services such as antenatal care and b) health outcomes such as nutritional status and infant mortality.

Table 1: Health financing indicators in Uganda compared to the average for Sub Saharan Africa (SSA) region.

Indicators	Uganda	SSA
Current health expenditure (CHE) as % of GDP	**7.3**	**5.35**
CHE per capita in PPP	**138.5**	**198.7**
**Catastrophic health expenditure: >25% (%)	**2.57**	**2.54**
**Catastrophic health expenditure: > 10% (%)	**12.0**	**10.27**
**Impoverishment (1.90/d) %	**2.68**	**1.64**
OOP as % of CHE	**47**	**36.25**

Source: Computations from WHO Health Expenditure Database, 2015 & UHC Monitoring report 2017

Government funding for health is still suboptimal. External sources and household contributions constitute 47% and 40 % of the total health expenditure (see fig 3 below).

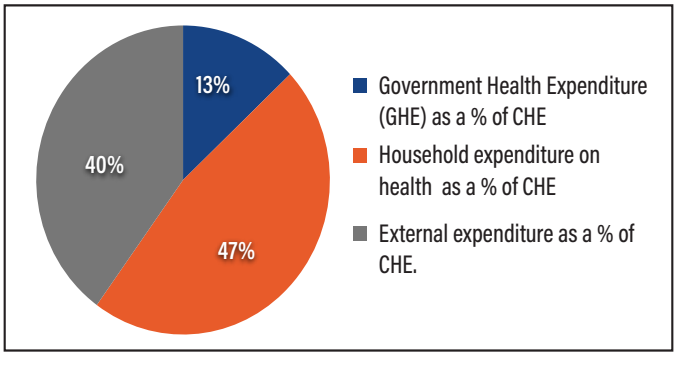

Fig 3: Contribution to current health expenditure. Source: WHO Health Expenditure Database, 2015

2.4 Fiscal Space for Health

The prospective outlook for health financing in Uganda is generally positive. The Ugandan economy grew at a rate of 5.0% in 2018 and is projected to increase to 7.35% in 2022 (REF). The prospects of mining oil offers a potential financial windfall for the country. Although government's income through taxes has been gradually increasing overtime, the tax base is still low at 14.2% of the GDP. The general assumption is that increase in GDP growth will translate into higher government revenues and general government expenditure on health. However, competing expenditure priorities for government such as debt repayment and infrastructure development may undermine these expectations.

Table 2: Uganda's Fiscal capacity to support NHIS Implementation

Indicators	Status (Ref year)	Comment
Real GDP Growth	5.0 (2018)	7.35% (2022)
Gov't spending as % of GDP:	6.08 (2016)	Lowest in last 50 yrs
Tax as % of GDP	14.2 (2017)	Gradual increase
Government debt % GDP:	41.5 (2018)	46.6 (2020)
Debt repayment as % of Gov't expenditure	12.1 (2018)	2nd after transport
Debt repayment as % of Gov't revenues	13.3 (2016)	10.7 (2015)
Government Health expenditure (GHE) as % of General government expenditure	6 (2018)	Decline over last 5 yrs

3. OBJECTIVES & QUESTION

The paper aims at achieving the following objectives

1) To assess the merits and demerits of the NHI model proposed in Uganda.
2) To explore the key considerations for successful initiation and implementation of NHI reforms.
3) To make recommendations on way forward.

Overall guiding question

What are main merits and demerits of the proposed National Health Insurance (NHI) model and their implications for successful NHI implementation in Uganda?

4. METHODOLOGY

The synthesis of available evidence was the main approach used. Accordingly, desk reviews of relevant documents/literature was conducted. Recently published literature and relevant documents (including databases) on health financing, health insurance in Uganda and beyond were reviewed. A critical assessment of the findings informed the policy options recommended.

5. KEY FINDINGS

5.1 Rolling Out NHIS in Uganda

The efforts to initiate the NHIS in Uganda are well articulated in the Health Financing Strategy (2015/16 - 2024/25). NHIS is considered as a resource mobilisation tool, a means to advance UHC objectives of equity, quality and access, and as instrument to operationalize the public-private partnership (PPP) in health policy. The objective of the NHIS is to ensure financial access to affordable, equitable and quality health services progressively to all residents in an efficient manner. The NHIS Bill highlights provisions for enrolment into the NHIS as well as the administrative and management arrangement to make it work.

In the next section, we characterize the perspectives that on the merits and demerits of the proposed NHIS model in the country. The arguments put forward highlight opportunities and reservations about introducing NHIS in general and as pertains the issues with the currently proposed design that the require attention for successful adoption and implementation of the NHIS in the country.

5.2 Advancing "Leaving no one behind" agenda

The major strengths of NHIS is its being premised on the principles of sharing risks and resources for health advancement and social protection objectives. The ultimate goal of establishing of single pool of resources where the rich subsidize for the poor and the healthy subsidize for the sick is based on fundamental principles of solidarity. They also fit within the current widely accepted discourse on the Sustainable Development Goal (SDG) era under the mantra of "leaving no one behind". Health insurance has the potential to reduce financial catastrophe associated with accessing health care and contributes to reducing impoverishment associated with having to pay for health care at the point of use.

However, the possibility of the proposed design for the NHIS to cater for everyone is less satisfactory. Three tenets have been proposed under the NHIS namely- 1) the Social Health Insurance (SHI) for the formal sector employees, 2) the Community Based Health Insurance (CBHI) Schemes for the informal sector and the 3) private health insurance (PHI) scheme. The formal sector employees in government and in big organisations with over 250 employees will be expected to join the SHI automatically. The following issues stand out:

Whereas enrolment of the formal sector employees is relatively straight forward, the involvement of a large informal sector as well as "indigents" into the proposed NHIS is less articulated. There is need to clarify mechanisms to bring the poor early into the NHIS as ignoring them will perpetuate inequities and may not be tenable politically. Having separate fund pools risks creating a multiple-tier health system in Uganda and would institutionalise inequities in the country. This reality is evident in Rwanda and Thailand. For instance, in Rwanda, the benefit package of the formal sector scheme is 100 times more lucrative than that of the mutuelles (the CBHIs)(Ssennyonjo 2013).

Current international evidence shows that nature of premiums could be a hindrance to enrolment into insurance schemes. Also, the mechanisms to ensure equitable contributions usually inbuilt into insurance designs such as graduated contributions and exemptions are hard to fully implement. For instance, the NHIS schemes in Ghana and Rwanda had proposed differentiated contribution based on income but these were in practice replaced by flat contributions (Ssennyonjo 2013). The mechanisms for targeting exemptions are problematic especially as regards choosing the optimal approach to assess eligibility.

a) Furthermore, the financial barriers to healthcare access are not limited to the costs of health care. There are costs related to transport and living expense of care attendants. The current bill is silent on these issues. The above reasons could make some people less likely to not access healthcare services even when enrolled into the NHIS.

b) For the Ugandan NHIS to advance national solidarity and strengthen the social fabric of the country, revision of the NHIS Bill clauses on membership is needed. The bill proposes four beneficiaries per enrollee. This does not take into account the size of most Ugandan families where every woman on average has six (6) children. The current criteria also does not consider the many extended families in Uganda. These issues are likely to hinder buy in and enrolment into the schemes.

5.3 Resource mobilisation and financial sustainability.

The current NHIS Bill proposed a 4% deduction from an employee's salary and a 1% contribution from the employer. The table (2) below shows the projected financial estimates for the medium term.

Table 3: The projected NHIS financial estimates for the medium term

	Source of Funds/Projected Expenditure (Billion UGX)				
	Financial Year	**2018/19**	**2019/20**	**2020/21**	**2021/22**
	GoU Employer Contribution (1%)	27.100	28.800	30.500	32.400
	GoU Employee contribution (4%)	108.500	115.100	122.060	129.451
	Private Employers contributions (1%)	422.832	479.575	543.935	616.931
	Private Employees contributions (4%)	1,691.325	1,918.301	2,175.738	2467.722
	Pensioner's contributions (1%)	0.027	0.028	0.031	0.032
	Self Employed enrolling 20% annually each contributing Shs 100,000/=	129.6540	272.273	428.831	600.363
	Enrolling 10% indigents annually	-	-	-	-
	Projected Total Revenue	**2,379.44**	**2,814.08**	**3,301.10**	**3,846.90**
	Medical expenditure	1,935.932	2,274.682	2,737.170	3,512.479
	Administration costs (2%) revenue	47.590	56.281	66.022	76.937
	Projected Total expenditure	**1,983.522**	**2,330.962**	**2,803.193**	**3,589.416**
	Reserve/Balance carried forward	**395.9160**	**483.1150**	**497.9020**	**257.4830**

Source: MoFPED, Certificate of Financial Implications 2017

Concerning financial sustainability of the NHIS, the following issues need attention:

1) From the certificate of financial implication, the average annual revenue from all sources will be **Shs 3,085.38bn** while the average reserve is estimated at **Shs 408.604bn** over the first four years of implementation. This is an encouraging prospect. However, the assumptions underlying these projections need to be interrogated further. For instance, the flat contribution of 100,000/= per self employed might not be realistic. The projection of private contributions also seems ambitious without the infrastructure and creating the necessary demand for insurance. There are also unanswered questions about the scope of benefit package as a very generous benefit package may escalate the medical expenses and erode the envisaged reserves.

2) The average salary of government employee in Uganda is 1,500,000 (~500 USD). At 4% and 1% percentage deductions, would yield USD20 and USD 5 respectively. Considering the NHIS Bill proposes for four (4) beneficiaries per employee, this translates into 6.25 USD per capita. This is too low compared to USD 84 needed per capita to attain UHC objectives2.

3) The NHIS envisages several funding sources including employee and employer contributions for the SHI component as well as individual contribution for CBHI component. Deductions that are proportional to salary levels are fairer compared to flat deductions. However, deducting higher percentages for higher income brackets would be more equitable. Fairness in taxation is a basis to inherently imbedding fairness into the NHI design.

4) The other drivers of sustainability relate to the probable administrative and operational costs under the scheme. The choice of provider and the payment method are important policy levers for cost containment. Current evidence shows that the operational costs of delivering services in Uganda is higher in private facilities than public facilities. This require attention to purchasing arrangements especially provider payment methods to use. Using fee for service payment method encourages utilisation but creates incentives for over service provision and cost escalations. The alternative provider payment method being considered in the NHIS is diagnostic related groupings (DRGs). These require implementation capacity and support systems that are not currently well developed in Uganda. Systems to monitor fraud by both the users and service providers will be critical for the sustainability of the scheme.

5) The NHIS phasing approach also has implications for sustainability. Starting with small SHI pool is unlikely to generate resource volumes adequate to cause health system improvements that would in turn encourage others to join the NHI. Poor quality of service provided to NHIS enrollees will deter new or renewal of subscriptions.

2 WHO estimates

5.4 The envisaged (Health) systems improvements and readiness concerns

1) *Inducing Quality Improvements*: One of the major presumption is that NHI will lead to improvements in service delivery. One school of thought is that insurance would inspire Ugandans to actively advocate for better service quality albeit with political implications. Competition among providers is argued to lead to internal adjustments within the service delivery networks as provider would have to attract clients to earn big from NHI. These will lead to quality improvement and efficiency gains through improvements in managerial and technical efficiency in service delivery. For instance, NHIS might lead to the harmonisation of prices between public and private sectors. In addition, competition with private sector would induce relevant improvements in government facilities to ensure their eligibility for NHIS. Improvements might arise from enhanced absorption of health workers.

2) One counterview is that the success of NHIS rests on having in the first place good quality service provision. Systems functionality is considered a precondition that should be built in advance of NHI roll out. Health facility accreditation for instance has been proposed such that the NHIS contracts only the providers with adequate levels of functionality. The perceived poor quality of health services in the country is likely to induce resentment from the population.

3) Some Insurance proponents argue that NHIS will be an important tool to take advantage of the large private sector in the country especially where the government facilities do not exist. The assurance of revenue from NHIS funds would spur growth of the private sector.

4) However, some actors counter argue that engaging the private sector would reduce the resources available to government facilities that are already inadequately funded. There are concerns that NHIS is a ploy to facilitate the proliferation of market based health systems in contrast to strong public health systems.

5) There are arguments that NHIS advances pro-curative healthcare system. The crucial shortcoming of the proposed bill is insufficient attention to preventive services. The provider payment arrangements are configured to reward provision of curative services. It is not clear how health promotion and disease prevention efforts such as those at community level will be resourced or invested in. For instance, funding treatment of diseases related to smoking instead or reducing cigarrete smoking is arguably not sustainable.

6) Existing shortages with the health system such as human resources remain prevalent in the current context. These will likely continue to constrain the health systems performance. Effective coverage of health services under NHI requires production of adequate numbers and their increased attraction and retention into the health system.

5.5 Broader system readiness

a) **ICT Infrastructure:** The role of IT is prominent in the operations of the NHIS. It is important that national ID registration systems have been established over the last decade. However, a large IT infrastructure will be needed to manage registration of clients, monitoring service utilisation or provision and supporting the claims and payment processes. Investments into this portfolio has not received due attention in the current discussions on NHI roll out.

b) **Unclear roles of district and sub national structures**

The NHI Bill proposed several management structures such as the Health Insurance Management Authority and tribunals for addressing complaints. A multisectoral board was also proposed. However, how the NHIS will function within a decentralized political administrative system in the country remains to be explained. The proposed NHIS model does not pronounce itself on the contractual arrangements with the district structures that are responsible for the service delivery under the Local Government Act (LGA) of Uganda. In light of this, aligning the NHIS Bill with the legal provisions of LGA will be critical. Broader questions about trust and accountability for the funds under NHIS stakeholders remain likely constraints to NHI implementation.

6. KEY IMPLICATIONS AND RECOMMENDATIONS

1) The design arrangement proposed under the NHIS does not guarantee the attainment of the 'leave no one behind' agenda. Uganda's ultimate goal should be to move from separate fragmented schemes towards a single national health insurance fund. The architects should develop guidelines that address the major implementation concerns such as enrolment of the large families prevalent among Ugandan communities.

2) The NHIS discussions are silent about how to manage the transition from the current 'free healthcare' policy to premium based insurance systems. There are considerable issues such as whether government should continue funding public health interventions and prevention activities or subject these to outsourcing from private

service providers. The proportion of government funding to be channeled to NHIS and the potential repercussions should be interrogated further.

3) NHI roll out requires implementation capacity and support systems that are not currently well developed in Uganda. For example, systems to monitor fraud by both the users and service providers will be critical for the sustainability of the scheme. Investment in these structures should be of utmost priority.

4) Introducing NHIS requires revision or alignment with certain legal frameworks such as labour laws and Local Government act. There is need to ensure that roles of mandated actor such as local governments are well clarified and communicated.

5) The proponents of NHI portray it as panacea to the health systems challenges in Uganda. What particular system challenge that NHIS could address is not well articulated. This requires moderation of expectations about what NHI can and could do. It is important to undertake adequate stakeholders engagement to ensure that expectations are managed harmoniously.

6) The current roll out plan envisages starting NHIS with concurrent reform in the three domains of health financing namely revenue mobilisation, pooling resources and purchasing services. This paper notes that there are considerable political economy concerns related to introducing premium contribution in a 'free health care" setting. We also note that poor health system functioning will undermine the buy in into the NHI. It is therefore recommended that the first phase of NHIS focuses on improving the supply side by investing in boosting the functionality of health facilities and strengthening capacity for buying results (strategic purchasing). This would allow reinforcement of support systems such as claims processing, patient data management systems and simulations. Charging premiums will be easier to 'sale' when clients are convinced of quality of the services provided.

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